Torbay and South Devon
NHS Foundation Trust

Council of Governors Meeting

Public

Date: Wednesday 12 August 2026

Time: 2.00 pm – 3.45 pm

Venue: Boardroom and via Microsoft Teams

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Public Council of Governors

Board Room / Microsoft Teams

Torbay and South Devon NHS Foundation Trust

12/08/2026 14:00 - 15:45

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	7.3 Date of Next Meeting - 2.00 pm, Wednesday 11 November 2026			

Torbay and South Devon NHS Foundation Trust

MINUTES OF THE PUBLIC COG MEETING

HELD ON 13 MAY 2026 AT 2 PM

VIA MS TEAMS

Governors Present:			
Sarah Adams	SA	Olivia Bath	OB
Joanna Bowtell	JB	Dave Cawley	DC
Loveday Densham	LD	Eileen Engelmann	EE
Alison Meadows	AM	John Nutley	JN
Jake O'Donovan	JOD	Maroria Oroko	MO
Vicki Payne-Cater	VPC	Andrew Stilliard	AS
Lee Thomas	LT	Vincent Williams	VW
Louise Winfield	LW	Radia Woodbridge	RW
Ged Yardy	GY		

Directors Present:		
Martin Beaman	Chair	MB
Liz Edwards- Smith	Non-Executive Director	LES
Mark Greaves	Non-Executive Director	MG
Paul Richards	Senior Independent Director/Non-Executive Director	PR
Chris Saxby	Non-Executive Director	CS
Sam Wadham- Sharpe	Deputy Chief Operating Officer	SWS
Kate Lissett	Chief Medical Officer	KL
Nicola McMinn	Chief Nurse	NM
Jane Harris	Deputy Director / Head of Strategy & Development	JH

In Attendance:

Sarah Fox	Corporate Governance Manager	SF
Kirsty Hewett	Membership Manager	KH

( ) denotes attendance for part of the meeting.

1.	**OPENING MATTERS**
1.1	**Chair's welcome and apologies** The Chair welcomed those present to the Council of Governors meeting and to his first meeting as Chair. Introductions were made for the benefit of new governors. Apologies for absence were received from the following Governors: Michael Joyce, Andrew Postlethwaite and Julie Spinks.

	Apologies were also received from: Joe Teape, Chief Executive Officer; Cath Parnell, Chief of Staff; Simon Tapley, Chief Strategy and Planning Officer; James Corrigan, Chief Finance Officer; and Jess Piper, Chief People Officer.
1.2	**Declarations of Interest** No declarations of interest were received.
2.	**BUSINESS FROM PREVIOUS COUNCIL OF GOVERNORS MEETINGS**
2.1	**Minutes of the meetings held on 11 February 2026** The Council of Governors approved the minutes of the Council of Governors meeting held on 11 February 2026.
2.2	**Matters arising not covered elsewhere on the agenda** There were no matters arising.
3.	**BUSINESS REPORTS**
3.1.	**Chair's Report** The Chair reported the following: • Chris Balch had stood down as Chair as his term of office had ended, and Robert Williams had moved roles to the ICB and was therefore no longer working for the Trust • Attended the Medicine for Members event • Participated in the Medical Staff Committee alongside the Chief Medical Officer • Took part in interviews for the Emergency Department Consultant position
3.2	**Lead Governor Update** The Interim Lead Governor reported the following: • Took on the role of Acting Lead Governor following the resignation of the Lead Governor in February • Attended the Governor induction, which included IT support • The Governor Nomination and Remuneration Committee participated in the interview process for Non-Executive Director appointments • Constituency groups appointed lead representatives, including Staff Governors • Supported the Medicine for Members event • Worked with Jane Harris to agree the theme for the next Annual Members' Meeting • Was involved in the 15 Steps walkaround • Encouraged all Governors to take the opportunity to observe Board sub-committees or join the Membership Committee • Requested that NEDs attend constituency meetings • Collaborated with Royal Devon University Hospital Governors
3.3	**Chief Executive's Report** Kate Lissett, Chief Medical Officer (CMO), presented the Chief Executive's Report, which had been circulated with the agenda pack prior to the meeting.

Q. *Do we currently not have a deputy CEO?*

A. CEO is investigating a different model of distributing the role across executives.

Key points from the report included:

Executive summary

- Operational issues
- Industrial action

Performance dashboard

- Medicine and emergency and urgent care
- Planned care, cancer, diagnostics and support services
- Families and communities
- Leadership updates

Strategic priorities and risks

- Electronic patient record go-live
- Cardiology
- Capital investment programme
- Development of Gadeon House for the long-term provision of Cellular Pathology Services
- Voluntary redundancy scheme
- Planning for 2026/27
- Segmentation and league table publication
- Provider capability ratings published
- Recovery Support Programme
- Maternity Incentive Scheme – Year 7
- Corridor Care action plan
- Adult Social Care in Torbay
- Children and Family Health Devon (CFHD)

System and partnership updates

- Local Government Review – organisational response to consultation
- South West Peninsula Cluster Integrated Care Board – Executive Appointments Update
- Five year commissioning plan for Devon (One Plan)
- Changes to clinical referral guideline model for Long COVID
- Our Torbay and South Devon NHS Charity
- Our Leagues of Friends
- MP engagement
- Governor engagement
- Look forward

The CMO highlighted the challenges of increased demand in the Emergency Department, long waiting times, the Epic EPR rollout, reductions in elective waiting lists, and the impact of industrial action. There was also discussion about digital patient records (MYCARE/MyChart), the request for Governors to download the app, primary care access, and oncology patient flow.

Governors reported positive experiences with the MYCARE app, highlighting its enhanced efficiency, particularly in delivering faster results.

<u>Governor questions and responses</u>

	Q. *Regarding the EPIC implementation, it has been observed that GP practices are finding it challenging to access, for example, blood results, whereas patients can do so through the MYCARE app. It was suggested that GPs did not have access. Please could you provide assurance about the communication of, for example, blood results and a timeline for when all results will be communicated to GP practices so that GPs can continue to support their patients?* A. General Practices were able to access the EPIC electronic patient record system; however, access was dependent on practices completing the necessary registration process and undertaking the appropriate training. This ensured that GPs and practice staff were fully equipped to utilise the system effectively and securely, supporting continuity of care for their patients. PR noted that the NHS app was being used alongside MY CARE. The overall objective was to transition towards the NHS app as the primary platform, rather than relying on individual system-specific applications such as MY CARE. It was important to advise patients carefully, as many functions would increasingly be managed through the NHS app. Therefore, it was recommended that patients use the NHS app, in addition to MY CARE, to streamline their healthcare experience. GY notified the CMO about a recent chemotherapy patient's experience in the Emergency Department and requested a written response to provide reassurance to the patient. **Action: Oncology patient communication** Kate was to work with Consultant Louise Medley, Associate Medical Director, to draft a reassuring paragraph for oncology patients experiencing Emergency Department delays, for sharing with Governors for constituent feedback. **Action:** Outstanding Governor questions would be answered formally outside the meeting. 1. *Land at Edginswell was recently purchased to turn into a much needed additional staff car park. When will these parking spaces come online, how many will there be, and will there be a park and ride facility?* 2. *Staff report they are having to pay £9 to park at Totnes when attending for clinical commitments. They are then required to fill out forms on a regular basis if they are to recoup the costs. This seems excessively onerous – can the system be streamlined* Q. Regarding the *Cardiology item, there were no planned changes to the location or configuration of cardiology services at Torbay or elsewhere in Devon as part of this programme. Could you confirm that nothing would be moved from this site over the next five years?* A. The five-year plan referred to was the ICB's plan. The reassurance being sought should therefore have been directed to the ICB, because it was the ICB five-year plan. The Chair and CMO were committed to ensuring that the patients of Torbay and South Devon continued to receive effective care. JH confirmed willingness to serve as a conduit for communicating questions from CoG to the ICB. Additionally, JH supplemented the Chair's comments by noting that, should any proposal be introduced to alter services, statutory engagement and public consultation would be required. During this process, the Trust would collaborate with Governors and the broader community to ensure that all perspectives were represented. While it was not possible to guarantee specific outcomes regarding

	future services, the Trust was committed to an open and transparent process, providing everyone with the opportunity to contribute their views. Governors sought additional positive news stories to provide a counterbalance to recent negative media reports. Q. *Were positive news stories being shared with the media?* A. The team regularly pitched stories to the media each week and maintained a steady pipeline of potential features. However, media outlets did not always accept the stories, as they had to align with their own editorial agendas. Additionally, negative coverage could often generate more engagement than positive news. Any further questions regarding the report were to be emailed to the FT Office.
3.4	**Membership Committee Chair's Report** The Membership Committee Chair reported the following: Key points included: • Governors were encouraged to communicate with members of the public • The Exeter RDUH Lead Governor had been invited to a Membership Committee meeting to share collaborative ideas • Membership had decreased since the previous quarter • The team was working with Jane Harris to plan the Annual Members' Meeting theme • The next Medicine for Members event was scheduled for October • All Governors were encouraged to join local patient participation groups and promote Trust membership to increase engagement and numbers
3.5	**Governor Observer (GO) Exception Report** None.
4.	**GOVERNANCE**
4.1	**Governance Report** The CoG received and noted the Governance Report presented by Corporate Governance Manager, circulated with the agenda pack prior to the meeting. Key highlights were: • New Chair • Governor update • Lead Governor and Deputy Lead Governor – **Voted and Approved** • Governor Observers – **Approved** • Governor Register of Interests • Governor Nomination and Remuneration Committee Members • Council of Governors Self-Assessment Feedback **Action: Governor Self-Assessment Feedback** Governors from each constituency were asked to review the self-assessment feedback and propose actions for improvement at the next Council of Governors meeting. • Governor Question Protocol - **Approved**

	• Draft CoG and Board of Directors' Policy of Engagement for Serious Concerns - **Approved**
4.2	**Lead / Deputy Governor Election** The Chair notified the Council of Governors that two governors had expressed their interest in serving as Lead Governor. Both candidates had the opportunity to present their statement for the role, after which a vote took place.
4.2.1	**Lead Governor Candidates:** ➢ **Dave Cawley** ➢ **Loveday Densham**
4.2.2	**Deputy Lead Governor – no election only one candidate: Mike Joyce** The Chair notified the Council of Governors that Mike Joyce was the sole candidate for the position of Deputy Lead Governor, and as a result, he was appointed to this role.
4.3	**Governor re-elections** Jane Harris, Deputy Director and Head of Strategy and Development, provided the CoG with an update following the King's Speech, noting that no specific time frame had been established for the standing down of Governor roles. Considering this uncertainty, the report set out a recommendation for the Governors to proceed with an additional election due to the number of current vacancies. This measure was advised to ensure that the Council could continue to conduct its business effectively and maintain operational continuity. Following a comprehensive evaluation of the advantages and disadvantages, the Governors reached consensus to proceed with a by-election. **CoG approved the recommendation to run an additional election.** **Action Governor Elections** - Sarah and Kirsty to initiate an additional election round for public governors, ensuring full representation and following mandated election rules.
5.	**UPDATE ON QUALITY ACCOUNT**
5.1	**Draft Quality Account 2025/26 and 2026/27 priorities** The Chief Nurse presented the draft Quality Account to the CoG, which had been circulated with the agenda prior to the meeting. Key highlights were: • The deadline was 26 June; NHS England would conduct a review at that time • The Lead Governor to finalise the statement for inclusion in the report **– Action** • Quality Objectives for 2025/2026 • Quality Priorities for 2026/27: The three key areas of focus are corridor care, stakeholder engagement, and digital technology Q. *In my experience of representing the people of South Hams, the public have not had a good experience with patient complaints. Has a full evaluation of PALS been undertaken? If so, I would like to see the results, as my experience has been that the service has not performed well.*

	A. Following the recent restructure and formation of a new team, complaint numbers had decreased. The objective was to proactively address concerns before they escalated to formal complaints. To support this goal, a new initiative had been introduced: Matron's open sessions, which provided a visible, accessible platform for patients and relatives to express their concerns directly. **Action:** The Patient Experience Annual Report would be circulated. **Action: Quality Account Stakeholder Engagement** Nicola was to work with Kirsty to obtain Governor sign-off for the Quality Account and ensure wider stakeholder engagement before publication. **Action:** The Quality presentation would be circulated after the meeting. Louise Winfield left the meeting at 3.55 pm.
6.	**GOVERNOR ENGAGEMENT**
6.1	**NED / Governor visits process** The Chair provided a verbal update to the Council of Governors regarding the proposed process for Governor visits. The plan specified that one or two governors would be selected to participate in site visits each month, accompanied by a Non-Executive Director. Insights and feedback from these visits would be presented to the Council of Governors, particularly when areas were identified as not functioning effectively. **Governor Visit Process** Sam Wadham-Sharpe would approve monthly NED visits to departments, with attendance restricted to one or two Governors (if appropriate) per visit to ensure effective participation.
6.2	**Governor Communications Log** CoG received the Governor Communications Log circulated with the agenda pack. Governors were reminded of the need to follow the agreed process to raise a Governor Question.
7.	**INFORMATION ITEMS**
7.1	**Governor Calendar and Information Items** The CoG received the Governor Information items circulated with the agenda pack.
8.	**CLOSING MATTERS**
8.1	**Any Other Business** • Lead Governor Election – Loveday Densham was elected to the position. • Sarah Adams, Lee Thomas and Vincent Williams left the meeting.
8.2	**Close of meeting** The Chair declared the meeting closed at 4.00 pm.
	Dates of Next Meeting: Wednesday 12 August 2026 at 2.00pm

Council of Governors
Action Tracker

No	Action	Lead	Due date	Update	Status
Meeting held on 11 February 2026					
12.	**Cardiology Update -** JT to email the ICB regarding the CoG concerns.	**JT**	**May 26**		**Closed**
13.	**DCG Report -** Governors would be emailed by FT Office to request preferences for Lead and Deputy Lead Governor.	**KH**	**May 26**	**Vote at May meeting**	**Closed**
14.	**DCG Report -** Governors would be emailed by the FT Office to request two Governor observers for each committee.	**KH**	**May 26**		**Closed**
15.	**Code of Conduct -** A Governor - led meeting to be arranged for Governors to agree the Code of Conduct process and review the draft document	**KH**	**May 26**		**Closed**
Meeting held on 13 May 2026					
16.	**Chief Executive's Report** **Oncology Patient Communication** - Kate to collaborate with Consultant Louise Medley, Associate Medical Director to draft a reassuring paragraph for oncology patients facing ED challenges, to be shared with governors for constituent feedback	**KL**	**Aug 26**	**Governor questions are answered and logged on question log**	**Closed**

17.	**Chief Executive's Report** Governor questions would be formally answered outside of the meeting: 1. *Land at Edginswell was recently purchased to turn into a much needed additional staff car park. When will these parking spaces come online, how many will there be, and will there be a park and ride facility?* 2. *Staff report they are having to pay £9 to park at Totnes when attending for clinical commitments. They are then required to fill out forms on a regular basis if they are to recoup the costs. This seems excessively onerous – can the system be streamlined*		**Aug 26**	**Governor questions are answered and logged on question log**	**Closed**
18.	**Governor re-elections** Sarah and Kirsty to initiate an additional election round for public governors, ensuring full representation and following mandated election rules.	**SF/KH**	**Aug 26**		**Closed**
19.	**Draft Quality Account 2025/26 and 2026/27 priorities** Circulate Patient Experience Annual Report	**SF/NM**	**Aug 26**		**Closed**

20.	**Draft Quality Account 2025/26 and 2026/27 priorities** Quality Account Stakeholder Engagement - Nicola to work with Kirsty to obtain governor sign-off for the quality account and ensure wider stakeholder engagement before publication.	**KH/NM/LD**	**Aug 26**		**Closed**
21.	**Draft Quality Account 2025/26 and 2026/27 priorities** To circulate Quality presentation after the meeting.? Post action	**KH**	**Aug 26**		**Closed**
Meeting held on 12 August 2026					

Actions recorded on this tracker should be grouped by meeting, with progress monitored at each subsequent meeting. Once complete the item should be marked as grey, noted by the Committee as complete and removed from the log before the following that meeting to ensure a proper auditable trail.

Torbay and South Devon NHS Foundation Trust

Council of Governors

Chief Executive's Report

Date of meeting	Date report produced
12.08.2026	04.08.2026

Author(s)		Report approved by	
Name and title:	Jane Harris, Director of Communications	**Name and title:**	Joe Teape, Chief Executive
Phone:		**Date:**	05.08.2026
Email:	jane.harris18@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

This report provides the Council of Governors with assurance on the handling of sensitive, confidential, and/or complex issues that affect our ability to achieve our vision and purpose.

Appendices

Committees that have previously discussed/agreed the report, and outcomes of that discussion

N/A

Key recommendations and actions requested

The Council of Governors is asked to receive and note the Chief Executive's report.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?
This report provides the Council of Governors with assurance on the handling of sensitive, confidential, and/or complex issues that affect our ability to achieve our vision and purpose.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	1
Quality of services provided	2
Sustainable and efficient use of resources	3

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality, Safety and Patient Experience	
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	

Risk

Risks lodged on Datix:

External Standards affected by this report and associated risks
Care Quality Commission Terms of authorisation, NHS England licence, and regulations National policy, guidance

Report to the Council of Governors

Chief Executive Officer update

Executive summary

1. Over recent months we have continued to operate under sustained operational pressure, particularly across urgent and emergency care, driven by demand running well above plan, high bed occupancy and ongoing challenges with patient flow through the acute hospital. Periods of prolonged hot weather have added to these pressures, increasing demand for some services while also creating additional challenges for colleagues working in parts of our estate that are less well suited to extreme temperatures. Throughout this period, our teams have continued to provide high-quality care for the people we serve.

2. We are beginning to see progress in several important areas. Community waiting lists have reduced significantly, diagnostic waiting times have improved, and community services continue to support people to remain independent and receive care closer to home. Reablement outcomes remain particularly strong, helping people regain independence and reducing the need for ongoing long-term support.

3. We continue to invest in the services and facilities our communities need for the future. During this period, we have seen the formal opening of The Harbour frailty service, the continued development of our surgical and emergency care facilities, investment in robotic surgery, and improvements to maternity care environments. These developments support our ambition to provide modern, high-quality care closer to home wherever possible.

4. Our electronic patient record programme remains a major transformational opportunity. Following successful implementation at Torbay and South Devon earlier this year and go-live at University Hospitals Plymouth in July, all three Devon acute trusts are now working on a common platform. This creates new opportunities to improve information sharing, support more integrated care and improve the experience of patients receiving care across organisational boundaries.

5. Our greatest strength continues to be our people. Throughout this report are examples of colleagues demonstrating professionalism, compassion and innovation, often in challenging circumstances. Alongside this, we have strengthened our executive and non-executive leadership teams and continue to invest in developing a strong and stable organisation for the future.

6. Above all, our focus remains firmly on the 300,000 people we serve and the 6,500 colleagues who work across our organisation. Whether through improving access to care, strengthening neighbourhood services, investing in our estate, developing partnerships or supporting our workforce, our aim is to create the conditions for healthier, more independent communities while ensuring Torbay and South Devon remains a great place to receive care and a great place to work

Performance dashboard

Medicine and emergency and urgent care

Emergency and urgent care

7. Demand across urgent and emergency care continues to exceed historical levels, placing sustained pressure on both our Emergency Department and inpatient bed capacity. During June, more than 11,200 people accessed our urgent care services, an increase of almost 4% compared to the same month last year, while ambulance arrivals increased by more than 7% year-on-year.

8. Performance against key national standards remains challenging. Emergency Department four-hour performance was 65.2% in June, reflecting the continued impact of high demand, pressures on patient flow and wider constraints across the health and care system.

9. Ambulance handover performance remains a particular focus. Average handover times increased to just over 49 minutes during June, with 779 handovers taking longer than 45 minutes, underlining the importance of improving flow through the hospital and reducing delays for patients.

10. High bed occupancy and the continued use of escalation capacity have created ongoing operational challenges. Although there has been some improvement in the number of patients experiencing extended waits in escalation areas, pressures remain significant and continue to require close management and whole-system action

11. Our priority remains improving flow through the hospital so patients can be assessed, admitted or discharged more quickly and safely. This includes a continued focus on discharge planning, reducing avoidable delays, embedding improvements following implementation of our electronic patient record, and taking forward actions identified through our recent corridor care improvement programme

Planned care, cancer, diagnostics and support services

Planned care

12. Planned care performance remains below the trajectories we have set ourselves, reflecting ongoing recovery following implementation of our electronic patient record and the continued impact of workforce and capacity constraints in several specialties. However, activity has now stabilised, and recovery plans are in place across key services.

13. The overall waiting list reduced slightly during June to 34,661 patients. However, long waits remain concentrated within a small number of specialties, particularly Trauma and Orthopaedics, Ophthalmology and Ear, Nose and Throat services. At the end of June, 169 patients were waiting more than 65 weeks for treatment and 1,088 patients were waiting more than 52 weeks

14. Long waiting times remain concentrated in a small number of specialties, particularly Trauma and Orthopaedics, Ophthalmology and Ear, Nose and Throat services. Reducing the longest waits continues to be a priority, supported by targeted additional activity and focused clinical oversight

15. As anticipated, implementation of Epic affected activity levels across several services. Clinical teams have appropriately prioritised patient safety and service stabilisation during the early post-go-live period, with activity levels now being restored in a controlled way.

16. Recovery plans include a combination of theatre productivity improvements, additional outpatient and surgical activity, recruitment to agreed posts and ongoing optimisation of Epic workflows. These actions are intended to support sustainable improvements in access while maintaining high standards of quality and safety

Cancer services

17. Cancer performance continues to present a mixed picture. Performance against the Faster Diagnosis Standard improved during June to 57.1%, reflecting work to streamline pathways and increase capacity in key areas.

18. However, performance against the 62-day cancer standard remains below the required level at 50.6%. Delays continue to be concentrated within a small number of specialties, particularly where capacity challenges and the impact of recovery activity following implementation of our electronic patient record have affected performance.

19. Targeted actions are in place, including additional clinical capacity, insourcing and pathway improvements. Cancer patients continue to be prioritised during periods of operational pressure and recovery plans remain under close clinical and executive oversight.

20. The results of the annual National Cancer Patient Experience Survey have been published and for the fourth year in a row we have been ranked as among the best performing trusts for patient satisfaction and experience.

21. The survey, which is overseen by a National Cancer Patient Experience Advisory Group and commissioned by NHS England, involved 130 NHS trusts across England. Nationally, more than 64,000 people responded to the survey, including 493 people who received cancer-related treatment at Torbay and South Devon from April to June 2025. This represented a 60% response rate, significantly higher than the national response rate of 48%.

22. All our results were above the expected performance levels and achieved above-expected results in more than 20 areas, particularly around communication, information, personalised care, care planning and emotional support.

23. Patients highly value the compassion of staff, the accessibility of their clinical teams and the quality of information they receive.

24. Report headlines:
    - cancer patients rate Torbay and South Devon are among the best in the country, with no areas performing below expectations
    - outstanding patient experience recognised across diagnosis, treatment, support and communication

- strongest-ever results in key areas of cancer care, with more than 20 measures performing above expected national standards
- no scores fell below the expected range
- we achieved an overall cancer care rating of 9.1/10 from patients
- 91% of patients said their care team worked well together and 91% rated administration of care as good or very good.

25. Areas for improvement. Although no areas were below the expected range, and patients report excellent hospital care, many felt the support from primary care following diagnosis could be strengthened.

GP and primary care support
- only 44% of patients felt they received the help or support they needed from their GP practice after diagnosis.
- only 29% reported having a cancer care review with their GP practice.

After care
- only 34% felt they could get enough emotional support at home after treatment, and the transition from treatment to living beyond cancer remains a challenge for many patients.

Diagnostics

26. Diagnostic waiting times remain challenging in a number of services where demand continues to exceed available capacity. Diagnostic performance remains a key enabler for both elective recovery and cancer pathways.

27. There have been encouraging signs of improvement, with the proportion of patients waiting more than six weeks for a diagnostic test reducing from 34.6% in May to 24.1% in June. This reflects the impact of additional capacity and focused recovery work across a number of services.

28. Recovery plans continue to focus on increasing capacity, recruitment, service redesign and use of external support where appropriate. Improving access to diagnostics remains an important component of our wider performance improvement programme.

29. Improving access to diagnostics is essential to reducing waiting times elsewhere in the system and remains a priority within our wider performance and recovery plans.

Families and communities

30. Our community and family services continue to play a vital role in supporting people to live well in their communities. Demand across community services remains high, with progress being made in some areas of waiting times and flow, while challenges remain in others.

31. Urgent community response services continue to support people safely at home, working closely with system partners to avoid unnecessary hospital admissions. The service responds within two hours to over 77% of referrals, supporting people to remain at home. So far this year (since 01 April) the service has handled 315 referrals demonstrating sustained demand for rapid community support.

32. Community waiting lists reduced from 7,890 to 5,349 during the year, improving access to services.

33. Our community hospitals have cared for 2,478 people year to date while maintaining strong discharge performance, with almost half of patients discharged before noon.

34. Reablement services continue to deliver excellent outcomes, with 95.7% of people completing reablement not requiring ongoing long-term social care support.

35. Our rapid response service and reablement services for Torbay which are based at St Edmunds Community Health Centre in Torquay have been rated as good in all five domains by the CQC – you can read the detail on the CQC website here: St Edmunds - Care Quality Commission

36. We marked the official opening of The Harbour at Newton Abbot Hospital in June. The Harbour began operating in autumn 2025 and has been developed in phases, with the formal opening recognising the expansion of the service and the difference it is now making for patients and our communities.

37. The service brings together a multidisciplinary team to support older people living with frailty, providing joined-up assessment, diagnostics and treatment. This includes same day emergency care (SDEC), alongside the Harbour at Home service, enabling patients to be assessed and treated quickly and, where possible, supported to remain in their own home.

38. Since opening, the service has received over 850 referrals, with more than half of patients supported to remain at home as a safe alternative to hospital admission. The Harbour is a practical example of our strategy to support people to live well in their neighbourhoods. It brings care closer to home, strengthens how we respond to urgent need outside hospital, and enables teams to work together around the person in a more coordinated way. This approach is improving patient experience and independence while also reducing avoidable hospital attendance and supporting better flow through our acute services.

39. We remain committed to working with local authority, voluntary sector and system partners to improve access, reduce inequalities and support people and families in their own communities.

Maternity services

40. We welcome the recent publication of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (Ockenden Report) and Amos Review and would like to recognise the experiences of the women, babies and families who contributed to it across England. It is right that these experiences are listened to and acted upon.

41. The safety, wellbeing and experience of women, birthing people and babies is our absolute priority for our maternity services and a key priority for our organisation.

42. Most births in our care are safe, and our teams work with professionalism, compassion and dedication every day.

43. We are working closely with our colleagues, Devon's Maternity and Neonatal Voices Partnership and our partners at NHS England and NHS Devon to continually review and improve our maternity and neonatal services, and people's experiences of them.

44. Following the regional insights visit on 11 June, it was acknowledged that our maternity and neonatal services are working collaboratively, and that it was clear we are listening to both our service users and our staff.

45. We will carefully review the findings and recommendations of these reports and, where needed, take further action to strengthen the care we provide. We would encourage any family who has concerns about their care to come forward so we can listen, support them and learn.

Leadership updates

46. I want to formally confirm to governors the recent leadership and Board changes.

47. Following a robust recruitment process we have appointed Sam Wadham-Sharpe to be our substantive Chief Operating Officer.

48. Sam has been our Interim Chief Operating Officer since May and joined us as Deputy Chief Operating Officer last year. I am delighted we have appointed Sam to this role and I know he will be a fantastic appointment for our organisation. In his last year working here he has gained the confidence of our teams across our services, has a visible presence, and brings with him wide experience of operational management.

49. I have also now concluded the review of the Executive Team and new portfolios are in place. It is pleasing to have a stable team in place with shared values and commitment to Torbay and South Devon and I am confident that our renewed Executive Team will provide the expertise we need alongside caring and compassionate leadership during a time of significant change.

50. We have concluded a successful recruitment to our Non-Executive Director vacancies and have appointed three new Non-Executive Directors and one Associate Non-Executive Director.

51. I was delighted to welcome Arwel Griffith and Joanna (Jo) Webber to their first Board of Directors meeting. They started in post on 01 July 2026. As did Debbie Stark, our new Associate Non-Executive Director.

52. We have also appointed Karen Cox as a Non-Executive Director and Karen will start on 01 September 2026 to support an effective handover before Paul Richards leaves us in the autumn after many years dedicated service.

53. These new appointments alongside our renewed and substantive executive team will provide us with a timely opportunity to refresh our Board development programme and this work will be taken forward via the Chief People Officer and our Chair.

Strategic priorities and risks

Segmentation and league table publication

54. The Quarter 4 NHS Oversight Framework (NOF) segmentation data was published online earlier this month. These relate to performance across January to March 2026.

55. In this latest update, we have moved from Segment 3 to Segment 4, with a score of 2.60, having previously been between 2.41 and 2.53. This is reflected in our league table position, where we have moved from 83rd to 102nd (joint) out of 134 trusts.

56. This is not the position we wanted to be in, particularly given the progress we have been making.

57. Overall, our position remains mixed. We are performing strongly on effectiveness and experience and are above average on patient safety. However, we are below average on workforce and low performing on finance and access.

58. The finance position reflects the loss of deficit support funding at system level and the impact this has had on us.

59. More broadly, the data reinforces a consistent set of areas where we need to improve, particularly access to care, workforce experience and some aspects of patient safety.

60. This reflects both the pressure our services are under, and the experience people are having when accessing care which is presently longer than we are aiming for. Recovery planning is underway for these areas.

NHS England Oversight

61. Since the last Council of Governors meeting we have attended Torbay and South Devon NHS Foundation Trust Provider Oversight Meeting which was held on 07 July 2026 and was chaired by Mark Cooke, Managing Director for NHS England South West.

62. We provided an updated to NHS England on:
    - our governance changes and Board Assurance
    - Adult social care transition
    - performance, finance and workforce
    - urgent and emergency care, corridor care and support requirements
    - estates, fire safety and other risks
    - Epic implementation, reporting and National Oversight Framework

Annual report and accounts 2025/26

63. The annual report and accounts for 2025/26 were formally laid before Parliament on 13 July 2026 and have been uploaded to our website.

64. The fully designed annual report summary for 2025/26 is also now on our website and is being shared with colleagues, governors and our wider communities: Our year, your trust - Annual Report Summary 2025-26.

Annual Members Meeting 2026

65. As agreed by the Membership Committee, this year's Annual Members' Meeting is being arranged as a community health event, rather than a stand-alone annual meeting. The formal statutory meeting will remain an important part of the event, but it will sit within a wider programme of community engagement, health promotion and involvement activity designed to support our vision of supporting every person, family and community we serve to live well.

66. Planning is progressing well. The event will take place on 30 September at Paignton Library and a site visit involving key colleagues was undertaken last week to review venue arrangements, accessibility, marketplace space, registration, audio-visual requirements and the overall visitor experience. We are working closely with Healthwatch throughout the planning process and are keen to ensure the event feels welcoming, inclusive and community-focused.

67. Alongside the formal Annual Members' Meeting, we are developing a programme of strategy engagement activity, providing members and local residents with opportunities to contribute directly to the development of our neighbourhood work. Governors are also exploring opportunities to host their own engagement session as part of the event.

68. A key feature of the day will be a community health marketplace. Interest has been strong and the event is increasingly becoming a partnership opportunity rather than simply a showcase for our services. Alongside teams from Torbay and South Devon NHS Foundation Trust, we are working with partners including Devon Partnership NHS Trust, Children and Family Health
Devon and public health as well as VCSE partners.

69. The market place offer includes NHS Health Checks, community services, a range of cancer screening, community dental services and oral health, The Harbour frailty service, our sensory team, TALKWORKS and Your Health Torbay. The emphasis is on interaction rather than information alone, with opportunities for attendees to take part in health checks, healthy ageing and living well activities and have conversations with frontline teams about the support available within their communities.

70. We recognise that attendance is likely to include people with a wide range of interests and views, including campaign groups, elected representatives, members of the public and partner organisations. Our approach is not to avoid challenge, but to create an event that is accessible and engaging. Success will be measured by whether attendees feel welcomed, listened to and able to engage constructively with services, governors and Board members.

71. Detailed planning is underway around public questions, governor and Board briefings, social media monitoring, media handling, escalation routes and support arrangements on the day. The intention is to ensure we can respond confidently and consistently should contentious issues arise, while maintaining the open and accountable approach expected of a Foundation Trust.

72. Overall, the event provides an important opportunity to demonstrate public accountability, support development of our future strategy, strengthen relationships with our communities and showcase the contribution that our

services, partners and the voluntary sector make to supporting people to live well across Torbay and South Devon.

Board meetings in public

73. At our Board meeting in public on 02 July, the Board approved a 12-month pilot rotating our Board meetings in public across our five localities. The pilot will begin with the November 2026 Board meeting in public and we will share details of where this meeting will take place in due course.

74. All our Board meetings in public are now accessible online and we are proactively seeking questions from the public in advance of each meeting through our social media channels and a local media release.

Capital investment programme

75. We have continued to make good progress across our capital programme, with several significant developments now complete or moving forward. These investments are improving our estate and creating better environments for care, but they are only possible because services have continued to operate throughout.

76. In Emergency Department, theatres, OMFS and maternity in particular, colleagues have continued to deliver care in the middle of major building work. That has required flexibility, resilience and a willingness to adapt day-to-day, and it is important to recognise the impact that has had on teams as well as the difference it has made for patients.

77. We welcomed the Lord Lieutenant of Devon to formally open our redeveloped Emergency Department at Torbay Hospital in early June, following a £14.2 million investment. Delivered in phases to allow services to continue, the redevelopment has created a significantly improved environment for patients arriving in urgent need - with more space, better flow through the department, and greater privacy and dignity.

78. Colleagues have worked through a prolonged period of disruption to make this possible, often adapting to temporary layouts and changing pathways. The benefit of that is now visible in a calmer, more organised environment, where patients can be assessed more quickly and teams can work more effectively together.

79. Work continues to refurbish and modernise our day theatre facilities, alongside the expansion of oral and maxillofacial surgery (OMFS). This is creating the capacity and environment needed to support more complex surgical work and reduce waiting times.

80. The new day theatre came into operation on 20 July and the refurbishment of existing day theatres are now underway.

81. Alongside this, the planned relocation of the Surgical Admissions Unit will improve how patients move through planned care. Patients will experience a more straightforward journey ahead of surgery, with less unnecessary movement around the Torbay Hospital site, while teams are better able to manage flow through theatres.

82. As with the Emergency Department, this work is taking place while services remain fully operational. Theatre and surgical teams are managing significant change alongside maintaining activity, which has required careful coordination and sustained effort over a long period.

83. The refurbishment of our cardiac catheter laboratories remains a key clinical priority. These facilities are central to the diagnosis and treatment of heart disease, including in emergency situations.

84. Work is progressing to modernise these facilities so that they remain safe, reliable and able to meet growing demand. This is essential to ensuring we can continue to provide timely access to life-saving interventions for our population.

85. We are continuing to invest in our maternity services to improve the environment in which care is provided. Enhancements to maternity triage on level 4 of the women's health unit at Torbay Hospital are supporting women to be assessed more quickly and in the right setting when they arrive.

86. I was pleased to join colleagues earlier this month for the opening of The Cove, our newly refurbished birthing suite at Torbay Hospital. The project has delivered a new birthing pool, a fully refurbished birth environment and, importantly, a dedicated accessible wet room, helping to ensure that more women can benefit from water-based pain relief and birthing options regardless of their mobility needs or disability.

87. The name was chosen in partnership with women and families through our Maternity and Neonatal Voices Partnership, reflecting the importance of involving people in shaping the services they use.

88. The Cove forms part of a wider programme of investment in our maternity services. Alongside the refurbishment, we have recently completed enhancements to maternity triage, creating additional assessment space and improving the environment in which women are received, assessed and supported when they arrive at hospital. These improvements are helping us provide care in a more timely, responsive and dignified way.

89. At a time when many families across Torbay and South Devon continue to experience significant health inequalities and financial pressures, it is important that we continue to invest in services that improve access, experience and outcomes for all women and babies. I am particularly pleased that The Cove has already welcomed its first babies, providing families with a high-quality environment at one of the most important moments in their lives.

Investing in our future – robotic surgery

90. We have taken the decision to invest £1.3 million in robotic surgery at Torbay Hospital, following a six-month clinical pilot which enabled our teams to evaluate the technology in practice before any commitment to purchase.

91. During this pilot, our surgical teams achieved a number of significant milestones, including what is believed to be the world's first robotic day case colectomy (bowel cancer removal), with the patient able to return home on the same day.

92. The team has since delivered further milestones, including what is understood to be the UK's first day case high anterior resection, as well as the first day case intra-thoracic stomach repair in the South West demonstrating how more complex procedures can be delivered safely without an overnight stay.

93. This investment will enable more people to benefit from minimally invasive surgery closer to home, with the potential for reduced post-operative pain, shorter recovery times and a quicker return to normal activities. It also supports the continued development of day surgery, allowing an increasing range of procedures to be undertaken safely as day cases.

94. The decision to invest has been supported by a £500,000 contribution from Torbay Hospital League of Friends, reflecting their long-standing commitment to improving care for local people. This represents an important step in the ongoing development of our surgical services, building on 30 years of day surgery at Torbay and ensuring that patients continue to benefit from advances in clinical practice and technology.

Level 2 Business Continuity incident, Torbay Hospital

95. On 28 July, we declared a Level 2 Business Continuity incident following the failure of an ageing electrical component within a distribution board at Torbay Hospital. The fault triggered a fire alarm and resulted in a temporary loss of power affecting the discharge lounge, decant area and several outpatient services.

96. Established fire safety and business continuity arrangements were implemented immediately. Patients, visitors and colleagues were safely evacuated from the affected area, the fire service attended promptly to support the response and services were progressively restored throughout the afternoon. The incident was stood down later the same day following the completion of repair works and restoration of power.

97. A multidisciplinary debrief undertaken the following day highlighted the professionalism and coordination demonstrated by colleagues across the organisation. More than 100 people, including both bedded and ambulatory patients, were evacuated safely within minutes. Participants reflected positively on the contribution made by recent training, regular exercises and clear command structures, which helped ensure a calm, coordinated and effective response.

98. The debrief also identified further opportunities for improvement, particularly around communication, accountability arrangements during evacuations and emergency lighting. These actions are now being incorporated into ongoing emergency preparedness and fire safety work.

99. While the circumstances were very different from those considered at our recent Fire Risk Summit, the incident provided a valuable real-world test of our emergency response arrangements. It demonstrated the importance of regular training, clear leadership and effective multi-agency working, while also highlighting the challenges associated with maintaining services within an ageing estate.

100. I have written to colleagues involved in the response to thank them for their professionalism and to recognise the way they worked together to ensure the safety of patients, visitors and staff throughout the incident.

Fire Safety – Hetherington Centre

101. As part of our ongoing programme of estate safety reviews, a recent walkaround of the Hetherington Centre identified a number of opportunities to strengthen fire safety arrangements. In particular, concerns were raised about corridor congestion in some areas and the potential impact this could have on the movement of beds, wheelchairs and evacuation equipment in an emergency.

102. While no incident or safety event had occurred, immediate action was taken with local teams to improve corridor clearance, review storage arrangements and remove unnecessary equipment. This work has helped ensure that escape routes and fire compartment areas remain clear and can function as intended should an evacuation ever be required.

103. Alongside these practical improvements, colleagues are reviewing local fire safety documentation, evacuation plans and risk assessments to ensure that arrangements remain up to date and well understood. Additional Fire and Evacuation Warden training is also being planned, together with a further multidisciplinary safety walkaround to identify any remaining opportunities for improvement.

104. Governors will recognise a common theme running through a number of the issues highlighted in this report. While much attention is understandably focused on major risks and significant estate challenges, maintaining safe environments also depends on the consistent management of day-to-day risks.

105. The work undertaken at the Hetherington Centre demonstrates the importance of proactively identifying and addressing concerns before they result in an incident and reflects our continuing commitment to safety, prevention and learning across all of our sites.

Teignmouth hospital site

106. On the evening of 03 August, a fire occurred at the former nurses' home building (Teignmouth Clinic Building) on the Teignmouth Hospital site. Emergency services attended promptly and the fire was contained. No patients, colleagues or members of the public were injured.

107. The incident did not affect the operation of hospital services, which have continued as planned. However, governors will appreciate that any emergency incident on a healthcare site can be unsettling for colleagues, patients, visitors and partner organisations based there.

108. Since the incident, we have been working closely with Devon and Somerset Fire and Rescue Service and Devon and Cornwall Police as investigations continue. At this stage, the cause of the fire remains subject to investigation and it would therefore be inappropriate to speculate on the circumstances.

109. Alongside supporting the emergency response and investigation, our focus has been on supporting colleagues and partners based at the site. Senior leaders visited Teignmouth Hospital the following morning to meet with colleagues, answer questions and understand any immediate concerns. We have also communicated directly with colleagues, partner organisations, including Volunteering in Health and Devon County Council, recognising the impact that incidents of this nature can have on the wider community.

110. The incident has also provided an opportunity to reinforce fire safety messages across our estate. Teams are being encouraged to review storage areas and remove unnecessary combustible materials, sometimes referred to as ‘fire loading’, to help reduce risk and support safe environments across our sites.

111. While the incident itself remains under investigation, the response demonstrated the effectiveness of established emergency arrangements and the strong partnership working between NHS colleagues, emergency services and other organisations. As with all incidents, we will review any lessons identified and incorporate these into our ongoing fire safety and emergency preparedness work.

Lord Mann review

112. Following publication of the Lord Mann Review earlier this summer and the letter to NHS leaders, I can confirm that we have submitted our response through the national reporting portal ahead of the deadline, confirming "yes" to both questions relating to adoption of the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility.

113. This aligns with our ongoing commitment to creating a great place to work where everyone feels they belong, is valued and respected, and is able to do their best work.

114. As I have share with Governors previously, we know there are significant cultural and morale challenges that we need to address across our organisation. While adopting these definitions is an important step, it is only one element of the wider work required to strengthen our culture, improve colleagues' experience and ensure Torbay and South Devon is an inclusive, compassionate and supportive place to work for everyone.

115. We have also begun discussions with system partners about adopting a more consistent public-facing approach to tackling abuse, aggression, discrimination and harassment.

116. This includes support for a *That's Not Okay* digital and print campaign which has been developed by Royal Devon using insight and data from real feedback and is being adopted across NHS organisations in Devon.

117. Over time, colleagues, patients and visitors can expect to see a more consistent approach across acute, community and mental health services, with aspirations to extend this further into primary care, community pharmacy and optician services as discussions progress.

Development of Gadeon House for the long-term provision of Cellular Pathology Services.

118. Work continues to progress the proposed relocation of Cellular Pathology services to Gadeon House, alongside development of the associated business case and supporting documentation.

119. As part of our ongoing engagement programme, a dedicated questions and answers resource has been published on our website addressing the issues and concerns most frequently raised through social media and stakeholder feedback.

120. The Pathology service is currently preparing its annual GP user survey, which is undertaken as part of the service's quality and accreditation requirements.

121. Additional questions have been included to understand awareness of the proposed changes, gather feedback from primary care colleagues and identify issues that should inform future engagement activity and communications. In addition, we will be asking GPs if they would like to receive regular dedicated updates on the programme.

122. Alongside development of the cellular pathology business case, colleagues from Torbay and South Devon and Royal Devon continue to work together to explore whether the co-location of pathology services at Gadeon House could create opportunities for future collaboration across cellular pathology, blood sciences and microbiology. This is being overseen by our joint Programme Board. The work is testing whether there is a robust clinical, operational and financial case for any future joint working and will help inform future decisions. No decisions have been taken at this stage.

Commitment to our Armed Forces community

123. In June we formally re-signed the Armed Forces Covenant on behalf of our organisation, reaffirming our commitment to those who serve or have served in the Armed Forces, and their families.

124. This recognises the important role that Armed Forces personnel, veterans and reservists play in our communities and our responsibility as a local employer and provider of health and care services to ensure they are treated fairly and are not disadvantaged in accessing employment or care.

125. The Covenant also reflects the contribution made by colleagues within our organisation who have links to the Armed Forces, including those currently serving as reservists. Our Armed Forces Community Staff Network plays a significant role in supporting colleagues, raising awareness and helping to shape how we continue to develop this work. Through this commitment, we will continue to strengthen the support we offer as an employer, including promoting flexible working where appropriate and recognising the specific needs of this group.

126. Re-signing the Covenant builds on the work already underway across our organisation and with system partners and reinforces our ongoing commitment to supporting Armed Forces communities across Torbay and South Devon.

Colleague response to incident on Torquay seafront

127. Following the serious seafront incident in Torbay during July, I would like to recognise the actions of two of our doctors, Dr Aslam and Dr Win Aung, who

responded as first responders at the scene and provided urgent clinical care in very challenging circumstances.

128. Dr Aslam and Dr Aung delivered care under significant pressure, including managing the situation while interventions were being challenged by members of the public. Their actions reflected the professionalism, compassion and clinical expertise demonstrated by our colleagues every day, often in circumstances that attract little public attention.

129. On 29 July, I met with both doctors to thank them personally for their response and to recognise the impact the incident had on them and their colleagues.

130. We have also supported arrangements for Steve Darling MP to visit the team and meet the doctors.

131. This incident serves as a powerful reminder of the contribution our colleagues make not only within our hospitals, community and adult social care services, but also when responding to emergencies in our communities.

Environmental Health rating back to 5*s at Torbay Hospital

132. In May I advised that Environmental Health (EH) had completed their annual inspection of food hygiene standards across Torbay Hospital and awarded a 4-star rating (previously 5).

133. The feedback mainly related to the fabric and condition of parts of the kitchen environment, along with some minor weekend processes around allergen information.

134. I am pleased to confirm that the feedback has been addressed, we have been reassessed and we have returned to a 5-star rating.

Mortuary Board Assurance Statement

135. In response to the NHS England letter dated 26 June 2026 concerning post-death care and mortuary oversight, the Board delegated authority to the Quality and People Committee to consider and approve the Trust's Board Assurance Statement, enabling submission by the national deadline of 31 July 2026.

136. At its meeting on 28 July 2026, the Committee reviewed the supporting gap analysis, action plan and mitigations, and approved the assurance statement.

137. The completed statement was submitted to NHS England on 29 July 2026. The assurance confirmed that appropriate governance and oversight arrangements are in place, with time-limited actions identified to address the remaining areas requiring further improvement.

System and partnership updates

MY CARE and NHS App now linked

138. Patients can now use their NHS App login to access MY CARE with a new secure link between the two online services.

139. MY CARE is the online service that allows patients to see detailed information about their hospital and specialist community care using a mobile device or

computer. The NHS App gives you information about your GP care, repeat prescriptions, vaccinations and NHS 111 online.

140. The new developments are linking these two systems, so that it's easier for patients to keep track of their care. There are two ways that patients can do this:
- Patients can log in to MY CARE by using their NHS App login details. They can go to the MY CARE log in page and then select 'Continue to NHS login'.
- Patients can click on their hospital and specialist community care appointments* in the NHS App to transfer to MY CARE and get more detailed information.

141. Patients will be asked to give consent for their NHS login details to be shared with the MY CARE team to log in to or set up a MY CARE account.

142. Thanks to the Devon-wide electronic patient record that has been introduced this year, these new developments will apply to patients attending appointments at Royal Devon University Healthcare NHS Foundation Trust and University Hospitals Plymouth NHS Trust.

143. A common request from patients has been to integrate MY CARE with the NHS app. The MY CARE team has worked with software provider Epic and NHS England to find a secure way to join up the two systems, making it simpler for patients.

144. *Please note, most appointments will be available in the NHS App, but some may not be visible. Please consult MY CARE for a full view of upcoming appointments.

One Devon EPR go live

145. On 23 July 2026 University Hospitals Plymouth successfully went live with the Epic electronic patient record (EPR), bringing our organisation, UHP and the Royal Devon onto the same system. This represents a major step forward for the One Devon EPR programme and creates new opportunities to improve how care is delivered, strengthen collaboration and support more integrated care across the county.

146. Benefits for patients and colleagues include:
- improved information sharing between organisations, supporting safer and more joined up clinical decision-making.
- better continuity of care for patients receiving treatment from more than one provider.
- reduced duplication of assessments and tests.
- more consistent clinical processes and ways of working across Devon.
- a stronger digital foundation to support any future service transformation.

147. As part of the go-live learning, we have strengthened our protocols for site team / on-call team coordination to ensure any technical issues with the potential to affect patient care across the three trusts are identified and resolved as quickly as possible.

148. The UHP go-live has also demonstrated the strength of the One Devon EPR partnership. A number of our Epic Super Users volunteered to support colleagues during the go-live period, sharing the expertise, insight and practical experience

gained through our own Epic implementation at Easter. Their contribution reflects the collaborative culture that underpins this programme and we'd like to extend sincere thanks to everyone who gave their time and expertise to support UHP and help ensure a successful transition for colleagues and patients.

South Local Care Partnership

149. Governors will be aware of ongoing work across Torbay and South Devon to develop Integrated Neighbourhood Teams, bringing health, social care, voluntary sector and community partners together to provide more joined-up support for local people.

150. At its July meeting, the South Local Care Partnership approved a new Action Learning Set approach designed to help partners turn shared ambitions into practical action. The approach will provide a structured way for organisations to come together around common challenges, learn from each other's experience and accelerate delivery of agreed neighbourhood priorities.

151. The proposal was presented by our Chief Strategy and Planning Officer, Simon Tapley, who emphasised that while we have helped develop the approach, its success depends on collective ownership across all partner organisations rather than leadership by any one organisation.

152. The framework is intended to support delivery of locally agreed priorities, strengthen relationships between organisations and provide a practical mechanism for sharing learning and spreading successful approaches more quickly across neighbourhood teams.

153. This is a positive example of the role we are increasingly playing within the wider health and care system: helping to bring partners together, supporting collaboration and contributing expertise, while ensuring that solutions are developed and owned collectively. It also reflects growing momentum behind neighbourhood working across Torbay and South Devon and a shared commitment to improving outcomes through closer partnership working.

154. The next phase of work will focus on agreeing the initial areas of focus and putting the arrangements into practice with partners across the South locality.

Strengthening partnership working

155. We have been advised of plans by NHS Devon and NHS Cornwall and Isles of Scilly ICBs to strengthen place-based partnership working across the integrated care system. The proposals are intended to provide greater clarity, consistency and responsiveness at Place level through strengthened leadership arrangements, closer alignment between NHS organisations and local authorities, stronger representation within local governance structures and an increased focus on neighbourhood-based models of care.

156. In practical terms, this will include the introduction of Executive Place Leads, who will provide continuity of leadership at Place level, represent local priorities within ICB decision-making, support alignment between NHS and local authority plans, promote opportunities for joint working and co-commissioning, and provide senior leadership across place-based partnerships involving NHS providers, local government, primary care and the voluntary sector.

157. For Torbay Place, Simon Gittoes-Davies, Chief Finance Officer for NHS Devon, will assume the Executive Lead role. Recruitment is underway to appoint a dedicated Torbay Place Director, with the appointment expected to be completed during summer 2026. The wider arrangements will see Peter Collins, Chief Population Health Officer, supported by John Groom as Place Director, leading the Devon Place arrangements, Libby Ryan-Davies, Chief Strategic Commissioning and Planning Officer, working alongside Chris Morley as Place Director for Plymouth and Susan Bracefield, Chief Clinical Officer, acting as Executive Lead for Cornwall and the Isles of Scilly, with recruitment also underway to appoint a Place Director.

158. The proposals reflect the growing emphasis on place-based leadership within the NHS and are closely aligned to the neighbourhood health agenda and the development of integrated neighbourhood teams. We will continue to engage with partners as the arrangements are implemented and consider how they can support our ambitions for neighbourhood working, prevention and stronger collaboration across health, care, local authority and voluntary sector organisations.

NHS England Quality Strategy

159. NHS England published its new Quality Strategy for NHS-funded care in England on 14 July. The strategy is published on behalf of the National Quality Board and provides a structured approach to making quality the organising principle of NHS-funded care in England during the next decade by setting out a shared approach across three interdependent domains: safety, effectiveness and experience.

160. Our Chief Nurse is benchmarking the strategy and will present her findings and recommendations to the Quality and People Committee.

Our Torbay and South Devon NHS Charity

161. Our Charity continues to make a visible difference for patients, colleagues and communities across Torbay and South Devon, thanks to the generosity of local supporters, volunteers, fundraisers and staff. From funding equipment and environmental improvements to supporting wellbeing and patient experience initiatives, charitable donations continue to help us go beyond what can be funded through NHS budgets alone.

162. One of the most visible recent examples is the new volunteer wall of fame on Level 2 at Torbay Hospital. Supported by our Charity and local corporate sponsor MW Benney, the installation celebrates our volunteers award winner and finalists while also recognising the important role volunteers play in supporting patients, visitors and colleagues every day.

163. Our Charity has also continued to work in partnership with local organisations to improve patient outcomes and quality of care. Selected as the President's Charity of the Year by Torquay Rotary, this is funding equipment including Blazepods and other resources designed to help tackle hospital-acquired deconditioning by encouraging mobility, activity and rehabilitation for patients during their hospital stay. Torquay Rotary have also continued to support the baby loss (Heartease) garden at Torbay Hospital, planting an alpine flower bed, installing additional seating and creating a calm, reflective and supportive space for families.

164. Through our "Helping to Make Things Better" grants programme, our Charity continues to support ideas generated by colleagues working closest to patients. Current projects include the creation of a dedicated seating area within the main entrance of Torbay Hospital, incorporating more accessible high-backed seating with armrests to better support patients and visitors with mobility needs while they wait for transport home. The programme is also funding artwork within the Community Dental Service waiting area at Castle Circus, helping create a calmer environment and reduce anxiety for people attending appointments.

165. In July, the Chair and I were delighted to celebrate our Charity's 30th anniversary with a special cream tea event attended by more than 60 supporters. The event provided an opportunity to thank the individuals, families, volunteers, community groups and organisations whose generosity has helped improve care and experience for patients over the past three decades.

166. Support from our communities remains strong. Recent fundraising activity has included events organised by Stover Golf Club, a sponsored skydive undertaken by colleague Lynn Wilson and a cycle challenge completed by NHS colleague Simon Clark, who cycled between three Devon hospitals to raise funds for local NHS charities.

167. Looking ahead, we have secured three places in next year's London Marathon, providing another exciting opportunity for colleagues and members of the public to support local NHS services.

168. Every donation, fundraising challenge and act of support helps our Charity make a difference. Whether improving clinical environments, supporting rehabilitation, creating more inclusive facilities or helping colleagues bring forward ideas that enhance patient care, our Charity continues to demonstrate the remarkable impact that local communities can have on local healthcare.

Our Leagues of Friends

169. We continue to work closely with our eight Leagues of Friends (Ashburton, Brixham, Dawlish, Newton Abbot, Paignton, Teignmouth, Torbay and Totnes) and are deeply grateful for their support and donations.

170. I met with representatives from Torbay, Totnes, Paignton, Dawlish and Newton Abbot Leagues of Friends as well as our Torbay Hospital Nurses League in June where we had a constructive conversation about the opportunities and challenges we all face and how we can work better together to maximise the benefits for local people and our communities.

MP engagement

171. I continue to prioritise regular engagement with our local Members of Parliament to ensure they are fully briefed on our challenges, priorities, and the needs of our communities. I meet regularly with Caroline Voaden MP and Steve Darling MP while Martin Wrigley MP prefers a more ad hoc arrangement, but I always make sure to respond to his calls and emails in a timely manner. These meetings provide valuable opportunities to discuss local health and care issues, share updates on our strategic plans, and listen to the concerns and ideas of our elected representatives. Maintaining these open lines of communication helps us to advocate effectively for our services and the people we serve and ensures that

our MPs are well informed and able to support our work at both local and national levels.

Governor engagement

172. I continue to visit as many areas of the wider organisation as I can and it continues to be extremely valuable for me to listen to all of our teams and their views of our services and what it is like to work here. The feedback from my visits is being used to inform our planning going forward and the detail of actions we will take will be included in our plan for better care.

173. During my visits over recent months, a consistent theme has been the tension colleagues are experiencing between increasing demand, constrained resources and the desire to continue to provide high-quality, compassionate care, alongside a strong sense of pride in their teams and professionalism.

174. My twice-monthly Meet Joe sessions continue to provide a valuable opportunity to hear directly from colleagues and in the past three months I appreciated being able to hear directly from colleagues at Totnes Hospital, Union House (Torquay), Dawlish Hospital and Torbay Hospital. I also hosted an online Meet Joe and joined, participated in and/or hosted our corporate induction and Trust Talk in the past two months.

175. During the past three months I have spent time with our volunteers at our annual volunteer thank you event, hosted our annual our people celebration event and our latest quarterly our people awards breakfast. I have met with and celebrated our Aspire students and our end-of-life ambassadors at Rowcroft Hospice. I had great pride in re-signing our commitment to the Armed Forces Covenant and in joining long-serving colleagues, governors, partners and community representatives in marking 100 years since the foundation stone of Torbay Hospital was laid. I also joined day surgery colleagues to mark 30 years of day surgery at Torbay Hospital and spent time with our breast care team, chaplaincy and a number of other services and teams.

176. I have continued to meet regularly with pathology colleagues, along with fellow executives and senior leaders, as well as fortnightly meetings with histopathology (cellular pathology) colleagues as we progress a long-term solution for our routine histopathology service.

177. My routine meetings with the Integrated Care Board, NHS England, the Peninsula Acute Provider Collaborative, Torbay Council and our Council of Governors continue and provide valuable opportunities for discussion and to listen to diverse voices.

178. As ever, my many conversations with governors have been especially valuable, providing honest feedback, constructive challenge, and a direct link to the concerns and aspirations of our wider membership. These ongoing discussions with governors, alongside broader community engagement, have helped to shape our planning and decision-making, ensuring that the voices of our staff, patients, partners and governors are at the heart of everything we do.

179. I am pleased that the recruitment to Governor Elections 2026 is progressing well and that we have received nominations in three of the four constituencies with vacancies. I understand that there will be contested elections in South Hams

and Torquay which will launch in mid-August while in Teignbridge there is an uncontested election. Our new governors will start in post on 01 October 2026.

Look forward

180. As we move into the second half of the year, our focus remains on balancing immediate operational priorities with the longer-term changes needed to secure sustainable health and care services for our communities. While demand, workforce pressures and financial challenges continue to require significant attention, we remain committed to delivering the ambitions set out in *Our Plan for Better Care* and translating those ambitions into practical improvements for patients and communities.

181. At the same time, we will continue to work closely with partners across Devon as plans develop for neighbourhood-based models of care and the wider *One Plan for Devon*. We support the ambition to improve prevention, deliver more joined-up care closer to home and tackle health inequalities. As these programmes develop, we will continue to advocate for approaches that are realistic, deliverable and reflect the needs of the communities we serve.

182. Addressing the challenges associated with our estate and infrastructure will also remain a significant priority. As governors will see throughout this report, much work is underway to manage risks associated with ageing buildings while also planning for future investment. We will continue to make the case locally, regionally and nationally for capital investment that reflects the needs of Torbay and South Devon and supports the delivery of safe, modern healthcare services.

183. Alongside these strategic priorities, we continue to work with Torbay Council, Devon ICB and other partners on the future of Adult Social Care services following our decision to give notice on the current arrangements. While considerable work remains ahead, our focus continues to be on ensuring continuity, quality and safety of care for local people while developing arrangements that are sustainable for the future.

184. Strong partnerships, effective leadership and the commitment of our colleagues remain critical to everything we are seeking to achieve. The challenges facing health and care services are significant, but so too is the opportunity to improve how we work together across organisational boundaries to deliver better outcomes for local people.

185. Throughout this work, our focus remains firmly on the 300,000 people we serve and the 6,500 colleagues who deliver care and support across our organisation every day. Whether improving access to services, investing in our estate, strengthening neighbourhood working or developing our workforce, our ambition is to create the conditions for people and communities to live healthier, more independent lives.

186. We also recognise our wider role as one of the largest employers and anchor institutions in Torbay and South Devon. Beyond the care we provide, we have an important contribution to make in supporting local employment, skills, economic prosperity, social value and community wellbeing. Working alongside our partners, we will continue to use our influence and resources to help create stronger and more resilient communities.

187. I remain grateful to our colleagues, volunteers, governors and partners for their continued support, challenge and commitment. Together, we will continue to focus on providing safe, compassionate care today while building a sustainable future for the people and communities we serve.

188. Governors play a vital role in helping us achieve these priorities. We ask for your support in community engagement and advocacy, helping to share with your communities what we are doing and why and listening to feedback from members.

189. For our staff governors, your voice is essential in championing staff engagement, particularly around our strategy and wellbeing initiatives.

190. We also encourage governors to promote membership and charity activities.

191. Finally, your strategic insight and challenge on financial recovery, estates planning and digital transformation will help ensure decisions reflect the needs of patients and communities.

Torbay and South Devon NHS Foundation Trust

Report of the Membership Committee Chair to the Council of Governors

Meeting date:	21 July 2026
Report by:	Loveday Densham, Chair, Lead Governor and Public Governor, Torbay
This report is for:	Information☒ Decision ☒
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private	Public ☒ or Private ☐

Key issues to highlight to the Council of Governors:

- **Annual Members' Meeting (AMM) 2026**– AMM 30 September 2026 at 2pm -4pm at Paignton Library. We need governors to confirm attendance to support AMM and be active on a focus group.
- **AMM Governor focus group –** Governor required from each constituency
- **Governor attendance to meetings and sending apologies –** Two MC have not been quorate
-

Key decision(s)/recommendations made by the Committee:

1. Annual Members Meeting – Themes were decided for this year's event which will be held at Paignton Library on Wednesday 30th September 2026. We are asking for any Governors interested in helping out at the event to contact the Lead Governor. In the meantime we are promoting this event on Hospital Radio, Patient Participation Groups, Community Hubs, Membership Stalls, ICON, E-mail, posters and social media. Word of mouth is of course very important.
2. We hope to hold a governor led focus group at the AMM where we can meet members of the public and take forward their ideas. Loveday and Jake have agreed to organise this group but if any other governors are interested in this idea please let them know.
3. Jake O'Donovan was appointed Deputy Chair.
4. Medicine for Members has been arranged for Tuesday 20th October 2026 and the talk will be given by Dr. Rosie Davis, Consultant Dermatologist on problems with the skin.
5. Members are successfully attending their local Patient Participation Groups.
6. Total Public Membership Figures: 7153
7. We have had several resignations from the Committee and places are available – if any governors would be interested in joining our active group please let Kirsty or Loveday know.

Torbay and South Devon NHS Foundation Trust

Charity Committee
Governor Observer Report for meeting dated 17 June 2026

Governor Observers are asked to consider the following questions:	
Question	**Comment**
Was the meeting well chaired?	yes
Were members engaged throughout the whole meeting including contributions by NEDs?	yes
Did the meeting discuss key risks\issues or did you see a risk register?	yes
If there was an action log, was this discussed and updated?	yes
Was there anything that concerned you about the governance of the meeting? If yes, please detail.	Just the amount of detail for anyone new, like me as an observer, it might have been of assistance if an introduction of the type of detail was had
Key issues to be escalated to the CoG which could be included as an item for discussion at a future Governor meeting.	None that I could see
Key issues to be escalated to the Board.	None that I could see

Report completed by: Michael D Joyce

Date:22/06/2026

Torbay and South Devon NHS Foundation Trust

Council of Governors

Governance Report

Date of meeting	Date report produced
12 August 2026	8 July 2026

Author(s)		Report approved by	
Name and title:	Kirsty Hewett, Membership Manager Sarah Fox, Corporate Governance Manager	**Name and title:**	Cath Parnell Chief of Staff
		Date:	13th July 2026

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

n/a

Executive summary

The report provides corporate governance updates on matters of relevance to the Council of Governors.

The assurance rating in this report is as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	n/a

Appendices

Committees that have previously discussed/agreed the report, and outcomes of that discussion
N/a

Key recommendations and actions requested
The CoG are asked to AGREE the recommended assurance rating and take assurance as to those matters reviewed by the Council of Governors.

How does this report further our Trust Strategy?
The report provides assurance to the Council of Governors that the Trust's governance processes ensure the Trust meets its statutory obligations which in turn support the people in its footprint to live well.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	All
Quality of services provided	
Sustainable and efficient use of resources	

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality, Safety and Patient Experience	All
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	

Risk	
N/a	

Risks lodged on Datix	
N/a	
External Standards affected by this report and associated risks	
Laws or regulations	

Care Quality Commission
Terms of authorisation, NHS England licence and regulations
National policy, guidance

Governance Report

Introduction

The report provides a series of updates concerning corporate governance matters that are pertinent to the Council of Governors (CoG). These updates encompass recent developments, procedural changes, and formal processes that directly impact the functioning of the Council. The intention is to ensure that members are kept informed of key governance activities and decisions, thereby supporting effective oversight and engagement. Each update is designed to provide clarity on processes, outcomes, and responsibilities relevant to the Council of Governors.

The report provides corporate governance updates on matters of relevance to the Council of Governors.

1. Governor update – Appointed Governors

1.1 Following on from the last meeting Council David Thomas, Appointed Governor for Torbay Council, resigned on 06 June 2026. We are currently waiting to hear from Torbay Council regarding the replacement.

Action: CoG to receive and note the Governor updates.

2. Governor Compliance

2.1 Following on from the last CoG meeting Lead Governor sent letters to those governors who were not fully compliant within their governor role.
The current outstanding requirements are:

- Annual Declarations - Sarah Adams
- Mandatory Training – Karen Barry

Action: Governors are asked to receive and note current non-compliance.

3. Governor Observers Update

3.1 After the Council of Governors meeting held in May 2026, Dave Cawley stood down from the role of Governor Observer for the Finance and Operations Committee. An expression of interest was sought and Olivia Bath has now taken on this role.

Action: Governors are asked to note the update to FOC Governor Observer.

4. Governors Elections 2026

4.1 At the previous meeting the Council of Governors were requested to review and approve the process for Governor Elections 2026. The annual elections for the Council of Governors have commenced.

The vacant seats are shown below:

Public Governor	Torbay	Two vacancies
Public Governor	Teignbridge	Two vacancies
Public Governor	South Hams	One vacancy
Public Governor	Rest of the Southwest Peninsula	One vacancy

4.2 The independent election company, Civica Election Services, will, as is usual, manage the elections on the Trust's behalf.

4.3 The election timetable is below:

ELECTION STAGE	OPTION 1
Notice of Election / nomination open	**Monday, 29 Jun 2026**
Nominations deadline	Monday, 27 Jul 2026
Summary of valid nominated candidates published	Tuesday, 28 Jul 2026
Final date for candidate withdrawal	Thursday, 30 Jul 2026
Electoral data to be provided by Trust	Tuesday, 4 Aug 2026
Notice of Poll published	Monday, 17 Aug 2026
Voting packs despatched	Tuesday, 18 Aug 2026
Close of election	Friday, 11 Sep 2026
Declaration of results	Monday, 14 Sep 2026

4.4 The Trust has launched its communications to members and the public using a variety of communication channels including member emails, social media, Trust website and hosting information webinars.

Action: CoG to receive and note the Governor Elections 2026.

5. Annual Members Meeting

5.1 The Council of Governors are asked to note that the Annual Members Meeting is scheduled on the afternoon of 30 September 2026; preparations are being discussed with Membership Committee and a verbal update will be provided at the meeting.

Action: To note the date of the Annual Members Meeting.

6. Annual Report and Accounts 2025/26

6.1 The Annual Report and Accounts for year ended 31 March 2026 was laid before Parliament on 13 July 2026, having been approved by the Board on 25 June 2026.

Action: To receive and note the Annual Report and Accounts 2025/26

Torbay and South Devon NHS Foundation Trust

Presented to:	**Council of Governors**			
Title of Report	Constitutional Amendments and Building on Governor Experience			
Date of Meeting	12th August 2026	**Author**	Cath Parnell, Chief of Staff	
Executive Lead	Joe Teape, CEO	**Executive Sign Off**	Yes – Joe Teape	
Governance Route				
Purpose of paper	**For Approval**	**For Assurance**	**To Update**	**For Information**
	X			
Executive Summary	This paper asks the Council of Governors to approve the proposed constitutional amendments arising from national legislation and local organisational change, and to consider how we continue to strengthen public, patient and community engagement in the future. The Health Bill, introduced in May 2026 as part of the Government's wider programme of NHS reform, proposes significant changes to the NHS foundation trust model, including changes to the role of councils of governors and membership constituencies. Until any relevant provisions are enacted by Parliament and brought into force, the Council of Governors retains all of its current statutory and constitutional functions. There is currently no change to the role of governors and we remain committed to supporting governors in those responsibilities. Governors continue to play a vital role in representing the interests of members, patients, colleagues and local communities, and in holding our Non-Executive Directors to account. We recognise and value the distinctive contribution governors make through their local knowledge, constructive challenge and oversight of the Board. Governors help us understand what matters to local people, test whether our plans reflect community priorities and maintain a clear line of accountability to the population we serve. While the future legislative position remains uncertain, we have a responsibility to ensure appropriate arrangements are in place to ensure the Trust's governance remains aligned with statutory requirements and maintain engagement, accountability and community involvement throughout any transition period. Taking practical steps now helps avoid uncertainty and ensures continuity should national reforms be			

Torbay and South Devon NHS Foundation Trust

<table>
<tr><td></td><td>implemented, rather than risking a gap in how local people influence and hold us to account.

Nothing in the proposed constitutional amendments diminishes the contribution governors have made or our commitment to meaningful public accountability. Rather, they are intended to provide continuity as the national picture evolves, while creating an opportunity to build on the strongest features of the current model.

Governors are therefore invited to work with us, alongside patients, partners and community representatives, to help shape how we engage with and remain accountable to local people in the future, ensuring that community voice continues to inform decision-making whatever the future legislative framework may be.</td></tr>
<tr><td>Recommendation</td><td>1. Approve an enabling amendment to the Constitution that will take effect only if or when the relevant legislative provisions are enacted by Parliament.
2. Approve the replacement of the five existing staff classes with one Staff Constituency, retaining five elected staff governor seats and unchanged staff membership eligibility.
3. Confirm that governors will be actively involved, alongside service users, carers, staff, community representatives and partners, in shaping and testing the Trust’s future approach to engagement with its local population, drawing on their knowledge and experience.</td></tr>
<tr><td>Link to Strategic Signature Moves</td><td>
<table>
<tr><th>Living well in our neighbourhoods</th><th>Reimagining acute and specialist care</th><th>Caring, skilled people ready for tomorrow</th><th>Joined up care, every step of the way</th><th>Smart use of technology for better care</th><th>Foundation</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>X</td></tr>
</table>
</td></tr>
<tr><td>How this paper supports delivery of the Strategy</td><td>This paper supports delivery of the Strategy by maintaining strong governance, accountability and community voice during a period of legislative change. Governor involvement and experience will help shape and test future arrangements, ensuring that the experiences and priorities of service users, carers, staff and local communities continue to inform strategic decisions and the development of accessible, equitable and joined-up care.</td></tr>
</table>

Torbay and South Devon NHS Foundation Trust

Board Assurance						
BAF Ref	**Principal Risk**	**Current Score**	**Impact of this paper**			
BAF-LG	Leadership and Governance	2x4=8	The paper provides positive assurance by supporting legal compliance, strong governance and continued community voice, without changing the current BAF risk score			
Link to CQC Quality Statement	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**	
					X	
Compliance / Regulatory Requirements	The proposed amendments support compliance with the Trust's current statutory and constitutional duties, with any enabling provisions taking effect only when the relevant legislation is enacted and commenced.					
Ethical or EDI implications?	The proposed co-design approach has positive ethical and EDI implications by promoting inclusive participation, protecting community voice and actively addressing barriers for under-represented groups; an equality impact assessment should inform the final model.					
Assurance rating	Significant	Moderate	Limited	Inadequate		
		X				
Assurance rationale	The paper sets out a clear, legally informed and inclusive approach to constitutional change, but full assurance depends on enactment of the legislation and completion of the proposed co-design and implementation process, informed by governors' involvement and experience.					
Appendices	Appendix One – Proposed wording changes to the Constitution Appendix Two - Current Constitution					

Torbay and South Devon NHS Foundation Trust

1. Preserving and Building on Governors' Contribution

The Council of Governors has developed substantial experience of representing diverse constituencies, raising community concerns, scrutinising the Board and translating complex organisational issues for members and the public. Governors hold trusted relationships and practical knowledge of local places, services and inequalities. The Trust is committed to ensuring these strengths are actively retained and transferred into future arrangements rather than lost through any legislative change.

For the avoidance of doubt, there is no change at this stage to governors' role, authority or responsibilities. Unless, and until, the relevant legislation is enacted and brought into force, governors will continue to hold, and must exercise, all of their current statutory and constitutional functions in full. The proposed enabling amendments to the constitution do not suspend, reduce or anticipate the removal of any current governor responsibility.

2. National Context and Proposed Enabling Provision within the Constitution

The Health Bill, introduced in May 2026, proposes changes to foundation trust governance intended to give NHS providers greater flexibility while maintaining responsiveness and accountability to local communities. The timetable for these legislative changes remains uncertain, although initial indications suggest that, if enacted, they may come into force during 2026/27. To support an orderly transition, provide clarity and ensure that the Trust's governance remains aligned with statutory requirements, the Trust's external legal advisers have recommended the addition of the following clause.

'Upon legislation being passed which removes the requirement for the Trust to have a Council of Governors, all constitutional provisions concerning Governors and the Council of Governors shall become invalid, and all Governors shall be deemed removed as of the effective date set out in such legislation. In the event that Governors and the Council of Governors cease to exist at the Trust, provisions in this Constitution relating to the appointment and removal of Non-Executive Directors will be deemed to be replaced by such other process as legislation requires until the Constitution is amended.'

This proposed constitutional enabling provision would allow only those amendments necessary to reflect any enacted legislation. These amendments do not:

- anticipate Parliament's decision
- remove any current governor function prematurely

- prevent the Trust from establishing non-statutory arrangements for public, patient, staff and stakeholder voice.

Including this provision within the Constitution at this time provides continuity and clarity should national changes be implemented. This supports the avoidance uncertainty during any transition period and ensures the Trust is able to maintain compliance with its statutory framework at all times.

Until the relevant statutory provisions come into force, the Council of Governors will continue to exercise all functions required by law and the Constitution.

3. Local Constitutional Amendment: Staff Constituency

Following the transfer of Children and Family Health Devon to Devon Partnership Trust and the current review of the Trust's operational structures, it is proposed that the five existing named staff classes are replaced by a single Staff Constituency. The total number of elected staff governor seats will remain five, and staff membership eligibility will not change. All eligible staff will vote across the single constituency. Related provisions on elections, eligibility, registers and annual reporting will be updated for consistency.

These staff constituency proposals simplify the current Trust arrangements, ensure representation regardless of organisational reshaping and retains the same level of Governor representation for our people.

4. Governor Involvement in Shaping and Testing Future Models of Engagement

The Council of Governors is asked to support and participate in a co-design programme to define how the Trust should listen, respond and demonstrate that local insight has influenced its decisions. Governors' involvement, knowledge and experience will provide continuity and credibility, preserve organisational memory, maintain public confidence and help ensure that future arrangements are rooted in local experience. Governors will play an important role alongside service users, carers, staff, community representatives and partners in shaping and testing options. The programme should reflect the geographical diversity of the Trust's population and actively involve communities whose voices are less often heard.

The Trust considers governors' involvement and experience essential in helping to shape and test a future model that embeds the following principles:

- **Meaningful influence**: service users can shape priorities at an early stage and understand how their contribution has affected decisions.
- **Value and respect**: participation is accessible, well supported and recognised, with feedback closing the loop after engagement.

- **Equity and inclusion:** arrangements reflect local demographics and geography and actively address barriers to involvement.
- **Proportionate governance**: clear routes connect service user insight to the Board and its committees without creating unnecessary bureaucracy.
- **Transparency and accountability:** the Trust reports on who has been engaged, what it has heard, what has changed and where change has not been possible.

5. Summary

The proposed constitutional amendments are intended to maintain legal and operational clarity and ensure continuity while the national position develops. They do not lessen the Trust's recognition of governors' contribution or pre-empt any legislative decision. The Trust wishes to preserve and draw on governors' local knowledge, representative experience and constructive challenge through their involvement in shaping and testing future engagement and accountability arrangements.

6. Proposed Next Steps

1. The Trust works with governors to agree the membership, scope, support and timetable for a co-design programme that draws on their involvement and experience.
2. The programme maps existing engagement routes and gathers views from service users, carers, staff, communities and partners, with particular attention to people whose voices are less often heard.
3. Governors help shape and test options for the future engagement approach, alongside service users, carers, staff, community representatives and partners, including clear routes for local insight to influence the Board.
4. A preferred model, implementation plan, resource implications and measures of success are presented to the Council of Governors before formal approval and implementation.

Torbay and South Devon NHS Foundation Trust

Appendix One – Proposed wording changes to the Constitution

Legal advice from DAC Beachcroft LLP has been sought and the proposed amendments outlined are recommended to ensure the Trust Constitution remains legally accurate, current and aligned with the Trust's present and future governance and operational structure arrangements.

1) Response to the Health Bill

The addition of the following clause to section 5 of Annex 4 (page 30) of the Constitution is recommended.

'Upon legislation being passed which removes the requirement for the Trust to have a Council of Governors, all constitutional provisions concerning Governors and the Council of Governors shall become invalid, and all Governors shall be deemed removed as of the effective date set out in such legislation. In the event that Governors, and the Council of Governors cease to exist at the Trust provisions in this Constitution relating to the appointment and removal of Non-Executive Directors will be deemed to be replaced by such other process as legislation requires until the Constitution is amended'.

2) Response to organisational operational changes

It is recommended that the five separate staff classes are removed. Staff will instead form a single Staff Constituency with 5 elected Governors. To achieve this the following changes will be made:

- References throughout the Constitution to membership, elections, eligibility, registers and representation by **"class"** will be deleted. (paragraphs 10 -12 on pages 5-6, paragrah16.1.2 on page 7, paragraph 43.2.3a on page 17, paragraph 4.1.2 of Annex 4 on page 26)
- The provision allowing the Secretary to determine an individual's staff class is removed. (paragraph 10.6 on page 5)
- Annex 2 will be simplified to reflect the minimum total membership of the Staff Constituency is set at 500 and the Staff Constituency retains five elected Governor seats. (page 24)
- Staff membership eligibility will remain unchanged
- Automatic staff membership continues, but without allocation to a particular class. (paragraph 14.3, page 6)
- Staff Governors will be elected by the Staff Constituency as a whole, rather than one Governor being elected from each staff class.
- The membership register and annual reporting requirements will record and report on the Staff Constituency overall, rather than by individual staff class.(paragraph 36.1.1, Page 14)

- Annex 3 will be amended to show a single Staff Constituency with five elected Governor seats to ensure consistency. (Page 25)

Torbay and South Devon
NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust

Constitution

Approved on 01 May 2024 (minor amendment to numbering post October 2023 review)

Table of contents

Paragraph heading and number — Page number

1. DEFINITIONS AND INTERPRETATION

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.2 References to legislation include all regulations, statutory guidance or directions. Headings are for ease of reference only and are not to affect interpretation.

1.3 In this Constitution the following definitions apply:

2006 Act	means the National Health Service Act 2006.
Accounting Officer	means the person who from time to time discharges the functions specified in paragraph 25(5) of schedule 7 to the 2006 Act.
Annual Members Meeting	is defined in paragraph 13 of this Constitution.
Annual Report	means the document prepared by the Trust pursuant to paragraph 43 of schedule 7 to the 2006 Act.
Appointed Governor(s)	means a member of the Council of Governors who is not an Elected Governor and who has been appointed in accordance with this Constitution.
Board of Directors	means the Board of Directors of the Trust comprising of the Executive Directors and the Non-Executive Directors.
Chair	means the chairperson of the Trust appointed in accordance with paragraph 27 of this Constitution.
Constitution	means this constitution together with each annex attached.
Council of Governors	means the Council of Governors as constituted in this Constitution in accordance with paragraph 7 of schedule 7 to the 2006 Act.
Director	means a member of the Board of Directors.
Director Code of Conduct	means any code of conduct applicable to all Executive Directors, Non-Executive Directors and such other persons as set out therein, as amended from time to time.
Elected Governor	means a Public Governor or a Staff Governor.

Executive Director	means an executive member of the Board of Directors of the Trust appointed pursuant to paragraph 30 of this Constitution.
Financial Year	means a period beginning on 1 April and finishing on the following 31 March.
Governor	means a member of the Council of Governors.
Governor Code of Conduct	means any code of conduct accepted by and applicable to all Governors, as amended from time to time.
Independence Criteria	means the indicative criteria set out at provision 2.6 of the Provider Code of Governance or such other guidance produced which the Trust must have regard to from time to time.
Lead Governor	means the governor appointed by the Council of Governors as Lead Governor in accordance with Annex 4.
Member	means a member of the Trust.
Model Election Rules	means the rules for the conduct of elections for a member of Council of Governors of Trust published by NHS Providers and set out at Annex 8.
NHS Body	means an NHS foundation trust and any body set out in section 9(4) of the 2006 Act.
NHS England	means the body corporate known as NHS England, established under section 1H of the 2006 Act.
NHS Provider Licence	means provider licence number: 110102 issued to the Trust by NHS England (as amended).
Non-Executive Director	means a non-executive member of the Board of Directors of the Trust appointed pursuant to paragraph 27 of this Constitution.
Principal Purpose	means the purpose set out in Section 43(1) of the 2006 Act and paragraph 3 of this Constitution.
Provider Code of Governance	means the "Code of governance for NHS provider trusts" published by NHS England, as may be amended from time to time.
Public Constituency	is defined in paragraph 9 of this Constitution.
Public Governor	means a member of the Council of Governors elected by the members of one of the Public Constituencies.

Secretary	means the secretary of Trust or any other person appointed to perform the roles and responsibilities as set out in any role description issued by the Trust, this Constitution and Appendix A of the Provider Code of Governance.
Staff Constituency	is defined in paragraph 10 of this Constitution.
Staff Governor	means a member of the Council of Governors elected by the members of the Staff Constituency.
Trust	is defined in paragraph 2 of this Constitution.
Trust Headquarters	Torbay Hospital, Lowes Bridge, Torquay TQ2 7AA
Vice Chair	means the vice chairperson of the Trust appointed in accordance with paragraph 28 of this Constitution.

2. NAME

The name of the foundation trust is Torbay and South Devon NHS Foundation Trust (the **Trust**).

3. PRINCIPAL PURPOSE

3.1 The Principal Purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

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

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

3.3.2 the promotion and protection of public health.

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

4. POWERS

4.1 The Trust is to have all the powers of an NHS foundation trust set out in the 2006 Act.

4.2 In the exercise of its powers the Trust shall have regard to:

4.2.1 section 63A of the 2006 Act (duty to have regard to wider effect of decisions), also referred to as the “Triple Aim”;

4.2.2 section 63B of the 2006 Act (duties in relation to climate change); and

4.2.3 guidance published by NHS England.

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

4.4 Subject to any restriction contained in this Constitution or in the 2006 Act, any of these powers may be delegated to a committee of Directors or to an Executive Director.

5. JOINT WORKING WITH RELEVANT BODIES

5.1 The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the relevant bodies set out in Section 65Z5(1) of the 2006 Act.

5.2 Where a function is exercisable jointly, the relevant bodies may arrange for the function to be exercised by joint committee as set out in section 65Z6 of the 2006 Act.

6. JOINT FINANCIAL OBJECTIVES

6.1 The Trust must:

6.1.1 seek to achieve any financial objectives set under section 223L of the 2006 Act;

6.1.2 exercise their functions with a view to ensuring that, in respect of each Financial Year, limits specified by NHS England are not exceeded as set out in section 223M of the 2006 Act;

6.1.3 comply with any NHS England directions pursuant to section 223N of the NHS Act; and

6.1.4 comply with section 223LA with regard to expenditure limits, if and when that section comes into force.

7. MEMBERSHIP AND CONSTITUENCIES

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

7.1.1 a Public Constituency; or

7.1.2 a Staff Constituency.

8. APPLICATION FOR MEMBERSHIP

8.1 Subject to paragraph 12, an individual who is eligible to become a member of the Trust may do so on application to the Trust.

9. PUBLIC CONSTITUENCY

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

9.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

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

10. STAFF CONSTITUENCY

10.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member provided that they:

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

10.1.2 have been continuously employed by the Trust under contract of employment for at least 12 months.

10.2 For the purposes of this paragraph 10, Chapter 1 of Part XIV of the Employment Rights Act 1996 (Continuous Employment) shall apply when determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the Trust.

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

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

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

10.6 The Secretary shall make a final decision about the class of which an individual is eligible to be a member.

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

11. AUTOMATIC MEMBERSHIP BY DEFAULT – STAFF

11.1 An individual who is:

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

11.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency, shall become a Member as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made unless they inform the Trust that they do not wish to become a Member.

12. RESTRICTION ON MEMBERSHIP

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

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

12.3 An individual must be at least fourteen years old to become a Member.

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a Member are set out in Annex 6.

13. ANNUAL MEMBERS' MEETING

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

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 7.

14. COUNCIL OF GOVERNORS – COMPOSITION

14.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

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

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

15. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

15.1 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules.

15.2 The Model Election Rules as published from time to time form part of this Constitution. The Model Election Rules current at the date of this Constitution are set out at Annex 8.

15.3 A subsequent variation of the Model Election Rules shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 46. An updated version of the Constitution may be published by the Secretary incorporating any revised Model Election Rules.

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

16. COUNCIL OF GOVERNORS - TENURE

16.1 Elected Governors

16.1.1 An Elected Governor may hold office for a period of up to three years.

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

16.1.3 Subject to paragraph 16.1.4, an Elected Governor shall be eligible for re-election at the end of their term.

16.1.4 An Elected Governor may not serve on the Council of Governors for more than nine years in aggregate. For the avoidance of doubt, this covers all constituencies such that once an Elected Governor has served for nine years in any one constituency or across a mixture of several Constituencies they are no longer eligible to stand for election in any constituency or be appointed to the Council of Governors.

16.2 Appointed Governors

16.2.1 An Appointed Governor may hold office for a term of up to three years.

16.2.2 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

16.2.3 An Appointed Governor shall be eligible for re-appointment at the end of their term.

17. COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

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

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

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

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

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

17.2 Governors must be at least sixteen years (16) of age at the date they are nominated for election or appointment.

17.3 Further provisions as to the circumstances in which an individual may not become or continue as a Governor are set out in Annex 4.

18. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

18.1 The general duties of the Council of Governors are to:

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

18.1.2 represent the interests of the Members as a whole and the interests of the public; and

18.1.3 feedback information about the Trust, its vision and its performance to Members, the public and stakeholder organisations.

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

19. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

19.1 The Chair, or, in their absence the Vice Chair, shall preside at meetings of the Council of Governors.

19.2 In the absence of both the Chair and the Vice Chair at a meeting of the Council of Governors, the Governors present shall nominate another non- executive director to preside over that meeting.

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

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

20. COUNCIL OF GOVERNORS – STANDING ORDERS

The standing orders for the practice and procedure of the Council of Governors shall be read alongside this Constitution.

21. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

21.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

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

22. COUNCIL OF GOVERNORS – TRAVEL EXPENSES

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

23. COUNCIL OF GOVERNORS – FURTHER PROVISIONS

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

24. BOARD OF DIRECTORS – COMPOSITION

24.1 The Trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

24.2 The Board of Directors is to comprise:

24.2.1 a non-executive Chair

24.2.2 Non-Executive Directors; and

24.2.3 Executive Directors.

24.3 One of the Executive Directors shall be the Chief Executive.

24.4 The Chief Executive shall be the Accounting Officer.

24.5 One of the Executive Directors shall be the finance director

24.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

24.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

24.8 At least half of the Board of Directors (excluding the Chair) should be Non-executive Directors. In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in their absence, the Vice Chair), shall have a casting vote at meetings of the Board of Directors.

24.9 The post of an Executive Director may be held by two individuals (provided that the provisions of this paragraph 24 are met in respect of required qualifications) on a job share basis. Where such an agreement is in force the two individuals may only exercise one vote between them at any meeting of the Board of Directors. In the case of disagreements, no vote may be cast.

24.10 The Trust may appoint other individuals who may receive a standing invite to attend meetings of the Board of Directors, but such individuals shall not be members of the Board of Directors, shall not have a vote and shall not count towards any quorum requirements.

25. BOARD OF DIRECTORS – GENERAL DUTY

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

26. BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

26.1 A person may be appointed as a Non-Executive Director only if:

26.1.1 they are a member of a Public Constituency, or

26.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university; and

26.1.3 they are not disqualified by virtue of paragraph 31 below.

26.2 On first appointment, re-appointment for each further term and throughout their term of office, the Chair and Non-Executive Directors are required to meet the Independence Criteria. In circumstances where, in relation to the Chair or a Non-Executive Director, the Independence Criteria are not met but the Board of Directors considers that the individual in question is independent this will be explained in the Annual Report.

27. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

27.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors. In doing so, the Council of Governors shall take into account the Provider Code of Governance.

27.2 Removal of the Chair or another Non-Executive Directors shall require the approval of three-quarters of the members of the Council of Governors.

27.3 Subject always to the Provider Code of Governance, the maximum tenure for any individual holding the office of Non-Executive Director shall be nine years in aggregate unless exceptional circumstances apply. For the avoidance of doubt, exceptional circumstances shall be determined on a case by case basis.

27.4 In a situation where a Non-Executive Director becomes the Chair, the maximum tenure runs from the time of first appointment to the position of Non-Executive Director.

28. BOARD OF DIRECTORS – APPOINTMENT OF VICE CHAIR

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Vice Chair.

28.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Council of Governors may consequently appoint another Non-Executive Director as Vice Chair in accordance with this Constitution.

29. BOARD OF DIRECTORS – APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

29.1 The Board of Directors shall appoint one of the independent Non-Executive Director (as set out in the Provider Code of Governance) to be the Senior Independent Director in consultation with the Council of Governors, for such a period not exceeding the remainder of their term as a Non-Executive Director, as they may specify on appointing them.

29.2 The Senior Independent Director will be available to Governors if they have concerns that the Chair is unable to resolve.

30. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

30.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

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

30.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Director shall appoint or remove the other Executive Directors.

31. BOARD OF DIRECTORS – DISQUALIFICATION

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

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

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

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

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

31.2 Further provisions as to the circumstances in which a person may not become or continue as a member of the Board of Directors are set out in Annex 5.

32. BOARD OF DIRECTORS – MEETINGS

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

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors. Minutes of meetings of the Board of Directors held in private shall be provided as required by the Provider Code of Governance unless exceptional circumstances apply which shall be determined on a case by case basis.

33. BOARD OF DIRECTORS – STANDING ORDERS

The standing orders for the practice and procedure of the Board of Directors shall be read alongside this Constitution.

34. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

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

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

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

34.2 The duty referred to in paragraph 34.1.1 is not infringed if:

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

34.2.2 the matter has been authorised in accordance with this Constitution.

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

34.4 In paragraph 34.1.2, “third party” means a person other than:

34.4.1 the Trust, or

34.4.2 a person acting on its behalf.

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

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

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

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

34.9 A director need not declare an interest:

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

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

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

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

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

34.10 A matter shall have been authorised for the purposes of paragraph 34.2.2 if:

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

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

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

35. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

35.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

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

36. REGISTERS

36.1 The Trust shall have:

36.1.1 a register of Members showing, in respect of each Member, the Constituency to which they belong and, where there are classes within it, the class to which they belong;

36.1.2 a Register of Members of the Council of Governors;

36.1.3 a Register of Interests of Governors;

36.1.4 a Register of Directors; and

36.1.5 a Register of Interests of the Directors.

36.2 The Secretary shall be responsible for compiling and maintaining the registers, and the registers may be kept in either paper or electronic form. Removal from any register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days of receipt.

37. ADMISSION TO AND REMOVAL FROM THE REGISTERS

37.1 The Secretary shall add to the register of Members the name of any individual who is accepted as a Member under the provisions of this Constitution. The Secretary shall remove from the register of Members the name of any Member who ceases to be entitled to be a Member.

38. REGISTERS – INSPECTION AND COPIES

38.1 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member, if the Member so requests.

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

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

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

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

39. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

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

39.1.1 a copy of the current constitution;

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

39.1.3 a copy of the latest Annual Report.

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

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

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

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

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

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

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

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

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

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

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

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

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

40. AUDITOR

40.1 The Trust shall have an auditor.

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

40.3 A person may only be appointed as the auditor if they (or, in the case of a firm, each of its members) are a member of one or more of the bodies referred to in paragraph 23(4) of schedule 7 to the 2006 Act.

40.4 The auditor is to carry out their duties in accordance with schedule 10 to the 2006 Act.

41. AUDIT COMMITTEE

The Trust shall establish a committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

42. ACCOUNTS

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

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

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

42.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

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

43. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

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

43.2 The Annual Report must

43.2.1 review the extent to which the Trust has exercised its functions in accordance with the plans published under:

(a) section 14Z52 of the 2006 Act (joint forward plans for integrated care board and its partners); and

(b) section 14Z56 of the 2006 Act (joint capital resource use plan for integrated care board and its partners),

43.2.2 review the extent to which the Trust has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) of the 2006 Act (views about how functions relating to inequalities information should be exercised);

43.2.3 give information:

(a) on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

(b) on any occasions in the period to which the report relates on which the council of governors exercised its power under paragraph 10C of schedule 7 to the 2006 Act;

(c) on the remuneration of the directors and on the expenses of the Governors and the directors;

(d) on the impact that income received by the Trust otherwise than from the provision of goods and services for the purposes of the health service in England has had on the provision by the Trust of goods and services for those purposes; and

(e) on any other matter which NHS England requires.

43.3 The Trust shall give information as to its forward planning in respect of each Financial Year to NHS England.

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

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

43.6 Each forward plan must include information about:

43.6.1 the activities other than the provision of goods and services for the purpose of the health service in England that the Trust proposes to carry on; and

43.6.2 the income it expects to receive from doing so.

43.7 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in paragraph 43.6.1 the Council of Governors must:

43.7.1 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 its principal purpose or the performance of its functions; and

43.7.2 notify the directors of the Trust and its determination.

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

44. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

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

44.1.1 the annual accounts

44.1.2 any report of the auditor on them

44.1.3 the Annual Report.

44.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

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

45. INSTRUMENTS

45.1 The Trust shall have a seal.

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

45.3 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.

46. AMENDMENT OF THE CONSTITUTION

46.1 The Trust may make amendments to this Constitution only if:

46.1.1 more than half of the members of the Council of Governors voting approve the amendments, and

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

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

46.3 Where an amendment is made to this Constitution in relation 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):

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

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

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

46.5 Amendments by the Trust to this Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with schedule 7 of the 2006 Act.

46.6 The following amendments to ancillary documents shall not be considered amendments to the Trust's Constitution and shall not be required to follow the process set out above:

46.6.1 new versions of the Model Election Rules which will be notified in accordance with paragraph 15.3 above;

46.6.2 amendments to the standing orders for the practice and procedure of the Council of Governors and the standing orders for the practice and procedure of the Board of Directors shall be made in accordance with those standing orders;

46.6.3 amendments to any Director Code of Conduct which will follow the amendment process in that document; and

46.6.4 amendments to any Governor Code of Conduct which will follow the amendment process in that document.

47. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

47.1 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.

47.2 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.

47.3 In paragraph 47.2, the following words have the following meanings:

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

(a) the total asset test; or

(b) the total income test; or

(c) the capital test (relating to acquisitions or divestments).

47.3.2 The total asset test is met if the assets which are the subject of the transaction exceed 25% of the total assets of the Trust.

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

47.3.4 The capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the Trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets, and the Trust's total taxpayers' equity).

47.3.5 For the purposes of calculating the tests in this paragraph 47.3 figures used for the Trust assets, total income and taxpayers' equity must be the figures shown in the latest published audited consolidated accounts.

47.4 A transaction:

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

47.4.2 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services;

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

47.5 The Trust may enter into Material Transactions provided that it has sought the views of the Council of Governors. A "Material Transaction" for the purposes of this paragraph 47.5 shall mean a transaction which meets one of the following tests:

47.5.1 the total asset test; or

47.5.2 the total income test; or

47.5.3 the capital test (relating to acquisitions or divestments).

where the definitions set out in paragraph 47.3 will apply, except that instead of the threshold being 25% it shall be "greater than 10%".

48. ELECTRONIC COMMUNICATIONS

48.1 Meetings of the Trust may be conducted by electronic means (in whole or in part) provided that each person attending has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication where the meeting is hybrid.

48.2 A meeting at which one or more persons attends by way of electronic means the meeting will be deemed to be held at such a place as said meeting shall resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of persons attending the meeting are physically present, or in default of such a majority, the place at which the chair of the meeting is physically present.

48.3 Meetings held by electronic means remain subject to requirements in respect of quorum. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

48.4 The minutes of a meeting held in this way must state that it was held by electronic means and that all persons were all able to hear each other and were present throughout the meeting.

48.5 Meetings open to the public, if held by electronic means, should be open to public attendance by such means.

48.6 For the purposes of this paragraph "electronic means" shall include telephone, video conference or any other such electronic methods, which allows all participating persons in the meeting to hear and interact with each other.

49. INDEMNITY

To the extent permissible by law, 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, the Council of Governors, the Board of Directors and the Secretary.

50. DEFECTIVE APPOINTMENTS

Acts done by the Trust or of a committee or by a person acting as a director or Governor shall not be invalidated by the subsequent realisation that the appointment of any such director or Governor person acting as a director or Governor was defective.

ANNEX 1

THE PUBLIC CONSTITUENCIES

The Trust has four (4) Public Constituencies as follows:

Areas comprising the Public Constituency	Local Authority areas/or local authority electoral areas falling within the following Electoral Wards	Minimum number of Members	Number of elected Governors
South Hams	South Hams District Council	Five hundred (500)	Three (3)
Torbay	Torbay Unitary Authority	Five hundred (500)	Seven (7)
Teignbridge	Teignbridge District Council	Five hundred (500)	Seven (7)
Rest of the South West Peninsula	All electoral wards in Cornwall, Devon, Dorset, Somerset and Bristol not included in the above Public Constituencies (which for the avoidance of doubt includes all wards within the district and unitary councils within those areas)	Ten (10)	One (1)

For ease of reference, a map identifying the footprint of the Trust is provided below:

ANNEX 2
THE STAFF CONSTITUENCY

The Staff Constituency is divided into five (5) classes as follows:

Classes comprising the Staff Constituency	Minimum number of Members	Number of elected Governors
Families and Communities	One hundred (100)	One (1)
Medicine and Urgent Care	One hundred (100)	One (1)
Planned Care and Surgery	One hundred (100)	One (1)
Children and Family Health Devon	One hundred (100)	One (1)
Professional Support Services	One hundred (100)	One (1)

ANNEX 3

COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors is to comprise:

Constituency	**Number of seats on the Council of Governors**
Elected Governors	
Public constituency	**18**
South Hams and Plymouth	Three (3)
Torbay	Seven (7)
Teignbridge	Seven (7)
Rest of the South West Peninsula	One (1)
Staff constituency	**5**
Families and Communities	One (1)
Medicine and Urgent Care	One (1)
Planned Care and Surgery	One (1)
Children and Family Health Devon	One (1)
Professional Support Services	One (1)
Appointed Governors	**9**
Devon County Council	One (1)
South Hams District Council	One (1)
Teignbridge District Council	One (1)
Torbay District Council	One (1)
NHS Devon Integrated Care Board	One (1)
Devon Partnership NHS Trust	One (1)
University of Exeter Medical School	One (1)
Plymouth University Peninsula School of Medicine and Dentistry	One (1)
Devon Carers Strategy Board or Torbay Carers Strategy Steering Group	One (1)
Total	**32**

ANNEX 4

Additional Provisions – Council of Governors

1. Elected Governors

A Member of the Public Constituency may not vote at an election for a public governor unless at the time of voting they have made and returned a declaration in the form specified in the Model Election Rules, that they are qualified to vote as a Member of the Public Constituency.

2. Appointed Governors

2.1 The Secretary (or such person as they may nominate) shall contact each relevant organisation in writing regarding the appointment of the Governor by it.

2.2 For the purposes of this paragraph 2 "relevant organisation" shall mean any local authority, university or other partnership organisation which is eligible to appoint a Governor to the Council of Governors under this Constitution.

3. Lead Governor

3.1 The Council of Governors shall appoint one of its public Governors as the Lead Governor in accordance with the conditions of appointment set out in the Lead Governor role description approved by the Council of Governors.

3.2 The Lead Governor shall have the responsibilities, and perform the tasks, set out in the Lead Governor role description.

3.3 The term of the Lead Governor shall be one (1) year.

4. Further provisions as to eligibility to be a Governor

4.1 In addition to paragraph 17 of this Constitution, a person may not become or continue as a Governor if:

4.1.1 they are not a Member;

4.1.2 in the case of a public governor or staff governor they cease to be a Member of the Constituency or Class from which they were elected;

4.1.3 in the case of an appointed governor, the organisation which appointed them terminates that appointment;

4.1.4 they are a person who is not a fit and proper person as required by the NHS Provider Licence;

4.1.5 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their

name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

4.1.6 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;

4.1.7 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;

4.1.8 they are the spouse, partner, parent, child of, or occupant of the same household as a director or a member of the Council of Governors;

4.1.9 they are a member of a local authority's Overview and Scrutiny Committee covering health matters or hold a role at a local authority which involves the review or scrutiny of health matters;

4.1.10 they are a director of the Trust;

4.1.11 they are a governor, non-executive director (including the chair) or, executive director (including the chief executive officer) of another NHS Body, unless they are appointed by an appointing organisation which is a NHS Body or the Chair agrees to them becoming, or continuing as, a governor of the Trust in exceptional circumstances;

4.1.12 they have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a NHS Body;

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

4.1.14 they have previously been removed as a Governor of the Trust;

4.1.15 they have previously been removed as a governor from another NHS foundation trust;

4.1.16 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of any Governor Code of Conduct;

4.1.17 they have committed a serious breach of the Governor Code of Conduct;

4.1.18 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor;

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

4.1.20 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales, and they have not subsequently had their name included in such a list;

4.1.21 they are deemed a vexatious or persistent complainant or litigant against the Trust without reasonable cause; or

4.1.22 they have failed to repay (without good cause) any amount of monies properly owed to the Trust.

4.2 For the purposes of this Annex 4 "a vexatious or persistent complainant" shall be as defined in the Trust's Feedback Complaints and Patient Advice and Liaison (PALS) Policy (or such other policy that may replace it from time to time). In the event of a dispute regarding whether an individual is a vexatious or persistent complainant, the Chair in consultation with the Senior Independent Director shall make the final decision.

4.3 A person holding office as a Governor shall immediately cease to do so if:

4.3.1 they resign by notice in writing to the Secretary;

4.3.2 they become disqualified from office under paragraph 17 of this Constitution or under paragraph 4.1 of this Annex 4;

4.3.3 they fail to attend two meetings of the Council of Governors in a period of one year unless the Lead Governor, Chair and Secretary are satisfied that:

4.3.3.1 the absence was due to a reasonable cause; and

4.3.3.2 they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

4.3.4 they have refused to undertake any training which the Council of Governors requires all governors to undertake unless the Lead Governor, Chair and Secretary are satisfied that the refusal was due to a reasonable cause; or

4.3.5 they are removed from the Council of Governors by a resolution passed under paragraph 5 below.

4.4 For the purposes of 4.3.3.1 and 4.3.4:

4.4.1 an absence will ordinarily be considered to be due to a reasonable cause if it is due to:

4.4.1.1 a conflict with work or personal commitments in circumstances where the Trust has changed the date of the meeting of the Council of Governors at short notice;

4.4.1.2 ill health (provided that the Governor in question, or someone on their behalf, has advised the Secretary of such circumstances as soon as reasonably practicable); or

4.4.1.3 a personal or family emergency.

4.4.2 For the avoidance of doubt, work commitments will not be considered a reasonable cause unless the Trust has changed the date of the meeting of the Council of Governors at short notice.

4.4.3 Instances of ill health will be reviewed on a case-by-case basis in consultation between the Lead Governor, Secretary, the Chair and the affected Governor with a view of acting in the best interests of the Trust.

4.5 Where a Governor becomes disqualified for appointment under this paragraph 4 or paragraph 17 of this Constitution, they shall notify the Secretary in writing without delay upon becoming aware the grounds for disqualification. Any failure to notify the Secretary of grounds for disqualification pursuant to this paragraph 4.5 shall result in such individual becoming ineligible to become a Governor at any future point.

4.6 If it comes to the notice of the Secretary that at the time of their appointment or later a Governor is disqualified, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

5. Removal of Governor from office

5.1 A Governor may be removed from the Council of Governors by a resolution approved at a meeting of the Council of Governors by not less than three-quarters of the Governor present and voting on the grounds that:

5.1.1 they have acted in a manner detrimental to the interests of the Trust or otherwise bring the Trust into disrepute; or

5.1.2 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor, for example because:

5.1.2.1 the individual's continuation as a Governor would be likely to prejudice the ability of the Trust to fulfil its principal purpose or discharge its duties and functions;

5.1.2.2 the individual's continuation as a Governor would be likely to prejudice the Trust's work with other persons or body within whom it is engaged or may be engaged in the provision of goods and services;

5.1.2.3 the individual's continuation as a Governor would be likely to adversely affect public confidence in the goods and services provided by the Trust;

5.1.2.4 it would not be in the best interests of the Council of Governors for the individual to continue as a Governor / the individual has caused or is likely to cause prejudice to the proper conduct of the Council of Governors' affairs; or

5.1.2.5 the individual has failed to comply with the values and principles of the NHS, the Trust or this Constitution.

5.2 The Council of Governors will agree a process for investigating complaints against Governor which may lead to a removal of a Governor under this paragraph 5.

6. Vacancies amongst Governors

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

Appointed Governors

6.2 Where the vacancy arises amongst the Appointed Governor, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office or to commence a new term of office.

Elected Governors

6.3 Where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either:

6.3.1 to call an election within three months to fill the seat for the remainder of that term of office;

6.3.2 to call an election to fill the seat for a new term of office;

6.3.3 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office; or

6.3.4 if the unexpired period of the term of office is less than twelve months, to leave the seat vacant until the next elections are held.

6.4 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment or election of the Governor attending the meeting.

7. Dispute Resolution

7.1 In the event of any dispute between the Council of Governors and the Board of Directors:

7.1.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

7.1.2 if the Chair is unable to resolve the dispute they shall appoint a special committee comprising equal numbers of directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute; and

7.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

ANNEX 5

Additional Provisions – Board of Directors

1. **Disqualification of directors**

1.1 In addition to paragraph 31 of this Constitution, a person may not become or continue as a Director if:

1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

1.1.2 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;

1.1.3 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;

1.1.4 they are the spouse, partner, parent, child of, or occupant of the same household as a Director or a member of Council of Governors;

1.1.5 they are a member of a local authority's Overview and Scrutiny Committee covering health matters;

1.1.6 they are a Governor;

1.1.7 they are a governor, non-executive director (including the Chair) or, executive director (including the chief executive officer) of another NHS Body, unless:

1.1.7.1 in the case of an executive director other than the Chief Executive, the Chair, following consultation with the Chief Executive;

1.1.7.2 in the case of the Chief Executive, the Chair, following consultation with the Board of Directors;

1.1.7.3 in the case of a non-executive director other than the Chair, the Chair following consultation with the Council of Governors; or

1.1.7.4 in the case of the Chair, the Senior Independent Director, following consultation with the Board of Directors and the Council of Governors,

agrees to them becoming, or continuing as, a Director;

1.1.8 they are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

1.1.9 in the case of a non-executive Director, they have refused, without reasonable cause, to fulfil any training requirement established by the Board of Directors;

1.1.10 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Director;

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

1.1.12 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list;

1.1.13 they are deemed a vexatious or persistent complainant (as defined in Annex 4) or litigant against the Trust without reasonable cause;

1.1.14 they have failed to repay (without good cause) any amount of monies properly owed to the Trust; or

1.1.15 they fail to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time.

1.2 Where a Director becomes disqualified for appointment under paragraph 1 of this Annex or paragraph 31 of this Constitution, they shall notify the Trust Secretary in writing of such disqualification.

1.3 If it comes to the notice of the Trust Secretary that at the time of their appointment or later the Director is so disqualified, they shall immediately declare that the Director in question is disqualified and notify them in writing to that effect.

1.4 Where a Director is disqualified their tenure of office shall automatically terminate and they shall cease to hold office with immediate effect.

2. Expenses

2.1 The Trust may reimburse executive Directors travelling and other costs and expenses incurred in carrying out their duties at such rates as the Remuneration Committee decides. These are to be disclosed in the annual report.

ANNEX 6

Further Provisions - Membership

1. Restriction on membership

1.1 In addition to paragraph 12 of this Constitution, the following restrictions on Membership apply:

1.1.1 The following will not be eligible to become or continue a Member:

1.1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;

1.1.1.2 an individual who exhibits inappropriate conduct (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors), including those who have been identified as the perpetrators of a serious incident involving violence, assault or harassment against Trust staff; and/or

1.1.1.3 a person who is a deemed a vexatious or persistent complainant or litigant against the Trust (as defined in Annex 4) without reasonable cause (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors).

2. Termination of Membership

2.1 A Member shall cease to be a Member if:

2.1.1 they resign by notice in writing to the Trust Secretary;

2.1.2 they cease to be eligible to continue to as a Member under paragraph 1.1.1 of this Annex 6 or paragraph 12 of this Constitution;

2.1.3 they are expelled from Membership under paragraph 1.1 of this Annex 6; or

2.1.4 they die.

2.2 The Trust shall give any Member at least fourteen days' written notice of a proposal to remove them from the Trust membership under this paragraph 2 of Annex 6. The Trust shall consider any representations made by the Member during that notice period, and the Secretary shall decide whether to remove the Member. Within fourteen days after receiving notice of the Secretary's decision, a person wishing to dispute

the decision may require the Secretary to refer the matter to the Council of Governors to determine whether the decision was fair and reasonable taking all relevant matters into account. Where a Member does not ask the Secretary to refer their proposed removal to the Council of Governors, they shall cease to be a Member fourteen days after receiving notice of the Secretary's decision. Where a Member does ask the Secretary to refer their proposed removal to the Council of Governors, they shall continue to be a Member until the Council of Governors has reached a decision on their membership and provided them with notice. The decision of the Council of Governors shall be final.

2.3 An individual member removed under paragraph 2.2 may make a request to the Secretary that their membership removal be reviewed and their eligibility to be a member be considered no sooner than 12 months from the date of the removal.

2.4 When making a request under paragraph 2.3 the individual must make such a request in writing to the Secretary and outline whether they wish to be considered as eligible to be a member and the reasons for the requested review. The Trust shall endeavour to issue a decision in writing within 28 days of receipt of the request. The Trust's decision shall be final and any further requests for review may only be made after intervals of at least two further years.

ANNEX 7

Annual Members Meeting

1.1 The Trust shall hold a members' meeting for all Members (called the **Annual Members Meeting**) within six months of the end of the financial year of the Trust.

1.2 Any members' meeting other than the Annual Members' Meeting shall be called a 'Special Members Meeting'.

1.3 Both Annual Members' Meetings and Special Members' Meetings shall be open to all Members, members of the Council of Governors and members of the Board of Directors, together with representatives of the Trust's Auditors, and to members of the public. The Trust may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend any such meeting.

1.4 The Board of Directors may convene an Annual Members' Meeting or a Special Members' meeting when it thinks fit. The Council of Governors may request the Board of Directors to convene a members' meeting.

1.5 The agenda shall set out the business to be conducted at the meeting. No business other than that set out in the Agenda shall be considered at any members' meeting.

1.6 The Board of Directors (or at least one (1) member of the Board of Directors) shall present to the members of the Annual Members' Meeting:

1.6.1 the annual accounts;

1.6.2 any report of the auditor on them;

1.6.3 the Annual Report;

1.6.4 a report on steps taken to secure that (taken as a whole) the actual membership of the Trust is representative of those eligible for such membership;

1.6.5 the progress of the membership plan; and

1.6.6 the results of any election and appointments to the Council of Governors, and any other reports or documentation it considers necessary or otherwise required.

1.7 The Trust shall give notice of all members' meetings:

1.7.1 by notice prominently displayed at the Trust's headquarters;

1.7.2 by notice on the Trust's website;

1.7.3 by notice communicated by email to the Members; and

1.7.4 to the Council of Governors, Board of Directors and the Trust's Auditors, stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least 14 working days before the date of the relevant members' meeting (or, in the case of an Annual Members' Meeting, at least 21 working days before the date of the relevant meeting).

1.8 Accidental omission to give notice of a members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

1.9 The Chair or in their absence, the Vice Chair, shall preside at all members' meetings of the Trust. If neither the Chair not the Vice Chair is present, the Governors present shall elect one of the Non-Executive Directors to act as Chair. If no Non-Executive Director is present, the Governors present shall elect one of their number to act as the meeting Chair. If no Governor is willing to act as Chair or if no Governor is present within fifteen minutes after the time appointed for holding the meeting, the members present and entitled to vote shall choose one of their number to act as Chair.

1.10 The quorum for a members' meeting shall be twenty (20) members present and entitled to vote. If a quorum is not present within thirty (30) minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven (7) days until such time as the Board of Directors determine.

1.11 No such meeting shall become incompetent to transact business by lack of a quorum arising after the chair has been taken.

1.12 The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time to time and from place to place or for an indefinite period.

1.13 A resolution put to the vote at a members' meeting shall be decided on a show of hands.

1.14 Every Member registered who is present shall have one vote. No proxies will be admissible.

1.15 The Trust's Auditor shall act as scrutineers in event of any voting.

1.16 No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.

1.17 If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting

at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date, and/or place.

1.18 Unless exceptional circumstances apply, in the case of a members' meeting is adjourned or postponed for fourteen (14) days or more, at least seven (7) working days' notice shall be given, specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted. Otherwise, it shall not be necessary to give any such notice.

1.19 The Board of Directors may make any such arrangement and impose any restriction it considers appropriate to ensure the security of a members' meeting.

1.20 Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. No proposal, speech or any reply may exceed three (3) minutes unless the Chair directs otherwise. In the interests of time, the Chair may, in their absolute discretion, limit the number of replies, questions or speeches which are heard at any one members' meeting.

1.21 A person who has already spoken on a matter at a members' meeting may not speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply or (ii) on a point of order, or (iii) at the Chair's discretion.

1.22 The ruling of the Chair on any matter of procedure or a point of order shall be final.

ANNEX 8

Model Election Rules

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Foundation Trust Network

Model Election Rules 2014

For use in elections to FT councils of governors

Lancashire Teaching Hospitals NHS Foundation Trust | Foundation Trust Network

Model Election Rules 2014

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

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

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

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

PART 6 COUNTING THE VOTES

STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
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STV47 Transfer of votes
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STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

PART 7 FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

Lancashire Teaching Hospitals NHS Foundation Trust | Foundation Trust Network

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) a Saturday or Sunday;

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

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

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

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

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:

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

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

7. Duty of co-operation

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

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:

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

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

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

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

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

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

(g) the contact details of the returning officer

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

9. Nomination of candidates

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

9.2 The returning officer:

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

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

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

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

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

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

11. Declaration of interests

11.1 The nomination form must state:

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

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

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

12. Declaration of eligibility

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

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

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

13. Signature of candidate

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

(a) they wish to stand as a candidate,

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

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

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

14. Decisions as to the validity of nomination

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

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

(b) decides that the nomination form is invalid,

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

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

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

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

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

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

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

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

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

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

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

15. Publication of statement of candidates

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

15.2 The statement must show:

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

(b) the declared interests of each candidate standing,

as given in their nomination form.

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

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

16. Inspection of statement of nominated candidates and nomination forms

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

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

17. Withdrawal of candidates

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

18. Method of election

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

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

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

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

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

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:

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

20. The ballot paper

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

20.2 Every ballot paper must specify:

(a) the name of the corporation,

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

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

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

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

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

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

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

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

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

(a) that the voter is the person:

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

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

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

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

("declaration of identity")

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

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

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

Action to be taken before the poll

22. List of eligible voters

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

22.2 The list is to include, for each member:

(a) a postal address; and,

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

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

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

23. Notice of poll

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

(a) the name of the corporation,

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

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

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

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

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

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

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

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

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

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

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

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

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

(a) a ballot paper and ballot paper envelope,

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

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

(d) a covering envelope;

("postal voting information").

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

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

(b) the voter's voter ID number,

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

("e-voting information").

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

(a) only be sent postal voting information; or

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

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

for the purposes of the poll.

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

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

25. Ballot paper envelope and covering envelope

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

25.2 The covering envelope is to have:

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

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

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

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

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

26. E-voting systems

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

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

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

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

(a) require a voter to:

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

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

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

(vii) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

(vi) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to:

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

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

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

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

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

(i) the voter's voter ID number;

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

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

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

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

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

The poll

27. Eligibility to vote

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

28. Voting by persons who require assistance

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

28.2 Where the returning officer receives a request from a voter who requires assistance to

vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

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

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

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

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

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

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

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

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

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

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

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

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

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer

was able to obtain it), and

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

30. Lost voting information

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

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

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

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

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

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

(a) the name of the voter

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

(c) the voter ID number of the voter.

31. Issue of replacement voting information

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

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

(a) the name of the voter,

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

(c) the voter ID number of the voter.

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

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

Polling by internet, telephone or text

33. Procedure for remote voting by internet

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

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

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

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

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

34. Voting procedure for remote voting by telephone

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

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

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

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

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

35. Voting procedure for remote voting by text message

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

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

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

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

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

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

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

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

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

(b) the unique identifier on a ballot paper.

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

37. Validity of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39. De-duplication of votes

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

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

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

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

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

(a) mark the ballot paper "disqualified",

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

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

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

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

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

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

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

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

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

40. Sealing of packets

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

(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:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(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.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

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 –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that 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.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

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.

The Foundation Trust Network (FTN) is the membership organisation for NHS acute hospitals and community, mental health and ambulance services.

The FTN acts as the public voice for those NHS trusts, helping to deliver high quality care and shaping the system in which they operate.

The FTN has over 227 members – more than 92% of all NHS foundation trusts and aspirant trusts.

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Foundation Trust Network

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust

Council of Governors

CoG Self-Assessment

Date of meeting	Date report produced
12 August 2026	9th July 2026

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	**Name and title:**	Cath Parnell Chief of Staff
		Date:	15th July 2026

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/A

Executive summary

The Council of Governors will recall that feedback from the self-assessment process was received at its last meeting. At that meeting, the Council was asked to establish a small working group to consider the feedback and bring proposed improvements back for consideration. Unfortunately, it has not been possible to establish the working group. The feedback has therefore been reviewed and is presented in the attached table. Each question has been RAG rated, with neutral responses excluded and ratings based on the response category (ie strongly agree and agree compared to disagree and strongly disagree) that exceeded others by a margin of three or more.

CoG will note that all categories have been rated green, however based on feedback received it may wish to consider suggesting improvements in the following areas for the Trust to consider:

- NED Engagement
- Holding Governors to account
- CoG strategic direction
- Training for Staff Governors
- Communication improvement – CoG and Trust

Noting that some governors may have individual areas of concern, please can these be raised with the Lead Governor in the first instance.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	n/a

Appendices

Self-Assessment Feedback RAG rated table

Committees that have previously discussed/agreed the report, and outcomes of that discussion

n/a

Key recommendations and actions requested

The CoG is asked to consider the self-assessment feedback received and propose improvements that could be made based on the feedback received.

How does this report further our Trust strategy?

A well-led CoG will support delivery of the Trust's Strategy.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	All
Quality of services provided	
Sustainable and efficient use of resources	

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	All
Leadership and Governance	
Performance	
People and Culture	

Strategy and Business Intelligence

Finance

Risk

n/a

Risks lodged on Datix:

n/a

External Standards affected by this report and associated risks

Best practice

CoG Self-Assessment

Question	Yes	No	Maybe	Governor Comment	Comment
Are you clear about your roles and responsibilities as a Governor	16	1	2		
Is the administrative support provided to the Council appropriate and effective	16	2	1		

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Governor Comment	Comment
Does the membership and size of the Council remain fit for purpose	1	7	6	4	1	I think that the CoG is well supported and represented	
Do the number of constituencies of Governors on the Council allow for effective representative of all stakeholders	2	10	4	3	0		
Do you receive sufficient high-quality information about Trust activities to enable you to hold the NEDs to account	3	9	1	4	2	We need better communication with the NEDs - they need to be more contactable and friendly it often feels like them and us with a sharp divide. The NEDs could have a lot stronger presence in meetings and CoG is often not aware of their input other than committee work. I'd like to see more engagement between the NEDs and Governors. I think we need more interaction with the NEDs so that when we do their appraisals we can truthfully perform this task. We need to have more engagement with the NEDs to be able to assess	

						their performance and be good to see them in action at other Trust premises and to hear their open thoughts on the direction and sustainability of the Trust.	
Is the Council of Governors well-chaired and managed	4	5	4	5	1	Overall, I am satisfied with the effectiveness of the Council of Governors. The environment encourages open, constructive dialogue and promotes collaborative working. Leadership of the CoG has been challenging. The person that steps forward to chair for this voluntary role needs to feel that they are supported from disrespectful vexatious repetitive allegations from other governors which undermine their appointed position and motivation. ie poor behaviour needs to be called out earlier and if a governor cannot understand that they have broken the principles then there should be the opportunity for a discussion, training and possible exclusion. Too much time in this last year has been spent inward looking. Too much time spent on disciplinary issues. We have taken the eye off the ball.	

Does the Council have open, constructive discussion between its members, focusing on relevant issues	2	8	4	4	1		
Does the Trust encourage open and honest communication between the Council and Board members	2	9	4	3	1		
Are you properly engaged in the strategic direction of the Trust	1	7	7	3	1		
As a member of the Council do you feel like a valued part of the organisation	3	10	3	1	2		
Do Council meetings focus on issues that are relevant to you	2	9	5	3	0		
Do you receive regular information from the Trust that helps you understand the general business of the organisation	3	13	2	1	0	Overall communication has been good. In my opinion the meetings run efficiently and meeting papers are thorough. I feel more engagement opportunities with the wider community would help governors fulfil their accountability role. I would appreciate being told of information that can affect myself in the instance of carer's representative so that I am able to clearly communicate with members of the public who wish to complain.	
Is the level of participation of NEDs at Council meetings appropriate	2	9	3	4	1		

By being part of the Council, do you feel you make a meaningful contribution to TSDFT and the communities it serves	1	10	3	3	2	We lack strategic direction moving forward. What has CoG achieved in the last 3 years?	
Does the Council represent the diversity of its staff and the local population	1	9	5	3	1		
Is the Council informed of any issues that could cause public interest before they become a risk	0	12	5	2	0		
Does the Council receive training or have issues explained to support understanding of topics	4	9	4	1	1	The training sessions have been helpful. At present, the training offered is designed for the Council of Governors as a whole, which is valuable. However, staff governors often have a unique perspective and set of responsibilities, and it may be beneficial to introduce specific training tailored for staff governors.	

Additional Comments

It would appear that there are enumerable boxes to tick and I question why ?

This being my first full year I still attempting to get my head around the various departments, communications and relevance.

Processes are very clear

I am unable to answer the questions because I have no experience of what the Trust is doing or not doing until I get involved.

We have spent too long on issues of conduct, at the expense of real Trust issues. Hopefully new leadership will give us more direction and purpose.

With no lead governor and no constituency meetings I feel isolated and unsupported.

After a year I still have no idea what meaningful contribution I am able to make.

I am a new member of the Council of Governors

ID	Date Requested	Governor	Constituency	Summary Description	Executive Lead	Response Date	Summary Response	C-O-G	Date emailed	Status
238	13.04.26	Vincent Williams	Torbay	Proposed questions: 1.EPR Integration & Shared Care Record Alignment Can the Board confirm how the Epic EPR implementation will integrate with existing shared care record systems across the ICS, including data flows, interoperability standards (e.g. FHIR), and any identified gaps? 2.Operational Readiness & Clinical Workflow Impact	Adel Jones / Sam Wadham-Sharpe	15.05.26	Epic integrates with the Devon and Cornwall Care Record (DCCR). This integration was already established at RDUH and as such, the data flows were already in place. DCCR respects role-based access and patient cohorts as seen within Epic by allowing in context launch. Although there were some account issues immediately at go-live, these were resolved promptly meaning there are currently no known gaps or issues with the integration. Our clinicians previously had access to DCCR through our clinical portal, but this has now become easier within Epic. There is a clickable icon which takes the user straight to the relevant DCCR record (in context access), demonstrated in this video. Anecdotal feedback from clinicians is that this is working well, and is a more convenient method of access.	12.08.26	15.05.26	Responded
				What assurance has the Board received regarding frontline usability of Epic, particularly in urgent and emergency care settings, and how does this align with access to shared care records for clinicians? 3.System-Wide Integration (Including Ambulance Services) How is the Trust working with partners such as South Western Ambulance Service to ensure timely and clinically usable access to patient records (including shared care records and EPR data) at the point of care?			Integration between South Western Ambulance Service NHS Foundation Trust (SWASFT) systems and Epic is a future aspiration. It would be a sizeable project in its own right, and with the magnitude of rolling out such a comprehensive EPR as Epic, across both acute and community, it was felt to be an increased clinical risk to try and integrate with SWASFT at go-live. We are now in a period of stabilisation with our Epic deployment, after which we will focus on optimisation. At this point, we will be in a far safer position to revisit this opportunity.			
240	19.04.26	Lee Thomas	Torbay	I wondered if it would be possible to clarify a few points further, mainly to help ensure there is clear and objective assurance for governors: •You noted that all recommendations are complete, with some elements ongoing. Would it be possible to provide a breakdown of which recommendations are formally signed off as complete versus those still in progress, and how "complete" has been defined?	James Corrigan	12.06.26	All recommendations have been implemented, when I say elements ongoing I am referring to recommendations that are recurrent ie improvements in Business Planning are implemented but need to be repeated annually rather than a process based recommendation such as development of a Operating Procedure which is a one off action revisited as required.	12.08.26	12.06.26	Responded
				In terms of validation, could you clarify which internal/external audits have reviewed this work, when these took place, and whether any findings or recommendations were raised? If available, it would be helpful to understand the level of assurance provided. •You mentioned review by NHSE, Internal Audit and External Audit, did any of these provide a formal opinion or conclusion on the effectiveness of the revised governance arrangements in practice? □			Internal Audit reviewed the effective of arrangements in place during 2025/26 across Our Plan for Better Care which covered programmes across Well Led, Workforce, Finance, Performance and Productivity and gave significant assurance of arrangements. The audit of financial controls was also significant assurance. The NHSE review was of Cost Improvement Programme (CIP) process in early 2025 when processes were being implemented. These are all now in place and are reflected in the significant assurance ratings on Audits of Our Plan for Better Care and Financial Controls during 2025/26. The overall assurance rating from Internal Audit is still draft at the moment (pending completion of the 2025/26 plan) but has been issued as Satisfactory assurance which is an improvement from Limited assurance in 2024/25. We are still awaiting the outcome of the Value for Money Audit (External) for 2025/26.			

				On financial risk identification, could you outline what has specifically changed compared to previous arrangements, and whether there are defined triggers or escalation thresholds now in place? •In relation to the savings programme, are you able to share what proportion of delivery to date is recurrent versus non-recurrent, and how delivery is being assured at scheme level? •Finally, what additional assurance does the Board receive beyond routine reporting to confirm that these arrangements are operating effectively in practice?			Financial risks (and mitigations) are summarised in the monthly financial report which is reviewed by the Executive Committee and Finance and Operations Committee for consideration. These were not clearly drawn out in previous the reporting. The CIP programme for 2026/27 is 80% recurrent. During 2025/26 our CIP was delivered 50% recurrently and has contributed to the increase in recurrent underlying deficit within the plan for 2026/27. The Board takes its assurance from monthly reporting and internal audit assurance from the internal audit programme. Other sources of assurance include external audit and any ad-hoc reports they may wish to commission either internally or externally.			
				I appreciate the work that has gone into strengthening these processes, having a bit more clarity on the above would really help provide confidence from a governor perspective.						
243	25.04.26	Lee Thomas	Torbay	I understand that an administrative team has been relocated to a site off the main hospital campus. It has been suggested that this site may not currently be accessible for wheelchair users, including a lack of suitable access (e.g. ramps) and disabled toilet facilities. I also understand that, as a result, a member of staff has been unable to work from that location.	James Corrigan Jess Piper Sam Wadham-Sharpe	04.06.26	The decision to relocate the Patient Access Team was driven primarily by the environment they were working in. The conditions in their previous location were not acceptable for colleagues - including ongoing issues with leaks, damp, limited space and uncomfortable working temperatures - and there was no capacity to support the team as it continues to grow. It was important that we addressed this. The move to Regents House provided a significantly improved working environment and the space needed to support the team properly. At the same time, the introduction of Epic has changed how the team can work. Previously, they were reliant on paper-based processes, which meant they needed to be on site. That is no longer the case, and it gives us more flexibility in how we organise teams.	12.08.26	04.06.26	Responded
				I appreciate that individual cases cannot be discussed, but I would welcome clarification on the broader position: •What was the rationale for relocating administrative teams off the main hospital site? •What processes are in place to ensure that any new or existing Trust sites are fully accessible to both staff and the public before they are brought into use? •Are there currently any Trust sites that are not fully compliant with accessibility requirements, and if so, what plans are in place to address this? □			Without going into individual circumstances or breaching confidentiality, we can assure governors that Individual needs were considered as part of the move. This included making adjustments to the space and taking advice from HR and corporate safety colleagues to ensure the environment was safe and appropriate. For example, only one of the two exits from the building had disabled access, therefore a mobile access ramp was ordered for the second exit. When we take on new buildings, our corporate safety team carry out on-site reviews to check they meet key requirements, including fire safety and accessibility standards. Where adjustments are needed, we agree these and build them into the work before teams move in wherever we can.For existing buildings - particularly older ones or those we inherit through transfer of service contracts- we know there can be limitations.			
							In those cases, we work closely with teams who are based there to understand what gets in the way and what would make a difference, and we put in place practical adjustments where possible. In some cases, buildings have limitations that cannot be fully removed. Where that is the case, our corporate safety colleagues work with the team and individuals to identify alternative arrangements. When teams move location or change how space is used, the corporate safety team reviews the environment and provides advice to ensure that requirements are met and that any necessary adjustments are identified early.			

							Like many other public sector organisations, some of the buildings we use – particularly our older or constrained sites – do not fully meet current accessibility standards.Where this is the case, we manage this through a combination of local adjustments and individual support, including Personal Emergency Evacuation Plans (PEEPs) where required. We also continue to review opportunities to improve these environments or provide alternative arrangements where appropriate. Kitson Hall, on the Torbay Hospital site, is one example where access is limited by the nature of the building, including a single stairwell exit. In the case of Kitson Hall, the building has already been identified for demolition as part of the wider site master plan for the Torbay Hospital site and our preparation for the New Hospital Programme.A planning application to support this was submitted in 2025. This is intended to ensure we are ready to move at pace as those programmes progress.As governors are aware, we have the third oldest NHS estate in the country at Torbay Hospital and this work provides an opportunity over time to address some of the inherent limitations within parts of the existing estate, including buildings like Kitson Hall.			
				What actions are being taken to ensure reasonable adjustments are consistently in place for staff with disabilities across all locations?			When a colleague tells us they have a disability, we work with them and their manager to understand what they need in practice. Where appropriate, we bring in Occupational Health to support that. We also take opportunities - such as room changes or team relocations - to check that environments work for people and to put adjustments in place early. The corporate safety team will undertake a review and provide advice and guidance on compliance with accessibility regulations. The aim is to take a consistent but practical approach, working with individuals to find solutions that work for them, while recognising that some of our buildings have real constraints.			
245	11.05.26	Ged Yardy	South Hams	Regarding the EPIC implementation, It has been observed that GP practices are finding it challenging to access e.g. blood results, however, patients of course can though the MyCare app. It was suggested that GPs do not have access. Please could you provide a statement of assurance on the communication of e.g. blood results and a timeline to the establishment of all results being communicated to GP surgeries so that GPs can continue to support their patients.	Kate Lisset	04.06.26	Thank you for raising this — it's an important question, particularly given the changes introduced through Epic. By way of reassurance, there has been no change to how GP practices access blood test results. GPs continue to use their established system (ICE), exactly as they did before Epic was introduced. In practice, this means: •GPs can view all blood test results, including those from acute services, through ICE •Where needed, results can be downloaded into their own clinical systems (such as EMIS or SystmOne) •For most practices, Epic is not something they use directly, so their usual routes for accessing information remain unchanged Based on what has been described, this is unlikely to be a system-wide issue. It may relate to a specific practice or a local technical issue, which can be investigated and resolved through the usual IT support routes.	12.08.26	04.06.26	Responded
							More broadly, there has been no interruption to the flow of results to primary care and GPs should be able to continue accessing results in the same way as before. At the same time, we recognise that digital integration across systems is something that can always be improved. Work is continuing locally and nationally to strengthen this, but safe and reliable access to results for GPs is in place now. In summary: there has been no change to GP access to blood results and no loss of information flow. If individual practices are experiencing difficulties, these can be looked into and resolved, but the underlying arrangements remain as they were prior to Epic.			

246	13.05.26	Ged Yardy	South Hams	A resident and TSDFT patient expressed concerns. What is the pathway in ED for immuno suppressed patients. (The indication were Eg neutropenia , sepsis) The patient experience is that there was not adequate recognition/ separation in ED. The same immuno suppressed patient waited for eg 8-12 hours without adequate access to drinks and food and was unable to access busy cafes for fear of losing their name being called or infection. There was concern about continuity at shift change. Ie being apparently forgotten	Kate Lisset	04.06.26	Thank you for raising this and we're really sorry to hear about this patient's experience. We recognise that extended waits, gaps in communication and the environment in the Emergency Department (ED) can be particularly difficult for patients who are immunosuppressed. It's not the experience we would want for anyone and especially not for people who are already more vulnerable. There are two areas we are focused on. Firstly, the immediate environment. We have made changes within ED to reduce crowding and improve separation between patients. These are practical steps, but they do make a difference - particularly for people who are more susceptible to infection. We also continue to remind teams of the importance of communication and basic care needs during longer waits.	12.08.26	04.06.26	Responded
				The communication from health care professionals to patient was dislocated ie the patient was unaware they were on a sepsis protocol. Overall the patient was happy with the interactions, however wished to express these concerns. Please can you provide assurance regarding these points.			Secondly, the model of care for patients known to oncology. We know that for some patients, ED is not always the most appropriate place to receive care. We are therefore working towards a different approach for patients already known to oncology, so that they do not always have to come through ED. This includes developing a more comprehensive ambulatory cancer care pathway, with a dedicated same-day oncology emergency service (ODEC). The intention is that this would: •p̄rovide earlier access to cancer specialist input •ōffer an alternative to ED or admission for appropriate patients •s̄upport people to be seen and treated more quickly, often without needing to stay in hospital			
							•ā̄llow some patients who do attend ED to be redirected into a more appropriate oncology setting •ēnsure care is provided within teams who know the patient and their needs This model is not yet fully in place and will depend on workforce, capacity and funding decisions. However, elements of it are being actively developed and this remains an important area of focus for us. In the meantime, where patients do need to attend ED, teams are mindful of the need to protect immunosuppressed patients as far as possible and to ensure that care is safe, coordinated and compassionate.			
247	13.05.26	Mo Oroko	Staff Governors	1.L̄and at Edginswell was recently purchased to turn into a much needed additional staff car park. When will these parking spaces come online, how many will there be, and will there be a park and ride facility?	James Corrigan	12.06.26	Subject to planning approval, we intend to build a new aseptic suite on Edginswell which is a two-year build. In phase one of the project, parking will be available for 155 spaces reducing to 120 spaces when the unit is built. This will not be a park and ride but rather a park and stride (with staff encouraged to walk from the car park to the Annexe or the main site (depending on their work location)).	12.08.26	12.06.26	Responded
248	13.05.26	Mo Oroko	Staff Governors	2.Staff report they are having to pay £9 to park at Totnes when attending for clinical commitments. They are then required to fill out forms on a regular basis if they are to recoup the costs. This seems excessively onerous – can the system be streamlined	James Corrigan	12.06.26	On parking at Totnes, staff permits are available if the member of staff meets the eligibility criteria. If they do not meet the criteria I am afraid the claim through expenses is the only current solution. We are reviewing car parking arrangements across the Trust this year and will consider options to ensure processes are as streamlined as possible.	12.08.26	12.06.26	Responded
249	18.05.26	Ged Yardy	South Hams	What are the TSDFT plans for the Council of Governors given the Kings speech? Empower providers through Foundation Trust reform: giving them more flexibility to design and deliver healthcare around local needs by removing the requirement for a Council of Governors.	Jane Harris	29.05.26	Thank you for your question. At this stage, there is no change to the statutory role of the Council of Governor, and our responsibilities as a Foundation Trust remain unchanged. That means the Council continues to play a vital role in holding the Non-Executive Directors to account, representing the interests of our members and the wider public and supporting openness and transparency in how we operate. For that reason, it is important that we continue to strengthen the Council, including proceeding with governor elections this year to fill our current vacancies. Having a full and representative Council is essential to ensuring we are hearing a broad range of voices from across our communities. Like our governors, we are aware of the direction set out in the King's Speech in relation to Foundation Trust reform (NHS Modernisation Bill). However, this is an early statement of intent and we do not yet have detail on the proposed legislative changes, the expected timeline, or what this might mean in practice for organisations like ours.	12.08.26	29.05.26	Responded

							If, in due course, there are changes to the role or requirement for a Council of Governors, we would expect there to be clear expectations about how organisations continue to engage effectively with patients, the public and local communities. That will remain fundamental to how we work. Subject to greater clarity on the policy and legislative timetable, I would be keen for us to work with governors, alongside patients, partners and community representatives, to co-design how we strengthen these arrangements locally — bringing together patient voice and experience with wider public and community insight and ensuring we have meaningful two way dialogue rather than one off engagement. For now, our focus remains on supporting the Council of Governors to operate effectively in its current role, while keeping a close watch on national developments and involving governors as that picture becomes clearer.			
250	08.06.26	Jake O'Donovan	Teignbridge	Could you help me understand what the intended model of post-diagnosis support for dementia patients and their families is within the Trust?In particular: •What level of ongoing contact, review, or follow-up would ordinarily be expected following diagnosis? •What information and support should families and carers typically receive? •How are patients and carers supported once they have been discharged from specialist services?	Nicola Mcminn	26.06.26	Thank you for your enquiry.The majority of diagnosis of people with dementia is made in memory clinics in Devon Partnership Trust (DPT). A small number of diagnoses are made by the Neurology Service within Torbay & South Devon NHS Foundation Trust (TSDFT). People diagnosed by neurology are then referred to memory clinics in DPT for advice. Typically all people with a diagnosis of dementia should be referred to dementia support workers within local community DPT mental health teams who then offer a range of support and information. DPT will also arrange follow up. Torbay and South Devon NHS Trust hospitals will provide care to people with dementia when they experience other health issues and will link with DPT staff in the psychiatric liaison team on site as necessary. Our community teams also provide care to people with dementia as and when other health needs arise.	12.08.26	26.06.26	Responded
				Are there any current challenges, gaps, or improvement programmes relating to post-diagnosis dementia support that Governors should be aware of? I am keen to better understand the pathway so that I can respond accurately when residents raise concerns and ensure that feedback from the public is being shared constructively.			At present the links between TSDFT community teams and DPT community teams can be inconsistent. We are engaging with the ICB work on developing neighbourhoods and note that mental health is a priority for neighbourhood work across primary care and other organisation. We are engaged in this work and are looking forward to stronger links with DPT.			
251	11.06.26	Dave Cawley	South Hams	When our Cottage Hospital closed, we were assured there would be continued access to Minor Injuries services. Unfortunately, parts of Dartmouth experience some of the highest levels of deprivation in Devon, and travelling to Totnes is extremely difficult by public transport and they are often closed. A return taxi journey to Torbay costs around £60+, which is simply unaffordable for many local residents. This will cause real difficulties for people in Dartmouth, and I'd be very grateful for your help in finding a solution. What can we do to resolve this?	Joe / Martin - Jane Harris	17.06.26	Dear Dave and Ged I have now had the opportunity to get a fuller briefing along with reviewing the correspondence you sent me over. This issue concerns a historic non-contracted payment arrangement of more than 10 years' standing rather than a formally commissioned service. Currently it is not TSD responsibility to commission minor injuries which is an ICB responsibility. On that basis, a decision was taken to end the arrangement following due process. Formal notice was issued in August 2025, with a cessation date of 31 October 2025, and written confirmation was provided that no further invoices would be authorised beyond that date. There was direct engagement with the practice through written correspondence and an offer to meet with partners; the matter was considered locally at partner level; an EQIA was initiated and progressed through governance; and the proposal was taken through the appropriate panel route.	12.08.26	17.06.26	Responded

							The practice's challenge is not about absence of due process, but about ongoing local access and its proposal for a reduced interim arrangement pending completion of its service review. No formal response was issued to the 50% counter-offer that was received from the practice although payments had ceased, the position on the proposed interim arrangement was not clearly confirmed by the Trust. I have asked the team to look at this, and we will propose formalising a revised offer at 50% of the original payment on an explicitly interim basis until the practice completes its service review, subject to monthly activity reporting on minor injuries work undertaken at the Health and Wellbeing Centre and a defined review point. Shelly will continue to be the point of reference for the service. This will maintain a proportionate level of local support, strengthen accountability through reporting, and mitigate current access and reputational concerns while preserving the integrity of the original decision-making process.			
							We can then review at a defined point the value for money of this service and seek the ICB view around funding going forward. I trust this will be helpful Joe			
252	12.06.26	Lee Thomas	Torbay	In light of recent public discussion and media coverage regarding maternity services in the UK, I would be grateful if the Trust could provide a five-year overview covering the following information to assist Governors in understanding long-term trends and outcomes. 1. Hospital deaths Please provide: • Total number of deaths within the Trust's establishments by year. • Deaths broken down by main recorded cause or category of death. • Deaths broken down by age band. • Deaths broken down by sex (male/female). • Any notable trends, changes or areas of concern identified from this data	Nicola Mcminn		CoG Priorties session in September			Closed
253	17.06.26	Vince Williams	Torbay	1. Exactly what pathology services are proposed to move to Gadeon House, and what will remain at Torbay Hospital?	Simon Tapley	26.06.26	We have secured £4.6m of NHS England capital funding to develop our cellular pathology (histopathology) services at Gadeon House and address the critical infrastructure risks associated with the current Torbay facility (which is a temporary structure more than 40 years old). Cellular pathology is part of our clinical support services rather than a patient-facing service. The change we are making is therefore about how we provide safe, sustainable laboratory facilities and diagnostic support, rather than changing where patients receive care. Following our own options appraisal, the agreed approach is: • routine cellular pathology (histopathology) will move to a new laboratory at Gadeon House, with transition expected in around 12–18 months following detailed design and implementation • there is an interim step of moving cytology to Royal Devon to release space and mitigate immediate safety risks on the Torbay site Urgent and time-critical cellular pathology work needed to support care at Torbay Hospital will continue to be available through clear and agreed clinical processes, including	12.08.26	26.06.26	Responded
				2. Is the proposed move limited to Cellular Pathology/routine histopathology?			At present that is the first priority. The Trust is also working with partners on what other routine (ie non urgent) pathology work can also be considered. This would have to be part of a full business case and agreed by Board. This has not been done yet.			
				3. Is any Torbay Blood Sciences activity moving to Gadeon House?			The move of blood sciences and microbiology services to Gadeon House relates to Royal Devon's services, under their agreement with Torbay Council. There are no plans that would reduce the availability of urgent or time-critical pathology support for care at Torbay Hospital. These services are critical to supporting urgent and emergency care and will continue to be provided We are exploring with partners whether a consolidated place for routine work would provide a more cost effective and resilient option. This work is being developed into a full business case for Board to consider and reflects approaches already being taken in a number of other parts of England			

				4.What will the Torbay Acute Service Laboratory provide, and how will it be staffed?			The Acute Services Laboratory at Torbay will provide urgent and emergency diagnostic testing, including work needed to support emergency departments, inpatients and intraoperative and other time-critical diagnostic support. It is a permanent on-site function, designed to ensure safe, timely clinical care. This includes, for example, rapid blood testing to support the management of patients with suspected sepsis in the emergency department, as well as time-critical intraoperative diagnostics such as frozen sections to support surgical decision-making. Our clinicians have developed a clear specification of our requirements for our Acute Services Laboratory which have been shared with the Peninsula Pathology Network. Staffing arrangements are being developed through implementation planning, with ongoing engagement and involvement of pathology colleagues in designing how this will work in practice			
				5.What is the expected impact on cancer diagnostic pathways and turnaround times?			We recognise concerns about whether changes to cellular pathology could affect cancer diagnosis or treatment times. Maintaining safe and timely diagnosis is a core requirement of the transition. The clinical approach to cellular pathology is being developed by clinical and laboratory leads across Torbay and South Devon and Royal Devon. This is aligned with national turnaround standards for histopathology, where most diagnostic work is reported over a number of days rather than hours. It will combine a modern laboratory for routine work with clearly defined pathways for any time-critical work, including intraoperative support such as frozen sections and urgent cancer requirements, to ensure safe and timely patient care. Performance, including cancer pathways, will continue to be closely monitored through existing governance and reporting arrangements as well as transition planning.			
				6.What are the current baseline turnaround times and the expected future turnaround times after transition?			National standards for cellular pathology reflect that most diagnostic work is not immediate, with 90% of cancer-related results expected to be reported within 10 calendar days. These standards underpin how services are designed and will continue to be used as the benchmark for quality and performance. Local turnaround times are already monitored and will continue to be tracked through transition, with the explicit requirement that standards are maintained.			
				7.How will samples be transported, tracked and protected between Torbay and Exeter?			The model assumes movement of samples between Torbay Hospital and Gadeon House. This will be supported by planned logistics, handling and tracking processes to maintain sample integrity and traceability as part of implementation. There are robust existing arrangements in place for the movement of samples between different sites as certain samples are already processed at different sites depending on specialist need. These arrangements are designed to ensure that sample movement does not impact the quality or timeliness of patient care.			
				8.What is the workforce impact, including relocation, retention, recruitment and equality impact?			We have been clear that: •this has been a difficult and uncertain period for pathology colleagues •there is ongoing direct engagement, including meetings with Joe and regular updates Colleagues will be: •involved in the design, fit-out and day-to-day planning of the new service Implementation planning includes: •retention and recruitment considerations •potential relocation linked to histopathology activity •formal equality impact assessment and mitigations The move also directly addresses known safety risks in the current environment.			

				9. What are the full financial implications of the TSDFT lease, including rent, service charges, liabilities and exit risks?			We have entered into a 15-year lease with Torbay Council, with a Trust break at 5 and 10 years. Annual rent is £189,803 plus VAT and service charges. There is an agreed forward rental payment and capital-funded fit-out arrangement. £4.6m NHS England capital (ring-fenced) covers: o lease-related costs o £600k design and fees o £3.123m fit-out costs This arrangement is separate from Royal Devon's lease and financial arrangements.			
				10. Does any part of the Torbay Council/Royal Devon £7.5m arrangement relate to TSDFT's services, space or lease?			No. • Royal Devon has a separate 25-year lease and fit-out arrangement with Torbay Council, including a Council capital contribution repaid over time • our cellular pathology development is funded through our own capital allocation and lease The two arrangements are co-located in the same building but are contractually and financially separate.			
				11. What options were considered before Gadeon House was selected, and can Governors receive a summary of the options appraisal/business case?			We undertook a detailed options appraisal for cellular pathology, which identified Gadeon House as the preferred option because it: • addressed immediate estates safety risks • provided a deliverable solution within the time-limited funding window • enabled development of fit-for-purpose laboratory facilities • supported future improvements including digital pathology. Options that were not supported included the Estover site which University Hospitals Plymouth NHS Trust are developing for their pathology services			
				12. What Board/NED scrutiny took place before and after the urgent decision, and what is the communication plan for staff, patients, Governors, MPs and the public?			An options appraisal and business case were considered through Executive Committee on 25 March 2026. The decision was taken on 26 March 2026 under urgent decision-making arrangements by the Chief Executive and Chair, in line with our governance. This reflected the requirement to commit funding by 31 March 2026 (or lose the funding). Board were formally briefed through the Chief Executive's report to Private Board on 02 April 2026. Board formally and retrospectively endorsed the business case on 07 May 2026 Governors were briefed through the Chief Executive's report at Council of Governors on 13 May 2026. Ongoing Board oversight continues, with further updates planned through Board reporting.			
254	22.06.26	Vince Williams	Torbay	1. Adult Social Care/Section 75 transition Given the decision to serve notice on the Section 75 adult social care agreement, what assurance can Governors take that there is a formal transition risk register and joint assurance route with Torbay Council, with clear accountabilities, risk-sharing, financial oversight and safeguards for continuity of care? How will key risks, milestones and any escalation issues be reported to the Board and, where appropriate, Governors during the transition?	Simon Tapley	26.06.26	There is a formal transition register both within our organisation and jointly with the Local Authority (Torbay Council). A transition board has been set up and is chaired by the Chief Executive of the Local Authority and attended by Trust executives. The terms of reference for the transition board has been signed off by the s75 Partnership Board. The project highlight report is included in the Our Plan for Better Care report that is received by the Board of Directors.	12.08.26	26.06.26	Responded

				2.Cyber/IG/Epic assurance Internal audit has highlighted limited assurance around cyber vulnerability management and disaster recovery. With Epic now live, what assurance has the Board taken on the current residual cyber/IG and business continuity risk, are any related actions overdue or rated high risk, and when will the Audit and Risk Committee receive evidence that the required actions have been closed?			The limited assurance opinion for the Vulnerability and Change Management Audit was largely driven by weaknesses in governance and documentation rather than failures in the underlying technical controls. The audit identified one high-risk recommendation relating to the need for more comprehensive information asset and contract records, alongside the formalisation of some policies and procedures. Good progress has been made against the agreed actions. Updated policies and procedures are already in place, and a new Information Asset and Contracts Register is being tested ahead of implementation by 01 October 2026. A follow-up review is currently underway, with the outcome due to be reported to the Audit and Risk Committee in October 2026. In addition, an independent Vulnerability Management Maturity Assessment commissioned through NHS England assessed the organisation at Level 4 out of 5, providing further assurance that our core vulnerability management arrangements are operating effectively while also identifying opportunities for further improvement.			
							In relation to Disaster Recovery, the audit identified no high-risk recommendations. At the time of the review, a significant upgrade to our backup and recovery arrangements was underway, which limited the auditors' ability to fully assess the new solution. That replacement platform is now live and provides enhanced resilience, including secure off-site backups and additional protections aligned to national cyber security standards. The remaining actions relate mainly to updating documentation and strengthening recovery information within our business continuity and disaster recovery plans. These are on track for completion by 30 September 2026.The Board has therefore accepted the current level of residual risk because there are no outstanding high-risk recommendations associated with Disaster Recovery, the single high-risk recommendation from the Vulnerability and Change Management Audit has a clear remediation plan and implementation date, and further independent assurance activity is already underway. The Audit and Risk Committee will receive updated assurance on progress and completion of the agreed actions later this year.			
255	25.06.26	Mike Joyce	Teignbridge	should a patient be referred by a GP or other clinical specialist, to a specialist at Torbay NHS Trust, irrespective of the cause, what is the procedure to ensure that the patient is kept informed of the progress of the referral and the time scales involved. How does any patient, who may not be IT compliance, be able to track the referral in question, be ensured that progress and time scales are being adhered to, and is there a list that is produced for each and every specialist area, to show this timescale and the number outstanding and duration	Sam Wadham-Sharpe					Assigned
256	26.06.26	Jake O'Donovan	Teignbridge	I appreciate that decisions relating to the future community hospitals involve several organisations, but I wondered whether you could provide an update on the Trust's understanding of the current position. In particular: -What is the latest position regarding services currently provided from Teignmouth Hospital? -If changes are planned, what reassurance can be given that local access to services such as physiotherapy and podiatry will be maintained where possible?	Sam Wadham-Sharpe					Assigned

				The constituent also shared concerns about waiting times for women's reproductive health services, including ultrasound appointments. Whilst I am not seeking information about any individual's care, it would be helpful to understand whether there are known pressures within these services and whether any work is underway to improve waiting times and patient access.						
257	29.06.26	Jake O'Donovan	Teignbridge	More broadly, I have noticed women's health beginning to emerge as a recurring theme in conversations with constituents in recent weeks, particularly around access to diagnostics, gynaecology and ongoing support. It would be useful to understand whether this is something the Trust is actively monitoring and whether there are any service developments or improvement programmes that Governors should be aware of.	Sam Wadham-Sharpe					Assigned
				I am not seeking information about this individual's care, but rather hoping to better understand the wider picture so I can respond accurately to constituents and ensure patient feedback is reflected in discussions about service performance.						
258	01.07.26	Vicki Payne-Cater	Staff Governors	I have been approached by a member of staff who is concerned about a number of health, safety and wellbeing issues affecting the Waste Team. The concerns raised are outlined below: •Waste cages are reportedly being stacked excessively high and secured unsafely on the back of the van, creating a risk of cages falling and potentially causing injury. •The volume of waste being generated across the site, particularly within the Tower Block and surrounding corridors, appears to be increasing significantly, with no corresponding increase in staffing resources.	James Corrigan		Thank you for raising these concerns. The health, safety and wellbeing of all our colleagues is extremely important and we take any concerns raised about working conditions seriously. The issues highlighted have been shared with the relevant operational, estates and health and safety teams for review. This includes concerns relating to the handling and storage of waste, sharps safety, welfare facilities and the suitability of accommodation currently used by the Waste Team. Risk assessments have been undertaken and we are seeking assurance that appropriate control measures are in place and that any identified actions are being progressed. We are also reviewing whether any further immediate measures are required to support staff and maintain a safe working environment. In addition, members of the senior team will be spending time with colleagues from the Waste Team to hear their concerns directly and ensure their experiences help inform any further actions that may be required. We recognise that some of the issues raised relate to the condition of the facilities currently available to the team.	12.08.26	10.07.26	Responded
				•There are concerns regarding several high-sharps-risk areas where current practices are reportedly not in line with established sharps safety guidance. The staff member also highlighted the challenges faced during last week's heatwave. The Tower ward and clinic areas reportedly became particularly unpleasant due to the volume of waste, creating difficult working conditions for the team.			Work is therefore underway to consider longer-term options for improving welfare and operational accommodation and to determine the most appropriate solution. We are grateful to colleagues who raise concerns, as this helps us identify issues and take action where improvements are needed. We will continue to monitor the situation closely and ensure that staff wellbeing and safety remain our priority.			

				In addition, the Health and Safety Team has recently deemed the Waste Team staff room area unsafe and closed it. However, no alternative welfare or rest area has been provided, leaving staff with nowhere suitable to take breaks. Furthermore, I understand that Health and Safety has raised concerns regarding the nearby toilet facilities and is considering their closure due to safety issues. The nearest alternative facilities are located at the Level 4 Main Entrance, which is a considerable distance from the team's working area and may not be practical for staff during their shifts.						
259	07.07.26	Mo Oroko	Staff Governors	Given challenges with flow through the hospital, it is understood medical patients can languish in the Emergency Department, experiencing longer waits for review by a senior decision maker in their care. How long is the average wait from ED team referral to medical consultant review for medical patients who remain in ED? And is there a sense of how disadvantaged they may be compared to patients moved to the Acute Medical Unit in terms of time to discharge?	Sam Wadham-Sharpe	06.08.26	Thank you for your contact and for raising this important question. As is widely recognised across the NHS, healthcare organisations are experiencing significant operational pressures. These pressures arise from a combination of increasing demand for services and static capacity, alongside a number of external factors that influence patient flow through the system. These include changes in access to primary care services, ambulance handover initiatives and availability of alterative services and social care, as well as the normal seasonal and local fluctuations in demand that all health systems experience. The cumulative impact of these pressures is an increase in patient length of stay across healthcare settings, with the effects often most visible within Emergency Departments. This is not a challenge unique to Torbay and South Devon NHS Foundation Trust but is being experienced nationally across the NHS.	12.08.26	06.08.26	Responded
							We fully acknowledge that patients are waiting longer for assessment and review than we would wish. Due to capacity constraints elsewhere in the system, there are occasions when patients remain within the Emergency Department for longer than is clinically appropriate while awaiting transfer to the Acute Medical Unit, an inpatient ward, or another suitable care setting or discharge destination. The Trust continually monitors waiting times and delays across all specialties. Where delays are identified, there are clear escalation processes in place to ensure timely senior clinical oversight and to maintain patient safety. Patients who experience extended waits are subject to ongoing review, and any concerns are escalated promptly through established operational and clinical governance arrangements.			
							Unfortunately, we are not currently able to provide precise comparative information regarding waiting times for medical review within the Emergency Department compared with patients who are transferred directly, or at an earlier stage, to the Acute Medical Unit. Following the recent implementation of our Electronic Patient Record system, Epic, we are seeing many benefits in terms of clinical information and patient care. However, as with any major system transformation, there remain some challenges in extracting certain quality metrics and datasets in the format required to answer specific questions of this nature. We therefore apologise that we cannot provide a more definitive response to this aspect of your query at present. I would, however, like to offer reassurance that delayed reviews are never the standard to which we aspire. The Trust has robust escalation processes, continuous monitoring of quality and safety indicators, and well-established governance arrangements to identify risks, implement mitigations, and ensure ongoing learning and improvement.			
							Reducing delays in assessment and reviews remains a key priority within our improvement programme. This work is closely linked to ongoing developments in patient pathways, improved care coordination, and planned expansion of services such as Same Day Emergency Care (SDEC) and Virtual Wards, all of which are intended to improve patient flow and reduce unnecessary waits. I hope this provides some context and reassurance. Thank you again for raising this important issue.			

260	07.07.26	Mike Joyce	Teignbridge	I thought you might like to see it as there appears to an item of concern being raised by one of its members as follows, "When we spoke about my unhappiness about Palantir continuing to have this data collection contract and the growing concern about them as a company, I said I would like to bring this up under the heading you have as EPIC. I personally feel that we should have been told about the national concern abut this company and that there were many people working in the NHS that felt they were the wrong company to use. I understand that it is felt their system is not all its cracked up to be in assisting the NHS. "	Jane Harris	13.07.26	Thank you for raising this concern. Firstly, it may be helpful to clarify that Epic and the NHS Federated Data Platform (FDP) are two separate things. Epic is our electronic patient record system. The FDP is a national NHS England programme designed to bring together information from multiple systems to support operational management, planning and service improvement. It is not a patient record system and does not replace local clinical systems such as Epic. We have not yet adopted the NHS Federated Data Platform at Torbay and South Devon NHS Foundation Trust. NHS England sees the FDP as an important part of its wider digital strategy and believes it can help NHS organisations make better use of data to support areas such as waiting list management, patient flow, theatre utilisation, discharge planning and operational performance. NHS England's current planning guidance includes an expectation that NHS organisations will increasingly adopt FDP products and capabilities over the coming years.	12.08.26	13.07.26	Responded
							Questions are often raised about what information is held on the platform and who can access it. NHS England's position is that NHS organisations remain the data controllers for their own information and determine how that information is used. NHS England has also stated that suppliers cannot access, use or share NHS data for their own purposes other than under NHS instruction, and that existing legal, data protection and information governance requirements continue to apply. There has also been public debate about NHS England's decision to award the FDP contract to a consortium led by Palantir. Some of that debate relates to data sharing and public confidence in the use of health information, while some relates to Palantir itself, including the company's previous work particularly with military and defence and broader questions about the role of large technology companies in public services.			
							NHS England's position is that the contract was awarded following a national procurement exercise and that the controls governing access to and use of NHS data apply regardless of the technology supplier involved. NHS England has also stated that NHS organisations retain control of their own information and that suppliers cannot use NHS data for their own purposes. There are a range of Frequently Asked Questions about the NHS Federated Data Platform and Palantir on the NHS England website which governors may find of interest: NHS England » Frequently asked questions (FAQs)			
261	04.08.2026	Vince Williams	Torbay	I would like to raise a formal governor assurance question concerning racist abuse and discrimination experienced by staff at Torbay and South Devon. Recent national reporting about racist abuse directed at NHS staff is deeply concerning. I recognise that governors need to focus on the evidence and assurance relating to our own Trust rather than assume that national findings automatically reflect the local position.	Jess Piper					
				The Trust's Workforce Race Equality Standard Annual Report 2026 provides sufficient local evidence to justify further discussion: https://www.torbayandsouthdevon.nhs.uk/uploads/wres-annual-report-2026.pdf?last-updated=20260522 The report records that: •946 employees, or 12.8% of the Trust workforce, were recorded as being from a Global Majority background, compared with 11.26% in the previous year.						

				•22.2% of Global Majority staff respondents reported experiencing harassment, bullying or abuse from patients, service users, relatives or the public. •15.7% reported discrimination from other staff, compared with 7.4% of White staff. •The report concludes that Global Majority staff continue to report higher levels of harassment and abuse from patients and the public, and discrimination from colleagues at more than twice the rate reported by White staff.						
				I understand that Global Majority is the umbrella term used by the Trust. However, this category covers staff from a wide range of ethnic and cultural backgrounds whose experiences may differ considerably. The combined figures may therefore conceal greater levels of abuse or discrimination affecting particular groups. The report also does not identify how much of the reported harassment, bullying or abuse was specifically race-related. Nor does it distinguish between Global Majority staff generally and internationally recruited colleagues.						
				These are important gaps in the assurance currently available to governors. The Trust increasingly depends on a diverse workforce to deliver essential hospital and community services. It is therefore important that the Board can demonstrate that colleagues are safe, supported and treated with dignity, and that racist behaviour is consistently challenged rather than accepted as part of the job. I would therefore like the following question formally raised:						
				What assurance do the Non-Executive Directors have that the Board understands the scale, nature and impact of racist abuse and racial discrimination experienced by staff at Torbay and South Devon, and that incidents are consistently reported, acted upon and followed by effective support for the staff concerned? It would be helpful for the response to address:						
				•the number and trend of reported race-related incidents over the last three years; •whether incidents involve patients, visitors, colleagues or other sources; •whether particular services, occupations or staff groups are more affected; •whether the evidence can be broken down by specific ethnic group, where numbers allow this without identifying individuals; •whether internationally recruited staff have been considered separately; •whether the Board believes there is significant under-reporting;						

				•what managers are expected to do when an incident occurs; •what support is offered to the member of staff concerned; •what action is taken against patients, visitors or staff responsible for racist behaviour; •how the WRES findings and resulting actions are monitored by the Board and its committees; and •whether staff have been asked directly whether they feel protected and supported by the Trust.						
				I am not seeking details of individual cases. Any information provided should be aggregated and anonymised. I appreciate that this may be an uncomfortable matter to discuss, but that should not prevent governors from seeking clear evidence and assurance. This is not an allegation that every reported incident was racist, nor is it criticism of individual patients, staff or services. It is a request to understand the local evidence, identify any gaps and establish whether the Trust's response is effective.						

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ALL Governor Meetings 2026

- Public Board – Bimonthly (excluding August and December) starts at 12:30 pm, all meetings are held in the Boardroom, Hengrave House and via MS Teams.
- Council of Governors – Quarterly, starts at 2pm held in the Boardroom and via MS Teams
- Membership Committee – Quarterly, starts at 10am held Virtually via MS Teams
- CoG Priorities – Bimonthly, starts at 2.30pm, held in the Boardroom, Hengrave House and via MS Teams
- Governor Only – Bimonthly, starts at 2.30pm. Boardroom, but FT Office will look at visiting other Trust sites for these, at request of Governors.
- Annual Members - Once a year in September, to present the annual report.
- Governor Nominations and Remuneration Committee – Ad hoc meeting when required.

Public Board meetings - attendance voluntary at Public Session		
Date	**Time**	**Venue**
8 January	12.30 pm	Boardroom
5 March	12.30 pm	Boardroom
7 May	12.30 pm	Boardroom
2 July	12.30 pm	Boardroom
3 September	12.30 pm	Boardroom
5 November	12.30 pm	Boardroom
Governor Obligations	Governors observe NEDs contributions at Board and hold NEDs individually to account for performance of Board – (Questioning NEDs on the Trust's quality and financial performance)	

Council of Governors Meetings (4 a year)		**Dates**	**Presentation**
Chaired by	Trust Chairperson	January	
Agenda Set by	Lead Governor and Chair	11 February MS Teams only	
Governor attendance	**Statutory Attendance**	March	
Exec & NED attendance	Yes	April	
Trust Office attendance	Yes	13 May	
Time	2pm – 4pm	June	
Venue	Boardroom, Hengrave House, Torbay Hospital	July	
Minutes	Required	12 August	
Description	Formal Statutory Council Meeting	September	
Purpose	Council of Governors are required to meet at least quarterly to ensure Governors can fulfil their statutory duties.	October	
Governor Obligations	Engagement with the Trust	11 November MS Teams only	
Additional Points		December	

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Membership Committee Meetings (4 a year)		Dates	Presentation
Chaired by	Membership Committee Chair	22 January	
Agenda Set by	Chair	February	
Governor attendance	**Only Governors who are on the Membership Committee attendance is required**	March	
Exec & NED attendance	No	30 April	
Trust Office attendance	Yes	May	
Time	10am – 12pm	June	
Venue	Via MS Teams	23 July	
Minutes	Required	August	
Description	Formal Committee Meeting	September	
Purpose	The purpose of the Committee is to support Governors in fulfilling their statutory duty to represent the interests of Foundation Trust Members and the public.	22 October	
Governor Obligations	Review FT membership data to target underrepresented groups	November	
Additional Points	Governors can self-nominate to join Membership committee	December	

CoG Priorities Meetings (6 a year)		Dates	Presentations
Chaired by	Trust Chairperson	20 January	Robotic Surgery
Agenda Set by	Lead Governor and Chair	February	
Governor attendance	**Voluntary Attendance**	17 March	CoC Workshop
Exec & NED attendance	Voluntary	April	
Trust Office attendance	Yes	19 May	NED Session
Time	2.30pm – 4.30pm	June	
Venue	Boardroom, Hengrave House, Torbay Hospital	21 July	A&E
Minutes	Yes, but the format may change to best suit the meeting, which may include PowerPoint slides as a record of the meeting	August	
Description	Formal meetings	15 September	Finance
Purpose	Meetings set aside to allow more complex priority issues to be heard and discussed by the CoG. Enabling the NED/CoG working relationship. Facilitating NEDs or Board Executives to present to the CoG in the form of a 'seminar' on key priority topics or CoG Questions. Allowing the CoG time to ask more detailed questions.	October	
Governor Obligations	Collective working and raise individual and collective questions to ensure views of FT	17 November	Carers

	Members and wider Public are received and responded to as required		
Additional Points	Priority sessions should where practical be linked to the Priorities set by the CoG and agreed by the Board	December	

Presentations – SIX Priorities 2026	**Date of Meeting: TBC**
Robotic Surgery	January
SWAST (Cancelled)	March
NED session	May
A&E	July
Finance	September
Carers	November

Governor Only Meetings (6 a year)		**Dates**	**Presentations**
Chaired by	Lead Governor and deputy Lead Governor	January	
Agenda Set by	Lead Governor	17 February	
Governor attendance	**Voluntary Attendance**	March	
NED attendance	No	21 April	
Trust Office attendance	Only if requested	May	
Time	2:30 pm to 4:30 pm Summer 4.15 pm – 6.15pm	16 June	
Venue	Boardroom, Hengrave House	July	
Minutes	As required, which may include a bulleted summary of the meeting or no minutes at all under the Chatham House Rule	18 August	
Description	Informal Governor **only** meetings	September	
Purpose	Regular Governor only meetings to ensure Governors can discuss and debate all relevant issues to ensure a level of collective knowledge and responsibility. The agenda may include Governor training as CPD, and reports by Governor Observers, CoG Committees and Constituency leads.	20 October	
Governor Obligations	Enables collective working	November	
Additional Points	Can be held in community settings if requested.	15 December	

Annual Members' Meeting (1 a year)		Dates
Chaired by	Trust Chairperson	January
Agenda Set by	Membership Committee, Lead Governor, and Chair	February
Governor attendance	**Voluntary or as requested to support**	March
NED attendance	Voluntary or as requested to support	April
Trust Office attendance	Yes	May
Time	TBC	June
Venue	TREC Lecture Theatre, next to Horizon Centre, Torbay Hospital	July
Minutes	Required	August
Description	Statutory Annual Members' Meeting to receive annual report, quality report and accounts.	September Date 24.09.26
Purpose	To present to members: and the public the annual accounts and report. Including any updates on membership and Governor elections.	October
Governor Obligations	Representing FT Members and Public and Hold NEDS collectively to account for performance of Board	November
Additional Points		December

Chair and Lead Governor Meetings		Dates
Chaired by	Trust Chairperson	January
Agenda Set by	Chair and Lead Governor	February
Governor attendance	**Bimonthly Lead Governor and Constituency Leads. Trust CEO may also attend if available.**	March
NED attendance	No	April
Trust Office attendance	No	May
Time	As diary permits – Chair PA arranges meetings	June
Venue	Chair's Office, Hengrave House	July
Minutes	Bulleted highlights produced for CoG	August
Description	Informal meeting	September
Purpose	Regular meetings between the Chair and the LG/DLG. Providing an informal meeting where issues or questions emanating from the Governor meetings can be discussed directly with the Chair.	October
Additional Points		November
		December

Constituency Meetings		Dates
Chaired by	Nominated Governor in each constituency	January
Agenda Set by	Constituency Governors	February
Governor attendance	**All Constituency Governors as available**	March
NED attendance	If invited	April
Trust Office attendance	No	May
Time	As diary permits	June
Venue	Local	July

Minutes	As required, which may be bulleted highlights produced for reference	August
Description	Informal meeting	September
Purpose	To enable Governors specific time to focus time on local constituency related issues	October
		November
Additional Points	Normally held quarterly	December

Governor Observer Reports from the Board Level Sub Committee Meetings		**Dates**	**Committee (Governor Initials)**
Observed by	Nominated Governor for each Committee	January 22 28 27	 Audit and Risk (ARC) (AR) Finance and Operations (FOC) (DC) Quality and People (QPC)(VB)
Governor attendance	**Nominated Governors as available**	February 24 25	 QP (VB) FOC (DC)
Report	Circulated via monthly email to all Governors and available in MS Teams channel	March 4 24 25	Charitable Funds Committee (CFC) (LD) QPC (VB) FOC (DC)
Description	Observations	April 28 29 30	 QPC (VB) FOC (DC) AR (AR)
Purpose	Assessing the NEDs performance	May 26 27 28	 QPC (AP) FOC (DC) ARC (VW)
Additional Points	New Governor observers decided to start in May.	June 17 23 24 25	 CFC (MJ) QPC FOC ARC
Governor Obligations	Hold NEDs individually to account for performance at each Committee	July 28 29 30	 QPC FOC ARC
		August 25 26	 QPC FOC
		September 22 26	 QPR FOC
		October 27 28 29	 QPR FOC ARC

		November 24 25	 QPR FOC
		December 9 15 23	 CFC QPR FOC

Governor Nominations and Remuneration Committee (AD HOC)		**Dates**
Chaired by	Trust Chairperson	Held as required
Agenda Set by	Chair	
Governor attendance	**Governor Members Only**	
NED attendance	Senior Independent Director	
Trust Office attendance	Corporate Governance Manager	
Purpose	Involvement input for performance appraisals for Chair and NEDs	
Governor obligations	Hold NEDs individually to account for performance of Board	
Additional Points		

Summary of standing and ongoing Governor Obligations:

- Ask about CQC judgements on the quality of care at the Trust – ad hoc
- Contact Senior Independent Director – if have concerns or if direct contact is inappropriate – ad hoc
- Jointly approve amendments to Trust's constitution – ad hoc
- Approve any "significant transactions" and approve a merger, acquisition, separation or dissolution – ad hoc as required
- Appoint and, if appropriate remove the Chair. Appoint and, if appropriate remove the NEDs – ad hoc, as required
- Appoint and if appropriate remove the Trust's external auditor – ad hoc, as required
- Approve the appointment of the Chief Executive – ad hoc as required
- Decide whether the Trust's non-NHS work would significantly interfere with its purpose – ad hoc as required.
- Have their views taken account of when Trust sets its strategy.
- PLACE Assessments (October 2024) Ensure views of public are added into the annual PLACE Assessments

NHS
Torbay and South Devon
NHS Foundation Trust

MAP TO LOCATE BOARDROOM WITHIN HENGRAVE HOUSE, TORBAY HOSPITAL, TQ2 7AA