

A meeting of the Board of Directors will be held on **Friday 31 July 2015** at 8.30am in the **Committee Room, Management Offices, Royal Bournemouth Hospital**.

If you are unable to attend on this occasion, please notify me as soon as possible on 01202 704777.

SARAH ANDERSON
TRUST SECRETARY

A G E N D A

TIMINGS			APPENDIX
	1. APOLOGIES FOR ABSENCE		
	Bill Yardley, Tony Spotswood, Derek Dundas, Peter Gill		
	2. DECLARATIONS OF INTEREST		
8.30-8.35	3. MINUTES OF THE PREVIOUS MEETING		
	(a) To approve the minutes of the meeting held on Friday 26 June 2015		A
8.35-8.40	4. MATTERS ARISING		
	(a) Update to Actions Log	All	B
	- CQC Action Plan Update	Paula Shobbrook	Verbal
8.40-9.00	5. QUALITY IMPROVEMENT		
	(a) Patient Story	Paula Shobbrook	Verbal
	(b) Feedback from Staff Governors	Jane Stichbury	Verbal
	(c) Workforce Race Equality Scheme	Karen Allman	C
9.00-9.55	6. PERFORMANCE		
	(a) Performance Exception Report	Richard Renaut	D
	(b) Quality Performance Report	Paula Shobbrook	E
	(c) Financial Performance	Stuart Hunter	F
	(d) Workforce Report	Karen Allman	G
	(e) Monitor Quarter 4 Report	Paula Shobbrook	Verbal
	(f) VLE Essential Core Skills	Basil Fozard	H
	(g) Individual Surgeon Outcomes	Basil Fozard	I
	(h) Emergency Department Improvement Plan (+ Presentation)	Richard Renaut	J
9.55-10.10	7. STRATEGY AND RISK		
	(a) Clinical Services Review	Paula Shobbrook	K
	(b) Trust Strategy	Paula Shobbrook	L
10.10-10.20	8. DECISION		
	(a) Constitution	Sarah Anderson	M

10.20-10.25

9. INFORMATION

- | | | |
|---|-----------------------|---|
| (a) Communications Update (including July Core Brief) | <i>Karen Allman</i> | N |
| (b) Corporate Events Calendar | <i>Sarah Anderson</i> | O |
| (c) Board of Directors Forward Programme | <i>Sarah Anderson</i> | P |
| (d) A338 Road works update | <i>Richard Renaut</i> | Q |

10. NEXT MEETING

Friday 25 September 2015 at 8.30am in the Conference Room, Education Centre, Royal Bournemouth Hospital

10.25-10.30

11. ANY OTHER BUSINESS

Key Points for Communication to Staff

10.30-10.45

12. COMMENTS AND QUESTIONS FROM THE GOVERNORS

Board Members will be available for 10-15 minutes after the end of the Part 1 meeting to take comments or questions from the Governors on items received or considered by the Board of Directors at the meeting.

13. RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS

To resolve that under the provision of Section 1, Sub-Section 2, of the Public Bodies Admission to Meetings Act 1960, representatives of the press, members of the public and others not invited to attend the next part of the meeting be excluded on the grounds that publicity would prove prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS
NHS FOUNDATION TRUST

Part I Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Board of Directors** held on **Friday 26 June 2015** in the Conference Room, Education Centre, Royal Bournemouth Hospital

Present:	Jane Stichbury	(JS)	<i>Chairperson (in the chair)</i>
	Tony Spotswood	(TS)	<i>Chief Executive</i>
	Karen Allman	(KA)	<i>Director of Human Resources</i>
	Ian Metcalfe	(IM)	<i>Non-Executive Director</i>
	Steven Peacock	(SP)	<i>Non-Executive Director</i>
	Paula Shobbrook	(PS)	<i>Director of Nursing and Midwifery</i>
	Dave Bennett	(DB)	<i>Non-Executive Director</i>
	Derek Dundas	(DD)	<i>Non-Executive Director</i>
	Peter Gill	(PG)	<i>Director of Informatics</i>
	Richard Renaut	(RR)	<i>Chief Operations Officer</i>
	Bill Yardley	(BY)	<i>Non-Executive Director</i>
In attendance:	Anneliese Harrison	(AH)	<i>Assistant Trust Secretary (minutes)</i>
	Nicola Hartley	(NH)	<i>Director of Organisational Development</i>
	James Donald	(JD)	<i>Head of Communications</i>
	Ruth Williamson	(RW)	<i>Proposed Interim Medical Director</i>
	Pete Papworth	(PP)	<i>Deputy Director of Finance</i>
	Sue Langlois	(SL)	<i>Matron, Anaesthetics</i>
	David Wyman	(DW)	<i>Charge Nurse, Anaesthetics</i>
	Dily Ruffer	(DR)	<i>Governor Coordinator</i>
	Jacqui Bowden		<i>Member of Public</i>
	Derek Chaffey	(DC)	<i>Public Governor</i>
	Mike Allen	(MA)	<i>Public Governor</i>
	Carole Deas	(CD)	<i>Public Governor</i>
	Roger Parsons	(RP)	<i>Public Governor</i>
	Paul McMillan	(PM)	<i>Public Governor</i>
	Eric Fisher	(EF)	<i>Public Governor</i>
	David Triplow	(DT)	<i>Public Governor</i>
	Doreen Holford	(DH)	<i>Public Governor</i>
	Brian Young	(BY)	<i>Public Governor</i>
	Colin Pipe	(CP)	<i>Public Governor</i>
	Paul Higgs	(PH)	<i>Public Governor</i>
	Guy Rouquette	(GR)	<i>Public Governor</i>
	Margaret Neville		<i>Chair of the Friends of the Eye Unit</i>
	Donald Smith		<i>Member of Public</i>
Apologies:	Basil Fozard, Stuart Hunter (Pete Papworth Deputising)		

54/15 **DECLARATIONS OF INTEREST**

None.

55/15 **MINUTES OF THE MEETING HELD ON 29 MAY 2015 (Appendix A)**

The minutes of the meeting on 29 May 2015 were confirmed as an accurate record.

MATTERS ARISING (ACTIONS LOG) (Appendix B)**(a) To provide updates to the action log**

The action log was discussed and updated:

- PS confirmed that the patient story was in progress with communications.
- 46/15 DB supported that at HAC the input from Matrons had been positive and the leadership impact reflected in the progress with noise at night and the care audit. PS added that she was confident that 50% of Matrons' time was being spent on wards noting additional visits during night periods. This will continue to be reviewed as part of the organisational structure.
- 24/15 'Freedom to speak up' review- PS advised that national information would be provided following the consultation on the roles. Work is currently underway within the organisation with regards to bullying and whistleblowing.

QUALITY IMPROVEMENT**(a) Patient Story (Verbal)**

SL and DW presented the patient story which concerned a complaint raised through PALS. The patient had arrived early in the morning for a day procedure however upon arrival was advised that they were not required to attend until later in the day. Upon their return the patient was again informed to return later in the afternoon due to delays in theatre. The patient had not been informed adequately and had been required to be nil by mouth prior to the procedure.

The anaesthetics team apologised to the patient for the inconvenience and recognised that communication and instructions required improvement. The team telephoned the patient to discuss the matter on a personal basis to assure them that the issue was being dealt with efficiently and that appropriate actions were being put in place.

Subsequently the anaesthetics team made a number of changes to the process which included informing patients when lists are delayed, introducing visual display boards to notify of any delays whilst patients are waiting, raising concerns about theatre lists at service lead meetings to ensure issues are understood at all levels, ensuring that staff are aware of the Trust's nil by mouth policy and when it is necessary, reorganising theatre lists to stagger the admittance of patients' and providing clearer information and communication to patients' prior to their arrival.

SP commented that interfacing with patients was key and emphasised that this focus must be applied to all areas within the Trust. SL noted that there are visual display boards that notify delays.

PS added that it was important to recognise that complaints had decreased and that being proactive and communicating with patients

immediately was the most beneficial way to ensure matters are resolved efficiently and improve patient experience. PS advised that ward teams were working to embed this as best practice and improve learning.

TS queried the availability of anaesthetists in the morning and what was being done to standardise the staggering of the admission process. DW outlined that some lists were staggered but that the team took ownership themselves and discussed the issue with surgeons. The Board discussed that proactive planning of theatre lists prior to admission was necessary in order to minimise disruption for patients.

RR added that communication underpinned the process and that cancellations at the last minute needed to be managed. Further he noted that the application of the QI methodology in theatres would support improvements and enhance patient experience.

(b) Feedback from Staff Governors (Verbal)

JS outlined the feedback from staff governors following the meeting on 23 June:

- Staff have raised concerns about the impact of the CSR. Staff have been advised that implementation of the CSR will not take place for 2/3 years;
- Workforce concerns following the recent media coverage about overseas staff returning due to insufficient salaries;
- To review the timings of the staff wellbeing events;
- Matron visibility on wards;
- Car parking remains an issue following applications for permits;
- To improve catering facilities in the west wing;
- Bank staff access to shift information was not easily accessible;
- Recruitment developments were discussed and that new appointments were being made;
- Concerns that additional electronic systems on wards will mean that front line staff will be using more than one device. PG confirmed that this would not be the case in practice.

TS advised that it was expected that the CSR would be implemented in 2018/19 and there would be a number of hurdles before this occurs. He emphasised that the Trust would need to provide as much clarity as possible to staff about the timing, impact and position of the Trust.

RR commented in response to requests for improved catering facilities in the west wing that the Trust were discussing with RVS Café to increase opening hours and also at Christchurch. In relation to car parking he added that staff had shown appreciation for the criteria process and patience and that there were a limited number of spaces. Those staff who are not allocated permits will be provided with travel plans. TS requested that further clarity about eligibility for on- call staff was provided.

RR

(c) CQC Inspection October 2015 (Appendix C)

PS outlined the CQC inspection process noting that both RBH and Christchurch sites would be inspected. A project plan has been put in place and the CQC have recently requested background information about the Trust ahead of their visit. The CQC will email staff and approach patients and invite them to provide their comments about the Trust following the same process as last year.

Executive leads are in place and will be required to present to the CQC team to describe the challenges for the Trust and its successes. PS advised that there may be more than one unannounced inspection. The inspection itself will focus on the five domains and the 16 fundamental standards. The ratings are to be published against the Trust's services and will determine the Trust's overall rating.

PS noted that from 1st July the Trust would be launching the electronic nursing assessment app on iPads to improve risk assessment completion. The document has also been reduced as a result of the QI programme for efficiency. It was emphasised that staffing had increased noting the busy weekend periods and that matrons had also increased on Wards. The Board noted that the CQC were in the process of developing the assessment of the use of resources which would be in effect from April 2016.

The Board discussed that responsibility was not delegated and emphasis was placed on the Board responsibility overall. JS proposed that the Trust should appoint an executive lead for quality and transformation in anticipation of the use of resources assessment.

PS

DB noted that temporary staff were not always aware of the current processes within the organisation and the Trust needed to ensure that when questioned staff were able to explain. PS confirmed that temporary staff will be inducted adequately. It was highlighted that vacancies had decreased from 31 in January and 14 in June and further recruitment would be taking place next month.

IM raised concern about the future planning for holiday challenges. RR added there was now a more strict leave policy in place and that the Trust was proactively looking at staffing numbers highlighting the junior doctor handover periods. It was noted that the October holiday period had been busy in previous years however changes had been made within the Trust. PS confirmed that staff had also been addressed at the Christchurch site. The Board discussed that the transformation programme incorporated the well led domains.

TS outlined that public and patient engagement would be important and that this should be increased and managed through the Trust's communications strategy. PS added that patient stories were to be shared with the CQC including examples of actions taken as a result of patient concerns. The peer review scheme was discussed and its success noting that these were based around the CQC domains. The

Board noted that the peer review scheme has been extended externally and supported that this reflected the Trust's openness and transparency.

PS confirmed that the action plan and process would be shared following HAC. The Board discussed that the wider business use of resources should be considered and an executive lead appointed and that staff needed to be prepared and supported ahead of the inspection. It was also suggested that assurance about the planning for holiday periods should be provided.

RR

58/15

PERFORMANCE

(a) Performance Exception Report (Appendix D)

RR outlined the following key information from the report:

- 2 week cancer waits - significant improvements had been made and the Trust would be compliant this quarter;
- Endoscopy remained an area at risk but it was anticipated that the target would be achieved;
- 31 day screening standards are being altered;
- 62 day cancer- urology remains problematic and pressured area. This is an issue throughout the country although the Trust is moving to improve performance;
- Diagnostics services are in place providing a safer service for patients;
- Impact of immigration rules- Doctors are being denied at the VISA application stage and presents a new risk for recruitment opportunities. The Trust are working with national bodies on this issue;
- ED 4 hour- the target will not be achieved this quarter. Actions have been put in place which includes the 'Breathe' model, reassessment of medical staff rotas to combine this with levels of activity. It was emphasised that the Trust were managing the safety aspect but this was an area of focus;
- QI methodology is being used to help improve the booking process, the surveillance and managing of patients and the mismatch of nursing staff. Additional funding for nurses within endoscopy has been approved and recruitment is underway to help deliver further capacity;
- RTT- there has been confirmation nationally that non- admit and admitted RTT pathways will not be counted. There will be a single standard of clock running. RR highlighted that the Trust would be compliant based upon this assessment;
- Risk areas- ENT now in bed balance and discussions will be taking place with specialist commissioners about oral surgery;
- Orthopaedics- Poole have indicated that additional consultant time will be made available;
- Good progress has been made in other specialties.

TS thanked RR and noted the improvements in RTT and cancer. The Board emphasised that attention needed to be placed upon achieving

the 4 hour standard. The Board sought assurance from the plans put in place within ED highlighting the extension of 'Breathe' and staffing and requested feedback at the July meeting. RR confirmed that the action plan would be submitted to the Board. RR requested executive support during the '5 daily actions' focus week commencing 5th July which was aimed to improve patient flow. **RR**

(b) Quality Performance Report (Appendix E)

PS updated the Board highlighting the key themes from the report:

- Harm free care had increased month upon month and the Trust had not achieved the target of 98%;
- Indications of improvement on pressure damage- prediction for next month is positive;
- Falls- 2 SIs this month and this is being monitored;
- Risk assessment compliance- new electronic nursing assessment system will improve compliance;
- Patient experience- national ranking is positive. The family and friends recommendation scoring had decreased within minors and the Trust is looking to improve communications in this area;
- The Trust is within the upper quartile nationally- 8.8 FFT ranking, third with 13 other Trusts.

SP queried the pressure ulcer data. PS explained that the Trust had been completing the right actions and work was underway with ward teams. Leaders are clinically driving good practice which will help to support continued improvements. DB provided assurance that the pressure ulcer data was discussed in detail at HAC and Matrons provided examples of good leadership in this respect. He added that the Trust was seeing the benefits from the changes in leadership and direction was being given not only in the area of pressure damage.

IM queried risk assessment compliance and what the CQC's perspective of the data would be. PS outlined that the CQC would consider the Board papers together with documentation on Wards. The Trust is aiming to ensure that when patients are moved at night they are reassessed and the new IT system will help to support this.

The Board requested the granular data for the FFT data, to include the Trust's ranking, was provided at future meetings. **PS**

(c) Financial Performance (Appendix F)

PP outlined the current financial position to the Board noting the following:

- Activity was below budget however the Trust was reporting an adverse financial position;
- Key drivers for the overspend continued as per month one and were mainly in relation to high cost drugs and devices ;
- Agency spend had been high but following appointments and further recruitment it is anticipated that improvements will be

made on the agency spend which will improve the overall financial position;

- The Trust welcomed the national support to manage the premium cost of agency staffing;
- Monitor is currently consulting on the financial risk ratings and the proposal is to include two previous criteria. The consultation will end on 1st July and will also take effect from this time. The Trust has fed back its concerns in relation to the sensitivity of the ratings. PP confirmed that if left unchanged, under the proposals the Trust would currently fall within the “risk and investigation” category.

IM commented that financial regulator would be more interventionist and the Trust will need to prove that there is adequate planning around finance to ensure it will remain viable and improve. He emphasised that the situation was complex but work was underway throughout the organisation and the Trust must ensure that care groups and departments are engaged.

SP questioned whether there were plans and the mind sets in place to ensure that the financial position does not worsen. PP responded that there was awareness but more was required in terms of transformation and bringing schemes forward to produce savings. The Trust must reiterate the importance of quality and transformation.

BY requested a projection for the next year to understand the position in month and for the rest of the year. PP confirmed that a forecast wouldn't normally be prepared at Month two, but that in future months a forecast would be available.

PP/SH

RR advised that the staffing structure and ownership at ward level was regularly tracked and from individual trajectories the Trust was seeing a reduction in the request for agency staff. The Board encouraged the expansion of this practice in other areas. TS emphasised that the Trust needed to understand the trajectories in line with the plan.

The Board raised concern for the proposed measures by Monitor and discussed that the Board should consider ways to mitigate this. The importance of understanding why the projections were not being achieved in relation to the annual plan was highlighted and that this would help to identify what needs to be done.

(d) Workforce Report (Appendix G)

KA outlined the workforce report noting the following:

- The Trust was not achieving the compliance target set for mandatory training. This has been discussed at care group meetings and areas of poor performance are being identified and addressed. KA proposed that staff who had not completed mandatory training should be prevented from other developmental training;

- New pilot for sickness which includes a triage process. This will be reported to the workforce committee and provided to the Board as an overview;
- Challenges were noted within overseas recruitment and salary limitations will be escalated to local members of parliament as this will impact upon recruitment and retention;
- Education and training- positive progress in widening participation with stakeholders and partners and RBCH is seen as a leader;
- Workforce- staff survey positive improvements;
- Each care group has an individual action plan. Within surgery the Trust is addressing areas of concern and working together with teams and successful progress has been made with positive feedback from staff. Within medicine, where themes of staff violence had been raised, actions are being considered and Matrons are playing a leading role;
- Positive work at care group and directorate level indicated from the staff survey information.

DD supported that there was greater optimism around recruitment. Themes of physical violence and harassment previously reported in the staff survey were determined to have been interpretation of body language and style of communication. He noted the time to lead presentations had highlighted the positive work in the development of the roles. The Board requested that the themes raised from the time to lead presentations were addressed and that an action plan was developed to address themes raised through the staff survey.

KA

The Board requested that the workforce report slides were circulated and that the financial projections for recruitment were provided at the next meeting.

KA

TS queried what could be done to secure the overseas appointments ahead of September and that the Board needed to consider how this could be addressed. KA advised that this issue was to be escalated nationally and encouraged the development of a strategy and contact with local MPs. JS suggested that she contacted the Prime Minister and a copy sent to the Health Secretary.

JS

BY added that compliance with essential core skill training had not improved and patient safety was key. He emphasised that the Board needed visibility of the elements of the training required against the challenge of the figures and to prioritise those elements of concern. JS requested Board approved the proposal that staff who had not completed essential core training would not be permitted to continue with developmental training. The Board confirmed their support.

NH added that the Board needed to reinforce the importance of mandatory training to staff to ensure the target is achieved as this also impacted upon the culture of the organisation.

(e) **Stroke SSNAP Report (Appendix H)**

RR highlighted that the Trust had made improvements across a range of measures through January- March and similarly for this quarter. RR felt assured that performance would continue to improve.

Appointments within the department have been secured and thanked the team for their work. He noted that the leadership of the multi-disciplinary team focused on a range of indicators.

During the next month performance will be compared with other trusts to identify areas to incorporate. RR noted that other trusts were not making improvements at the same rate as RBCH. It was emphasised that the full impact of the changes made were yet to be realised following the start of the outreach stroke service.

DD noted the encouraging work within stroke and that there was a complex team in place and commended the work. JS supported that recent appointments were encouraging.

59/15

STRATEGY AND RISK

(a) **Clinical Services Review (Verbal)**

TS updated the Board on the recent CSR developments:

- Considerable debates remain on-going between Dorset County and Commissioners as to the options for the west concerning paediatrics and obstetrics. The CCG will consult on a range of options;
- The provision of paediatric and obstetric services in the East will be impacted upon by travel times from the West. Therefore this will need to be considered when assessing RBCH and Poole sites;
- CCG pre- consultation business case will consider the options and form an appraisal of the emergency care site;
- The data will alter but the Trust is ensuring that the process will move forward
- Engagement strategy being developed as the CSR progresses.

60/15

DECISION

(a) **'Freedom to Speak Out' (Verbal)**

The item was deferred. JS emphasised that staff need to be encouraged to speak out to escalate any issues they encounter.

61/15

INFORMATION

(a) **Communications Update (including May Core Brief) (Appendix I)**

The item was noted for information.

(b) Corporate Events Calendar (Appendix J)

The item was noted for information.

(c) Board of Directors Forward Programme (Appendix K)

The item was noted for information.

62/15 **DATE OF NEXT MEETING**

Friday 31 July 2015 at 8.30am, **Committee Room, Management Offices,**
Royal Bournemouth Hospital

63/15 **ANY OTHER BUSINESS**

Key Points for Communication to Staff

1. Quality performance
2. Finance
3. Performance- Stroke
4. Patient story
5. Board decision concerning mandatory training

64/15 **QUESTIONS FROM GOVERNORS**

1. DT commented on the CQC patient event and the detrimental impact this had last year. PS advised that this would be CQC led and form part of the engagement work with patients. Patients and staff will be encouraged to share their stories with the CQC. PS highlighted that positive comment cards had been received following the August inspection and that she hoped the same would occur this year.
2. RP queried the timing of the inspection and the impact of the increase in activity at that time of year. RR added that the Trust continued to encounter increased periods of activity however that the Trust would be opening a further ward as part of its overall plan later on in the year and that the QI programme and 5 daily actions would help to improve patient flow.
3. PM queried the Trust's ranking in the FFT data. PS confirmed that this detail would be provided to the Board and Governors.
4. DC commended the work within stroke and encouraged that this positive information should be shared with the public. DC also supported that Christchurch Hospital should be promoted as becoming a HUB within the CSR.

There being no further business the meeting closed at 10:31
AH 26.6.15

RBCH Board of Directors Part 1 Actions June & previous

Date of Meeting	Ref	Action	Action Response	Response Due	Brief Update
26.06.15	57/15	<u>QUALITY IMPROVEMENT</u>			
	(b)	<u>Feedback from Staff Governors</u>			
		Provide clarity on the eligibility for car park permits for on call staff	RR		The application process requests information, and appeals process allows clarifications and additional info, so that whilst total number of permits remains the same, these are allocated to the most deserving.
	(c)	<u>CQC Inspection October 2015</u>			
		Consider appointing an executive lead for quality and transformation in anticipation of the use of resources assessment criteria.	PS		Lead for use of resources is the Director of Finance. Quality leads are Director of Nursing and Medical Director.
		Provide assurance for the planning of the holiday periods.	RR		Planning for Summer holidays and junior doctor training, and sufficient cross cover for key staff groups in place.
	58/15	<u>PERFORMANCE</u>			
	(a)	<u>Performance Exception Report</u>			
		Provide assurance for the plans in place within ED to improve performance against the 4 hour target and provide the action plan to the next meeting.	RR		Presentation to next BoD meeting.
	(b)	<u>Quality Performance Report</u>			
		Include the granular FFT data within future reports in order to assess the exact rating/ position of the Trust.	PS		Included within quality report
	(c)	<u>Financial Performance</u>			
		Provide a forecast of the financial position.	SH/ PP		A verbal update will be provided to the July BoD
	(d)	<u>Workforce Report</u>			
		Address the themes raised in the 'time to lead' presentations.	KA		Currently being collated; some evaluation forms still awaited from delegates. Once completed, next steps for TTL will be formulated and a formal report will be produced and shared with the Board.

RBCH Board of Directors Part 1 Actions June & previous

		Contact the Health Secretary Jeremy Hunt to raise concerns about securing overseas appointments and escalate this issue nationally.	JS/KA		Awaiting impact analysis of policy upon RBCH staff.
29.05.15	46/15	QUALITY IMPROVEMENT			
		Address any issues concerning the visibility of matrons on wards	PS		Discussed further with HONs and Matrons. Feedback from the 'time to lead' ward sisters positively highlighted support from matrons to ward areas.
27.03.15	24/15	QUALITY IMPROVEMENT			
	(c)	Freedom to speak up review			
		Identify non- executives and executives to lead on the freedom to speak up review.	PS/KA		On- going. Discussions underway with DON and HRD contacts to understand approaches in other Trusts. Recommendation then to be brought back to the board. HRD to provide an update on progress with whistleblowing
	(f)	Staff Survey Results			
		Provide an update from the Workforce Committee on the monitoring of the staff survey results.	KA	July	Care group updates will be reviewed again at the workforce committee on 22 June and reported verbally at the June BOD and in the workforce report in July.

Key:

	Outstanding
	In Progress
	Complete

BOARD OF DIRECTORS	
Meeting Date and Part:	July 2015 – Part 1
Subject:	Equality Delivery System (EDS2)
Section:	Quality Improvement
Executive Director with overall responsibility	Karen Allman
Author(s):	Sarah Davidson
Previous discussion and/or dissemination:	Discussed at Diversity Committee.
Action required: The Board of Directors is asked to agree implementation of EDS2 within the Trust.	
Summary: Equality Delivery System (EDS2) is a toolkit, previously voluntarily used across the NHS, which aims to help organisations improve the services they provide for their local communities and provide better working environments for all groups. The Workforce Race Equality Standard (WRES) and the EDS2 will for the first time be included in the 2015/16 Standard NHS Contract. The regulators, the Care Quality Commission (CQC), National Trust Development Agency (NTDA) and Monitor, will use both standards to help assess whether NHS organisations are well-led.	
Related Strategic Goals/ Objectives:	To offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care. To strive towards excellence in the services and care we provide. To work with partner organisations to improve the health of local people
Relevant CQC Outcome:	1,6 and 16
Risk Profile: i. Have any risks been reduced? No ii. Have any risks been created? No	
Reason for Part 2	N/A

Equality Delivery System

1 Purpose

The aim of this paper is to introduce the Equality Delivery System (EDS), as a framework to:

- i. improve the equality performance of this organisation, making it part of mainstream business for the Board and all staff; and
- ii. help NHS organisations to meet the evidential requirements of the Equality Act (2010), [especially the public sector equality duty] and the statutory duty to consult and involve patients, communities and other local interests (NHS Act 2006 and Equality Act).
- iii. Ensure compliance with CCG Assurance framework, CQC Inspection Regime and TDA's Planning Guidance.
- iv. Replace the now dated Single Equality Scheme.

2 Background

The NHS Equality and Diversity Council (EDC) supports the NHS to deliver services that are fair, personal and diverse. Since the original EDS which was written in 2011, it has been refreshed and has arisen out of NHS England's commitment to an inclusive NHS that is fair and accessible to all.

Introduced by the NHS EDC, the Equality Delivery System (EDS2) is a mandatory framework by which NHS Trusts embed Equality and Diversity. It is a framework designed by the NHS for the NHS. Through 18 outcomes it is expected that Trusts are able to improve the services they offer, their employment environment, and comply with the Equality Act 2010 including the general and specific public sector duties contained within it. The EDS2 framework is designed to be cyclical.

EDS2 is a generic tool designed for both NHS providers and NHS Commissioners. It has now become part of the system architecture of the NHS, and CCG's and providers will be issued with a set of Equality Objectives and Outcomes, against which each NHS organisation will analyse and grade its performance in the form of Red (Undeveloped), Amber (Developing), Green (Achieving) and Purple (Excelling) ratings, in collaboration with local interests.

There are 18 Outcomes in total, grouped under four headings:

- 1. Better health outcomes for all**
- 2. Improved patient access and experience**
- 3. A represented and supported workforce**
- 4. Inclusive leadership**

These outcomes cover areas that matter the most to the patients and staff. By working with patient's local voluntary organisations and staff, the Trust need to analyse their performance against the 18 outcomes and use the results for the next business planning round.

As a result of this analysis, NHS organisations, again in discussion with local interests, need to confirm their Equality Objectives for the coming business planning period (as required by the Equality Act) and agree a limited number of priority actions. Performance against the selected priorities should be annually reviewed. These processes should be integrated within mainstream NHS business planning.

The Care Quality Commission will take account of concerns highlighted by the EDS through the Quality Risk Profiles it maintains on all registered NHS providers

3 Drivers

There are a number of important EDS drivers to note:

- i. The White paper, '*Equity and Excellence: Liberating the NHS*' stated clearly the previous Government's commitment to promoting equality and that NHS England will have an explicit duty to address inequalities in outcomes from healthcare services.
- ii. The EDS is referenced within the NHS Operating Framework with the strong emphasis that NHS Boards will need to comply with the Equality Act 2010 and its specific public sector duties, by implementing the EDS and to maintain progress and demonstrate compliance with the Act.
- iii. The EDS will support NHS Organisations to comply with their legal duties arising from the Equality Act 2010 which aims to ensure that all public bodies within the health service comply with principles of equality.
- iv. The 2015/16 NHS Standard contract states: *The Provider must implement EDS2*. It is recommended that NHS Organisations implement EDS2 faithfully and robustly in line with the "Steps for EDS2 Implementation" as cited in the 2013 EDS2 guidance document. The EDS guidance document is available at: <http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf>

4 Benefits of the EDS

Once effectively implemented the EDS will:

- help the NHS deliver on the Government's commitment to fairness and personalisation, including the equality pledges of the NHS Constitution and maintain a focus on equality during the NHS transition;
- help organisations to respond more readily to the Equality Act duty;
- deliver improved and more consistent performance on equality;
- help providers to respond better to CQC registration requirements;
- provide excellent evidence of engagement and consultation with patients and staff.

5 How does this fit with the organisations Operational Planning Process?

The EDS should form part of the organisation's strategic and annual business cycle and help guide future planning and resource allocation.

6 Financial implications

There are no direct financial implications arising from this new framework. However, there will be on-going resource implications in terms of:

- developing and implementing an on-going community engagement exercise around developing equality objectives and prioritised actions and assessing organisational performance against these;
- ensuring that the public sector equality duty is complied with and reporting as necessary each year.

However, it should be noted that as organisations need to meet the Public Sector Equality Duty (part of the Equality Act 2010), the above cost implications would be incurred regardless. The NHS organisation would be at risk of legal challenge if it failed to meet its duties under equality legislation, or if it knowingly or unknowingly allowed discrimination to occur.

7 Legal issues

The EDS does not replace legislative requirements for equality; rather it is designed as a performance and quality assurance mechanism for local NHS Boards and a means by which NHS organisations are helped to meet the requirements of the Equality Act (2010) and the NHS Act (2006).

8 Next steps

A Board sponsor to be nominated, and Service Development/Operations Lead to be identified for the Trust who will have responsibility for EDS implementation and work closely with the CCG's on the EDS plan, including grading and milestones. Equality objectives need to be drawn up for the Trust, together with some priority actions against which performance can be reviewed annually.

9 Recommendation

The Board is asked to note the Trust's adoption of the now mandatory Equality Delivery System and to approve the development and implementation of such in 2015. A proposal will be brought back to the October Board, identifying key areas for action planning.

Annex 1: EDS OBJECTIVES AND OUTCOMES

The analysis of the outcomes must cover each protected group, and be based on comprehensive engagement, using reliable evidence.

Objective	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities
		1.2 Patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
		1.3 Changes across services are discussed with patients, and transitions are made smoothly
		1.4 The safety of patients is prioritised and assured
		1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds
		2.2 Patients are informed and supported so that they can understand their diagnoses, consent to their treatments, and choose their places of treatment
		2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised
		2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and well-supported staff	The NHS should Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades
		3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing the same work in the same job being remunerated equally
		3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately
		3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all
		3.5 Flexible working options are made available to all staff, consistent with the needs of patients, and the way that people lead their lives
		3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle

Objective	Narrative	Outcome
		issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond
		4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination
		4.3 The organisation uses the NHS Equality & Diversity Competency Framework to recruit, develop and support strategic leaders to advance equality outcomes

BOARD OF DIRECTORS	
Meeting Date and Part:	31 st July 2015 - Part 1
Subject:	Performance Report
Section:	Performance
Executive Director with overall responsibility	Richard Renaut
Author(s):	Donna Parker/David Mills
Previous discussion and/or dissemination:	PMG
Action required: <p>The Board of Directors is asked to consider the information provided and support any actions highlighted in relation to non-compliant or 'at risk' indicators.</p>	
Summary: <p>The attached Performance Indicator Matrix and Performance Report outlines the Trust's performance exceptions against key access and performance targets for the month of June 2015.</p> <p>The Matrix also incorporates an indicative RAG rating for expected performance in the following month based on internal monitoring to date, as well as an indication of Trust level risk in relation to the metrics in the next reporting quarter for each metric.</p> <p>As an overview of the key risks for Q1, these are non-admitted waits (especially Dermatology, Orthopaedics, GI and Poole based specialties), Cancer 62 day and 4 hour ED compliance. The report also includes some key updates on progress against our detailed recovery action plans.</p>	
Related Strategic Goals/ Objectives:	Performance
Relevant CQC Outcome:	Section 2 – Outcome 4: Care and welfare of people who use services. Outcome - 6 Co-operating with others.
Risk Profile: <p>The following risk assessments remain on the risk register:</p> <ul style="list-style-type: none"> i. Cancer 62 day wait non-compliance and national guidance on 'high impact' changes. ii. 4 hour target due to the continued high level of ambulance conveyances, attendances and admissions and our continued non-compliance, though noting strong July performance to date. iii. RTT non-admitted performance due to speciality pressures and clearance of backlogs. iv. Significant risks for endoscopy wait times. <p>The urgent care impact risk assessment remains on the Trust Risk Register given the continued activity pressures, 4 hour non-compliance and other indicators such as the increase in outliers. However, due to some early indication of improvement the risk score has reduced slightly.</p>	
Reason paper is in Part 2	N/A

Performance Report June 2015/16 For June 2015

1. Introduction

This report accompanies the Performance Indicator Matrix and outlines the Trust's actual and predicted performance exceptions against key access and performance targets. These targets are set out in *Forward View into Action – Planning for 15-16*, the *Monitor Risk Assessment Framework (RAF)* and in our contracts.

The report also includes some key updates on progress against measures not required by Monitor, such as for diagnostics and planned patients.

This report also highlights key changes that have been signalled by NHS England in relation to RTT targets and greater focus on Cancer 62 day waits.

2. Risk assessment for 2015/16 - update

There is currently only two changes to our risk assessment against the Monitor Framework based on our performance for Q1 to date and current projections. All indicators continue to have some risk but current predictions continue to place us below the Monitor trigger score of 4. Our assessment will be reviewed monthly. Based on information to date, means we do not anticipate being below threshold, for the new main indicator of incomplete pathways for 18 weeks (clocks still running), for Q2. However the 62 days is heightened risk into Q3 due to Urology.

Monitor Risk Assessment Framework: 2015/16 updated prediction	Q1	Q2	Q3	Q4
Referral to treatment time, 18 weeks in aggregate, admitted patients	No	No	Yes	No
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	Yes	Yes	No	No
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	No	No	No	No
A&E Clinical Quality- Total Time in A&E under 4 hours	Yes	No	No	Yes
Cancer 62 Day Waits for first treatment (from urgent GP referral)	Yes	Yes	Yes	No
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	No	No	No	No
Cancer 31 day wait for second or subsequent treatment - surgery	No	No	No	No
Cancer 31 day wait for second or subsequent treatment - drug treatments	No	No	No	No
Cancer 31 day wait for second or subsequent treatment - radiotherapy	No	No	No	No
Cancer 31 day wait from diagnosis to first treatment	No	No	No	No
Cancer 2 week (all cancers)	No	No	Yes	Yes
Cancer 2 week (breast symptoms)	No	No	No	No
Clostridium Difficile -meeting the C.Diff objective	No	No	No	No
Compliance with requirements regarding access to healthcare for people with a learning disability	No	No	No	No

The non-admitted RTT waits in Q1 continues as a “planned” breach, especially due to pressures previously outlined and as backlog waits are reduced in a proactive way. Recovery is underway in Q2, although particular risk is flagged due to the ongoing work with the CCGs, Poole Hospital and NHS England in relation to ENT, Oral Surgery and Neurology. There are also pressures on Endoscopy. In addition, the work

to reduce clinic waits across specialities runs the risk of a surge of patients being added to admitted waiting lists. This is why the Admitted RTT

indicators are flagged as risks for Q2 & Q3 respectively. These will though, continue to be closely managed to minimise the risk.

As confirmed previously, Cancer 62 day waits will breach in Q1 & Q2 as a result of reducing Urology patients waiting (discussed below in relevant section). Recovery is strongly on track for the Cancer Two Week Wait and other cancer targets for Q1. The final NICE Guidance on Two Week Wait referrals may double referrals in some specialities and remains a risk for Q3 & 4. This is especially so in already pressured areas such as GI/Endoscopy and Dermatology.

Unfortunately we were below the 95% threshold for the 4 hour ED target in June, at 93.46%, though improvement has continued since April. Whilst Q1 performance stood at 93.27%, the risk was known and highlighted in the previous report. We have started Q2 with a strong performance (97.65% to date).

2. Infection Control

Number of Hospital acquired C. Difficile due to lapses in care
Number of Hospital acquired MRSA cases

Guidance is now focused on those cases attributed to lapses in care. A challenging national target for 15/16 has been confirmed as a maximum of 14 C.Diff cases “due to lapses in care.” Actions are being developed in conjunction with the Nursing Directorate and Infection Prevention and Control Committee.

For May 2015, one case of C. Difficile was reported on the Wards, however, in line with the national guidance, it was not due to lapse in care. For June 2015, a further one case of C. Difficile was reported on the wards. This is currently being investigated to determine cause.

There have been no reported cases of MRSA.

3. Cancer

Performance against Cancer Targets

Key Performance Indicators	Threshold	Qtr 4	May-15	June Predicted
2 weeks - Maximum wait from GP	93%	91.6%	97.6%	96.8%
2 week wait for symptomatic breast patients	93%	98.1%	100.0%	100.0%
31 Day – 1st treatment	96%	96.2%	97.6%	94.7%
31 Day – subsequent treatment - Surgery	94%	86.1%	100.0%	96.0%
31 Day – subsequent treatment - Others	98%	100.0%	100.0%	100.0%
62 Day – 1st treatment	85%	81.9%	86.9%	76.7%

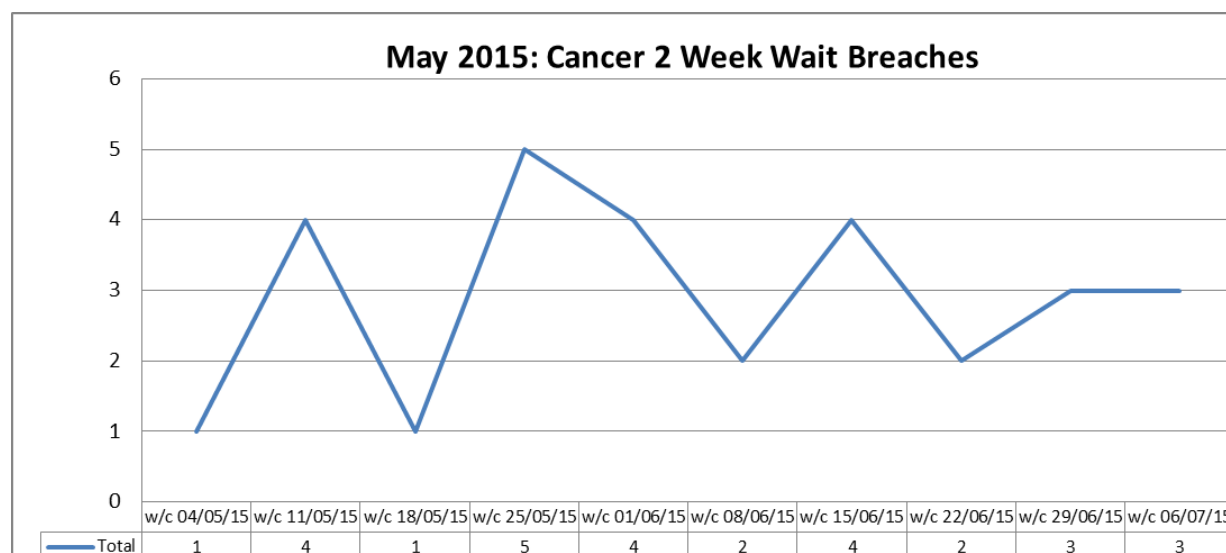
62 day – Consultant upgrade (<i>local target</i>)	90%	83%	67%	100%
62 day – screening patients	90%	89.6%	81.8%	100.0%

Two Week Wait

The overall improvement against the Two Week Wait target has been sustained with compliance being achieved for May and continuing through June and July to date, resulting in compliance for Q1. Endoscopy capacity remains the main risk. However, all areas are currently being managed through targeted capacity and prioritisation, together with a clear escalation process.

The NICE guidance on fast track referrals indicates that significant growth is likely in a range of specialities. Greatest in Gastro and Dermatology, our two services already under greatest pressure. Others like Urology may also be affected. We are monitoring to see if growth increases above the current levels (which have near doubled over 5 years).

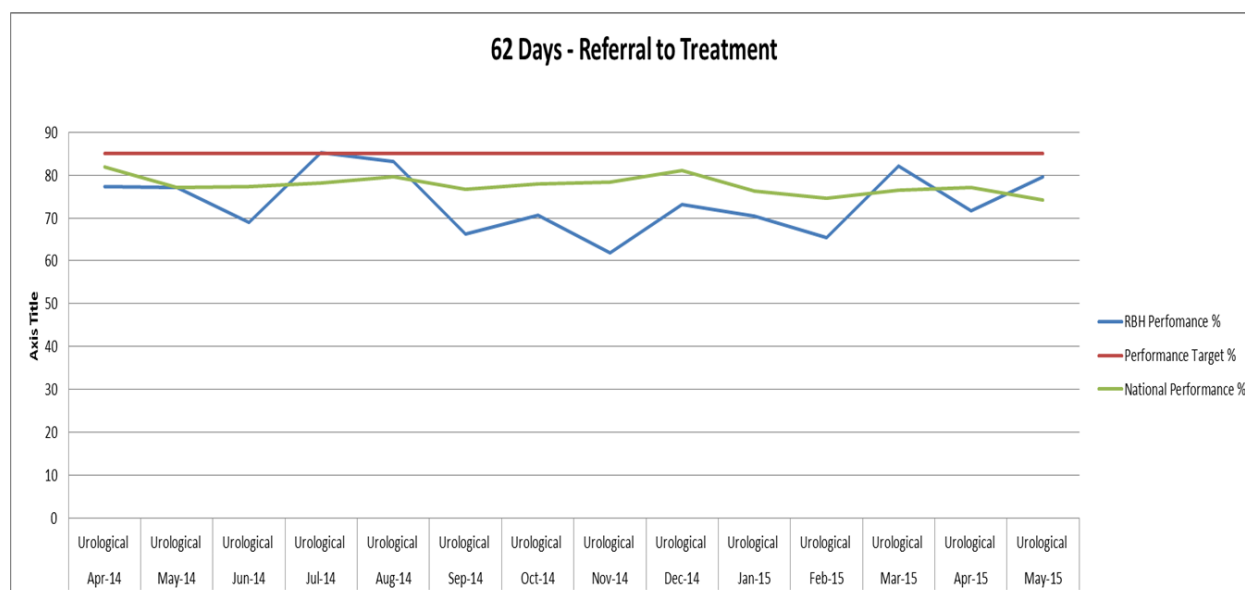
The Breast symptomatic target also continues to be achieved.



62 Day Referral to Treatment

Whilst the number of 'breach' patients treated in May means we achieved 85% target, we currently expect to be non compliant for Q1 overall, as we continue our focus on treating the longer waiting patients in Urology. The success of the 'robot weeks' for prostatectomies has continued and the plan has been extended with the aim of clearing the current backlog by September, subject to clinical urgency of cases over the period. This plan also incorporates clearing the current known backlog at Dorchester, however, this will remain under review as confirmed diagnoses are made. As highlighted previously, positively, the local template biopsy service has now commenced which will reduce delays in diagnostic pathways for Urology. This backlog clearance, together with some delays in Lung patient pathways across providers, is currently challenging a Q2 compliance trajectory and this is therefore, projected to continue for Q3 and is the change against our overall Risk Assessment Framework.

The attached table compares RBH with the national Urology 62 day performance. This is a challenging service for the whole of England and has not been compliant nationally for over a year. RBCH is especially affected as Urology makes a disproportionate element of workload and accents for around 60% of all our breaches.



There is increased nationally focus on 62 Days because it is not being achieved. Guidance on “8 high impact” changes is attached, and a detailed update will follow for the next Board. The main gaps are Capacity and Demand for Endoscopy and Urology, and commissioners agreed stages of care time standards.

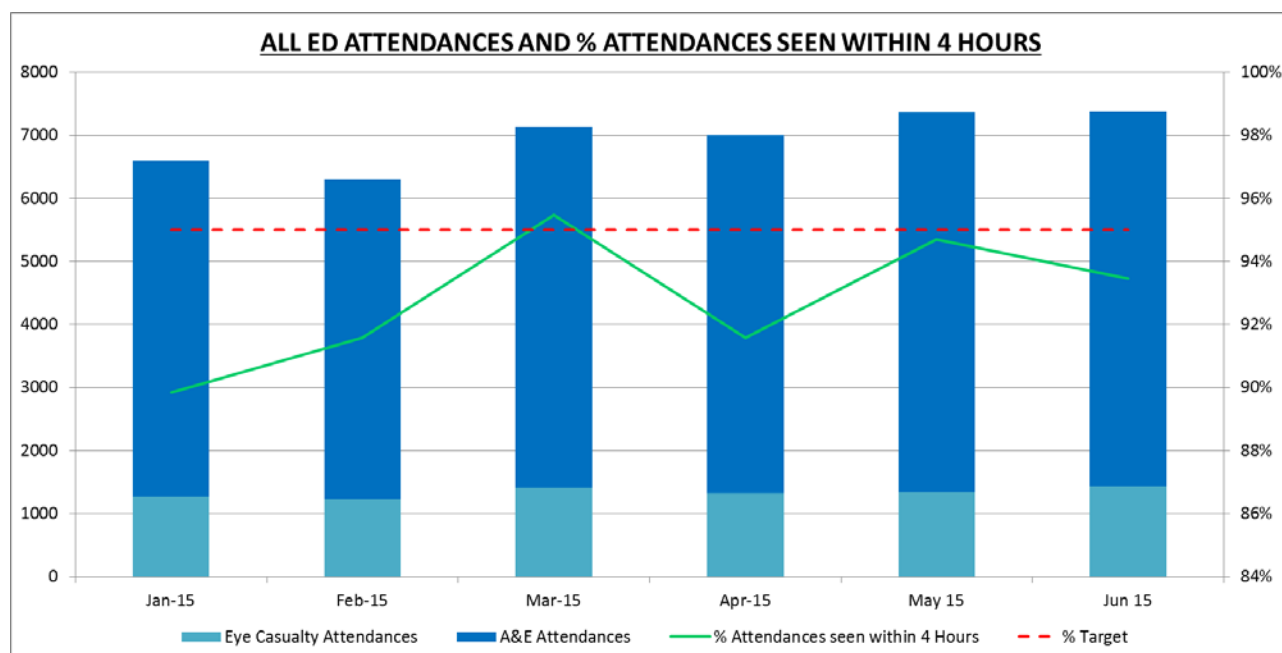
31 Day First Treatment, Subsequent Surgery and 62 Day Screening

May has continued shown positive improvement against 31 Day First Treatment and Subsequent Surgery, with both all maintaining compliance. This is expected to be a sustainable trend since cover for Skin and Breast Services has now improved. 62 Day Screening missed the 90% target with a performance on 81.8%. These small number performance targets, often relying on a small number of specialist staff, can experience a handful of patient breaches that can tip these into non-compliance. Therefore, an underlying risk remains.

4. A&E

95% of patients waiting less than 4 hours from arrival to transfer/discharge

The trend of rising emergency attendances continues. June saw a very slight increase in ED attendances compared to May (+10, +0.14%), and saw an increase in ED breaches (91 more, +18.88%). Emergency admissions were up 0.7% (+19) in June compared to May. Non-Elective admissions (e.g. transfers in) were up +34 in June compared to May, however this reflects seasonal trends.



The ED performance in June decreased to 93.46%. As anticipated and raised as a risk, the quarterly target was not met, with performance reported as 93.27%. Progress is being made, with July's performance (up to 21st July) currently reporting at 97.92%. The improvement by ED staff and downstream clinical area should be commended.

Analysis of the continuation of below threshold performance in June shows 70.7% of the breaches in June were within the ED itself, with 62.2% of the breaches being attributed to clinician assessment delay (a reduction on Mays' 85.4%). 19.9% of the breaches were attributed to inability to move to downstream bed. This is expected to improve when the BREATH model is extended to 10pm from late June and further supported by a move to Nurse Practitioner cover in July as well as commencement of an additional consultant in August. The team in ED are currently re-reviewing the rotas and locum cover to ensure key shifts have allocated 'senior decision makers'. Policies are also being developed to support joint working and faster access to specialist opinions, direct admission where appropriate and pathways for reattendances.

We continue to see the shift towards increased minors attendances (with 3,537 for June and 3,603 for May, compared with 3,310 in April), reflecting the seasonal summer trend and we will be monitoring this closely against previous/expected activity levels. A review of pathways direct from ED to the Out of Hours service is also underway to support this activity trend. Work with parties to avoid "batching" of GP admissions and ambulance conveyances in late evening is being requested.

The Board will receive a presentation from ED providing further information and a chance to question lead staff.

5. Learning Disability

Patients with a learning disability: Compliance with requirements to healthcare access

We were compliant with requirement to healthcare access for Q1 15-16 against the target.

6. Diagnostics

99% of patients to wait less than 6 weeks for a diagnostic test

Unfortunately Junes' diagnostic result of 97.74% (and 96.8% for the quarter) missed the 99% threshold due to Endoscopy waits. In June these were Colonoscopy, with 40.2% of the >6wk patients, and Gastroscopy with 23.7% of the >6wk patients. Additional work and outsourcing within Endoscopy has continued through May and June to alleviate some of the pressures and to ensure appropriate and timely clinical care for patients.

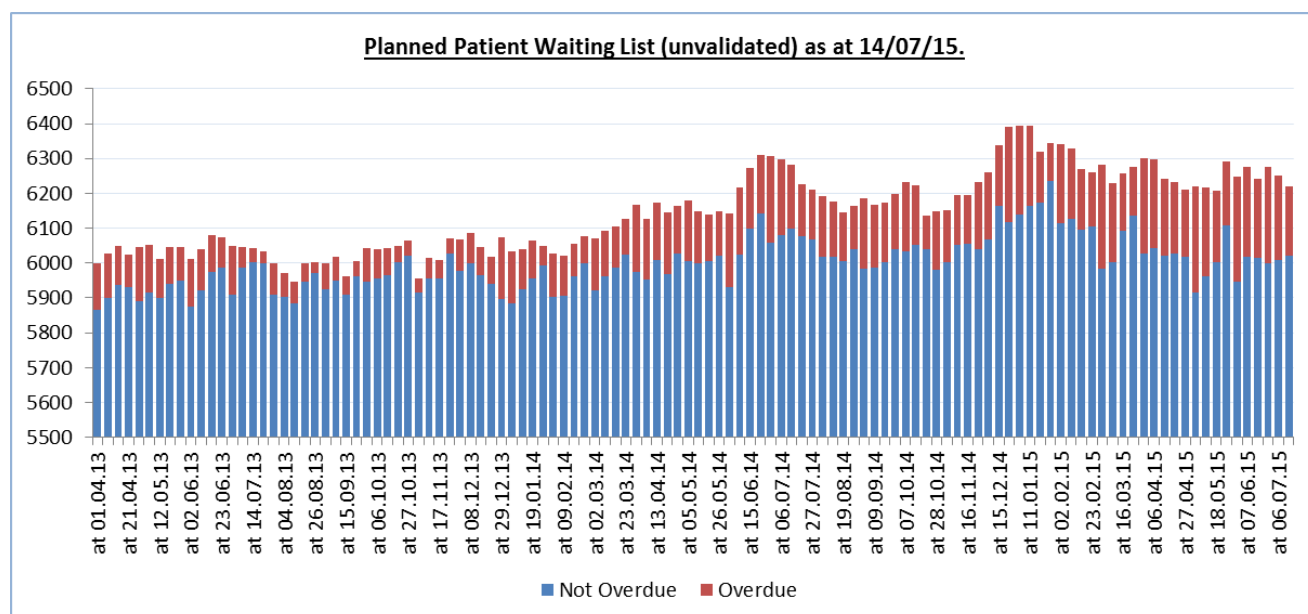
The QI improvement project related to admin and booking processes is now well underway working on the design and implementation of new lean processes. This, together with a significant piece of work analysing demand and capacity analysis, will inform our forward looking trajectory which is expected by the end of the month. A decision on nursing staffing levels has significantly helped, with recruitment underway. Extra lists using overtime are planned for September.

Endoscopy waiting times will grow considerably over the next quarter, until the extra nurses to allow extra capacity are in place. This therefore remains a major risk to cancer and RTT waits. We have lost our JAG accreditation as a result, and can only recover this when our waits are compliant.

Radiology and Cardiology diagnostics remain compliant despite increases in demand, which continues to be testament to the flexibility and dedication of these services.

Planned Patients

In addition to our patients who have been newly referred for a diagnostic procedure, we also have patients who are on a 'planned' or 'surveillance' waiting list. These are patients that have repeated procedures on a planned basis (e.g. annually or three/five yearly). As indicated in the table below (*note this is an unvalidated position*), we have seen an increasing number of patients on this list as well as in the number of patients who are past their indicative 'due date'. This is predominantly due to the pressures referred to above in Endoscopy. The work being undertaken in Endoscopy will support our forward plans for reducing this and this continues to be monitored on a weekly basis, with clinical reviews requested as require. The success of this work is shown in the reduction of overdue patients.



7. Stroke

The latest Stroke Sentinel Audit data as at a headline level our score improved from 57 to 66.7 This is moving us for the first time into C rating, with the highest score in Wessex (using the previous quarter) at 67. Further progress is being made this quarter. The BoD/CoG training session in September will provide further, detailed walk through of the latest available data.

8. Referral to Treatment Times (RTT) – Aggregate and Speciality Level

90% of patients on an admitted pathway treated within 18 weeks
95% of patients on a non-admitted pathway treated within 18 weeks
92% of patients on an incomplete RTT pathway within 18 weeks

Non Admitted RTT

The Trust performed as planned on the RTT targets, with non compliance against aggregate Non Admitted target (94.1%) due to the focus on reducing the backlog of non admitted long waiting patients. The specialities which were non-compliant were: General Surgery, Urology, Orthopaedics, ENT, Oral Surgery and Neurology. The ongoing work to reduce backlogs is also now starting to see an improving position on our Incomplete Pathways (see below), which remained compliant and have improved to 94.4% and is beginning to put us on a stronger footing for more sustainable performance across the RTT targets. The biggest risks to non admitted pathways remain the visiting specialities of ENT, Oral Surgery and Neurology. Other risks are pressures in Gastroenterology/Colorectal and Endoscopy (as indicated above), plus increases in late transfers from other providers (e.g. Orthopaedics and Dermatology) and medical staffing gaps.

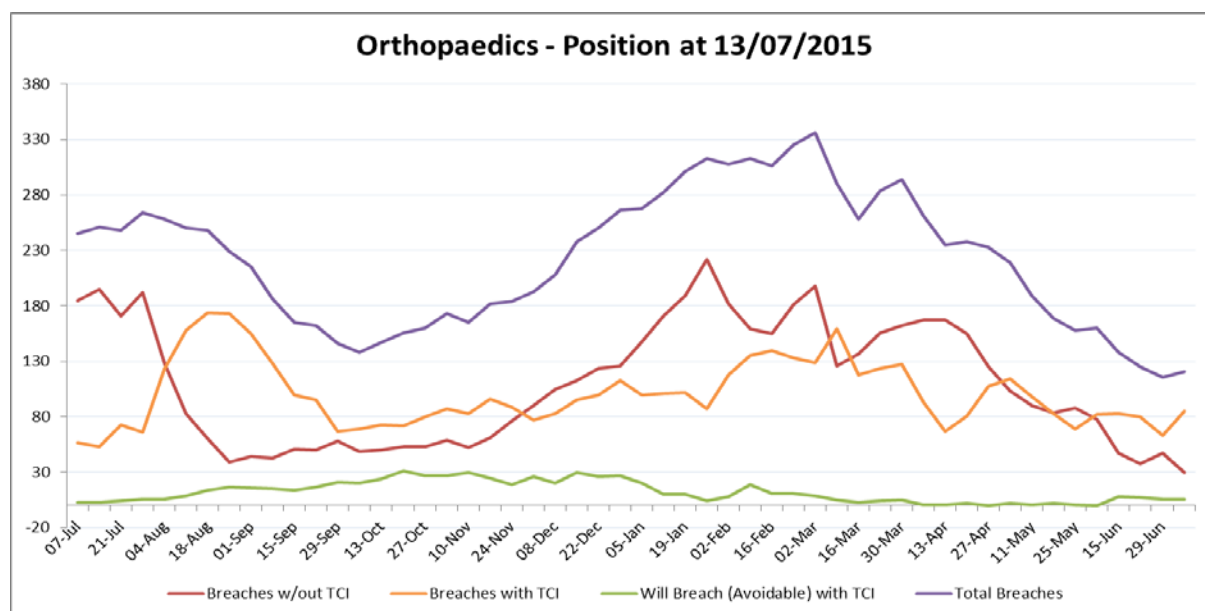
An action plan has been agreed with our commissioners regarding the visiting specialities and Dermatology. However, due to the cross provider and/or specialist commissioning complexities relating to these services, together with the need for detailed demand and capacity analysis, this is unlikely to be fully resolved in Q2. We continue to seek additional, 'ad hoc' capacity in the meantime wherever possible, in order to reduce waits for patients whilst also continuing to ensure that GPs are fully informed of our waiting times and choices available for patients.

Admitted and Incomplete Pathways

Admitted aggregate and Incomplete Pathways were above threshold with a return of 90.8% and 94.4% respectively. Again this reflects trajectories and the results of ongoing work to reduce backlogs and process delays, and better use of capacity.

The Admitted RTT backlog has now reduced significantly in Orthopaedics (see graph below) together with outpatient waits, and we have commenced some specific targeted pathway work in some specialities where we have seen some smaller increases in backlogs (e.g. Gynae and Vascular).

Specialist surgical capacity remains a challenge in Dermatology due to current medical gaps, however performance is improving and compliant for June with 94.1%. Additional sessions are being secured to provide capacity and we are also reviewing the external demand/capacity modelling that is being undertaken, as well as reviewing current pathways and approaching referring providers in relation to joint work on late transfers, especially for Mohs surgery.



RTT National Measures – Going Forward

Going forward, NHS England have announced plans to improve access and simplify measurement of some waiting times standards. Whilst the NHS Constitution standards relating to 18 weeks continue to be fully endorsed, the RTT indicators will be rationalised to focus on one measure which tracks the complete patient experience – the Incomplete Pathway measure.

As previously reported, since April the Trust moved fully to the new recording system (PPW) which has significantly improved our patient tracking processes. This move is key to full tracking and ‘pull’ of patients on incomplete pathways and has put us in a strong position as we move towards the focus on the Incomplete Pathways measure.

The table below shows our June Incomplete Pathways “clocks still running” and the progress made to reduce backlogs and increase the percentage of patients still within 18 weeks on their pathway. The total backlog of patients waiting on admitted or non admitted pathways for *more* than 18 weeks currently stands at 1,067 (5.6%).

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15		
						<18 wks	Total	Performance
100 - GENERAL SURGERY	92.4%	94.0%	92.8%	91.1%	93.0%	2351	2548	92.3%
101 - UROLOGY	92.1%	91.9%	91.0%	89.9%	90.1%	1317	1464	90.0%
110 - TRAUMA AND ORTHOPAEDICS	87.3%	84.8%	86.3%	89.2%	92.9%	2953	3136	94.2%
120 - EAR NOSE AND THROAT	85.1%	87.2%	85.3%	87.8%	87.4%	233	258	90.3%
130 - OPHTHALMOLOGY	94.9%	95.7%	96.3%	97.4%	97.3%	3734	3829	97.5%
140 - ORAL SURGERY	90.4%	87.5%	86.5%	80.5%	73.3%	150	228	65.8%
150 - NEUROSURGERY						0	0	
160 - PLASTIC SURGERY						0	0	
170 - CARDIOTHORACIC SURGERY	100.0%	100.0%	100.0%	100.0%	100.0%	6	6	100.0%
300 - GENERAL MEDICINE	94.0%	98.2%	96.0%	93.0%	94.6%	1551	1589	97.6%
301 - GASTROENTEROLOGY						0	0	
320 - CARDIOLOGY	94.0%	94.7%	94.5%	94.6%	94.9%	1562	1630	95.8%
330 - DERMATOLOGY	77.6%	72.1%	79.4%	84.6%	89.3%	416	467	89.1%
340 - THORACIC MEDICINE	95.8%	100.0%	99.5%	97.9%	99.4%	370	378	97.9%
400 - NEUROLOGY	98.5%	94.1%	91.8%	86.7%	85.6%	89	109	81.7%
410 - RHEUMATOLOGY	99.5%	99.1%	99.5%	97.1%	96.1%	803	850	94.5%
430 - GERIATRIC MED	98.0%	98.9%	100.0%	97.8%	97.0%	151	154	98.1%
502 - GYNAECOLOGY	96.5%	95.8%	93.3%	91.8%	95.1%	898	971	92.5%
Other	99.8%	99.3%	98.6%	97.3%	97.7%	1370	1404	97.6%
TOTAL	92.4%	92.7%	92.7%	92.6%	94.0%	17954	19021	94.4%

Whilst the risks highlighted throughout this section of the report currently continue to challenge our RTT performance, the progress to date on our incomplete pathways , tracking processes and the action plans in place in relation to these risks mean that we currently expect a return to compliance on the measures in Q2.

9. Recommendation

The Board of Directors is requested to note the performance exceptions to the Trust’s compliance with the 2015/16 Monitor Framework and ‘The Forward View into Action’ planning guidance requirements.

2015/16 PROPOSED PERFORMANCE INDICATOR MATRIX FOR BOARD OF DIRECTORS

Area	Indicator	Measure	Target 15/16	Monitor	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Forecast - Next Month	Forecast - Quarter	RAG Thresholds		
Monitor Governance Targets & Indicators																> trajectory		<= trajectory
Infection Control	Clostridium difficile	Total number of hospital acquired C. Difficile cases under review	n/a	1.0	5			9			2	1	1	n/a	n/a			
	Clostridium difficile	C. Difficile cases due to lapses in Care	14 (1 pcm)		-			-			0	tbc	tbc				>1	
Referral to Treatment	RTT Admitted	18 weeks from GP referral to 1 st treatment – aggregate	90%	1.0	88.1%			90.2%			90.1%	91.3%	90.8%			<90%		≥90%
	RTT Non Admitted	18 weeks from GP referral to 1st treatment – aggregate	95%		95.6%			91.9%			93.0%	94.0%	94.1%			<95%		≥95%
	RTT Incomplete pathway	Patients on an 18 week pathway awaiting treatment – aggregate	92%		95.0%			92.6%			92.6%	93.9%	94.4%			<92%		≥92%
Cancer	2 week wait	From referral to to date first seen - all urgent referrals	93%	1.0	86.1%			91.6%			94.3%	97.6%				<93%		≥93%
	2 week wait	From referral to date first seen - for symptomatic breast patients	93%		91.5%			98.1%			96.3%	100.0%				<93%		≥93%
	31 day wait	From diagnosis to first treatment	96%		93.0%			96.2%			98.8%	97.6%				<96%		≥96%
	31 day wait	For second or subsequent treatment - Surgery	94%	1.0	94.2%			86.1%			97.0%	100.0%				<94%		≥94%
	31 day wait	For second or subsequent treatment - anti cancer drug treatments	98%		100.0%			100.0%			100.0%	100.0%				<98%		≥98%
	62 day wait	For first treatment from urgent GP referral for suspected cancer	85%		82.3%			81.9%			86.2%	86.9%				<85%		≥85%
	62 day wait	For first treatment from NHS cancer screening service referral	90%	90.7%			89.6%			100.0%	81.8%				<90%		≥90%	
A&E	4 hr maximum waiting time	From arrival to admission / transfer / discharge (Type 1 & 2)	95%	1.0	92.32%			92.39%			91.6%	94.69%	93.46%			<95%		≥95%
LD	Patients with a learning disability	Compliance with requirements regarding access to healthcare	n/a	1.0												No		Yes
TOTAL	CURRENT QUARTERLY MONITOR (PREDICTION) / SCORE		0.0	0.0	5			5			(3)			n/a	n/a	n/a		
Indicators within The Forward View into Action: Planning for 2015/16.																		
MSA	Mixed Sex Accommodation	Minimise no. of patients breaching the mixed sex accommodation requirement	0		0	0	0	0	0	0	0	0	0			> 0		0
Infection Control	MRSA Bacteraemias	Number of hospital acquired MRSA cases	0		0	0	0	0	0	0	0	0	0			>0		0
Cancer	62 day – Consultant upgrade	Following a consultant's decision to upgrade the patient priority *	90%		100.0%	60.0%	100.0%	100.0%	100.0%	100.0%	66.7%	66.7%				< 90%		≥90%
VTE	Venous Thromboembolism	Risk assessment of hospital-related venous thromboembolism	95%		94.2%	94.7%	95.0%	95.5%	95.8%	96.1%	95.4%					<95%		≥95%
Diagnostics	Six week diagnostic tests	More than 99% of patients to wait less than 6 wks for a diagnostic test	>99%		99.8%	98.9%	97.0%	94.2%	94.8%	98.4%	94.8%	97.9%	97.7%			≤99%		≥99%
A&E	Admission via A&E	No. of waits from decision to admit to admission over 12 hours	0		0	0	1	2	5	0	0	0	0			≥1		0
	Ambulance Handovers	No. of breaches of the 30 minute handover standard	0		75	74	72	66	55	49	20	20	22	n/a	n/a	tbc		
	Ambulance Handovers	No. of breaches of the 60 minute handover standard	0		13	13	27	31	31	6	5	2	2	n/a	n/a	tbc		
Cancelled Operations	28 day standard	No. of patients not offered a binding date within 28 days of cancellation	0		1	0	1	0	2	0	0	0	1			≥1		0
	Urgent ops Cancelled for 2nd time	No. of urgent operations cancelled for a second time	0		0	0	0	0	0	0	0	0	0			≥1		0
Stroke & TIA	SSNAP indicator	% of Stroke patients are treated on a dedicated stroke ward for 90% of spell	SSNAP threshold tbc		70.0%	59.3%	61.4%	66.7%	83.7%	72.7%	51.1%	69.4%	84.3%	tbc	tbc	tbc		
	SSNAP indicator	Direct admission to Stroke Unit within 4 hours of admission	SSNAP threshold tbc		66.2%	60.7%	54.2%	64.9%	68.1%	70.0%	53.3%	75.0%	62.9%	tbc	tbc	tbc		
	SSNAP indicator	Patients receive CT Scan within 24 hours of admission	SSNAP threshold tbc		96.9%	98.4%	100.0%	98.2%	97.9%	98.1%	96.7%	100.0%	92.0%	tbc	tbc	tbc		
	SSNAP indicator	Patients with acute stroke receive brain imaging within 1 hr	SSNAP threshold tbc		26.2%	39.3%	35.6%	35.1%	42.6%	55.8%	46.7%	41.1%	40.0%	tbc	tbc	tbc		
	SSNAP indicator	Thrombolysis Rate	SSNAP threshold tbc		9.2%	9.8%	12.0%	14.0%	19.1%	17.3%	13.3%	12.5%	12.3%	tbc	tbc	tbc		
	SSNAP indicator	% appropriate patients receiving thrombolysis (within 1 hour of clock start)	SSNAP threshold tbc		16.7%	33.3%	14.0%	37.5%	33.3%	11.0%	50.0%	14.3%	62.5%	tbc	tbc	tbc		
	TIA indicator	High risk TIA cases investigated and treated within 24hrs	SSNAP threshold tbc		53.0%	68.0%	58.0%	75.0%	70.0%	71.0%	67.2%	63.0%	60.0%	tbc	tbc	tbc		
	TIA indicator	Low risk TIA cases, seen within 7 days	SSNAP threshold tbc		84.0%	85.0%	79.0%	76.0%	86.0%	91.0%	89.2%	92.0%	91.0%	tbc	tbc	tbc		
Referral to Treatment	Clocks still running - 52 weeks	Zero tolerance of over 52 week waiters (Incomplete Pathways)	0		1	0	1	0	0	0	0	0	0			≥1		0
	Clocks still running - admitted	Total number of patients with an admitted incomplete pathway	tbc		n/a	n/a	n/a	n/a	n/a	n/a	5976	6097	5967	n/a	n/a	tbc		
	Clocks still running - admitted	Number of patients with an admitted incomplete pathway over 18 weeks	tbc		n/a	n/a	n/a	n/a	n/a	n/a	656	600	568	n/a	n/a	tbc		
	Clocks still running - non admitted	Total number of patients with an non admitted incomplete pathway	tbc		n/a	n/a	n/a	n/a	n/a	n/a	14169	13434	13054	n/a	n/a	tbc		
	Clocks still running - non admitted	Number of patients with a non admitted incomplete pathway over 18 weeks	tbc		n/a	n/a	n/a	n/a	n/a	n/a	826	581	499	n/a	n/a	tbc		
Planned waits	Planned waiting list	% of patients overdue from their planned date	0		n/a	n/a	n/a	n/a	n/a	n/a	96.9%	95.2%	95.6%			tbc		
RTT Specialty	RTT Admitted	100 - General Surgery	90%		84.7%	85.1%	84.1%	86.9%	88.7%	85.5%	84.3%	86.6%	83.1%			<90%		≥90%
	RTT Admitted	101 - Urology	90%		92.5%	90.1%	92.7%	88.4%	93.3%	92.8%	90.7%	91.7%	86.8%			<90%		≥90%
	RTT Admitted	110 - Orthopaedics	90%		84.0%	80.3%	80.1%	82.3%	86.2%	84.7%	84.7%	85.7%	86.8%			<90%		≥90%
	RTT Admitted	130 - Ophthalmology	90%		83.2%	85.0%	85.6%	91.9%	88.6%	92.9%	92.5%	92.2%	94.1%			<90%		≥90%
	RTT Admitted	300 - General medicine	90%		99.4%	98.3%	98.0%	99.4%	98.3%	97.6%	98.6%	98.8%	98.8%			<90%		≥90%
	RTT Admitted	320 - Cardiology	90%		89.3%	92.8%	92.7%	94.5%	93.5%	91.3%	92.5%	94.6%	92.4%			<90%		≥90%
	RTT Admitted	330 - Dermatology	90%		91.7%	87.6%	82.0%	84.3%	84.8%	85.3%	84.8%	87.9%	94.1%			<90%		≥90%
	RTT Admitted	410 - Rheumatology	90%		98.1%	94.5%	97.1%	98.2%	100.0%	96.9%	96.0%	96.3%	100.0%			<90%		≥90%
	RTT Admitted	502 - Gynaecology	90%		85.7%	75.7%	87.6%	84.4%	78.9%	77.7%	81.1%	82.6%	74.8%			<90%		≥90%
	RTT Admitted	Other	90%		99.4%	97.7%	98.9%	97.8%	100.0%	99.3%	97.8%	98.8%	95.8%			<90%		≥90%
	RTT Non admitted	100 - General Surgery	95%		90.9%	96.4%	95.5%	95.1%	92.5%	93.4%	94.1%	95.5%	94.8%			<95%		≥95%
	RTT Non admitted	101 - Urology	95%		99.5%	96.5%	99.4%	96.2%	92.8%	97.0%	91.2%	98.4%	94.2%			<95%		≥95%
	RTT Non admitted	110 - Orthopaedics	95%		96.7%	91.4%	91.8%	87.9%	82.9%	83.2%	88.4%	87.6%	91.3%			<95%		≥95%
	RTT Non admitted	120 - ENT	95%		92.6%	89.9%	87.6%	83.6%	85.4%	84.6%	84.6%	91.9%	83.5%			<95%		≥95%
	RTT Non admitted	130 - Ophthalmology	95%		100.0%	96.4%	96.3%	95.5%	89.3%	96.1%	95.1%	96.5%	95.8%			<95%		≥95%
	RTT Non admitted	140 - Oral surgery	95%		91.0%	90.6%	78.7%	76.0%	68.2%	72.2%	65.7%	68.0%	58.6%			<95%		≥95%
	RTT Non admitted	300 - General medicine	95%		93.3%	96.5%	99.1%	95.7%	96.8%	96.3%	93.9%	92.5%	96.7%			<95%		≥95%
	RTT Non admitted	320 - Cardiology	95%		95.8%	93.4%	93.4%	95.5%	96.5%	97.1%	95.8%	99.1%	97.5%			<95%		≥95%
	RTT Non admitted	330 - Dermatology	95%		100.0%	94.5%	85.0%	80.4%	81.3%	82.1%	90.3%	97.4%	96.5%			<95%		≥95%
	RTT Non admitted	340 - Thoracic medicine	95%		97.5%	98.5%	98.9%	96.9%	100.0%	95.8%	98.0%	99.3%	99.4%			<95%		≥95%
	RTT Non admitted	400 - Neurology	95%		97.4%	96.4%	95.3%	87.5%	81.0%	82.1%	87.8%	83.5%	85.1%			<95%		≥95%
	RTT Non admitted	410 - Rheumatology	95%		95.9%	95.3%	97.5%	97.9%	97.3%	98.5%	98.8%	96.4%	98.0%			<95%		≥95%
	RTT Non admitted	502 - Gynaecology	95%		98.3%	96.2%	98.2%	93.0%	94.4%	91.0%	94.8%	92.1%	96.2%			<95%		≥95%
	RTT Non admitted	Other	95%		98.8%	99.3%	98.8%	99.5%	99.3%	99.1%	98.7%	98.9%	98.2%			<95%		≥95%
SUS Submissions	NHS Number Compliance	Completion of NHS Numbers in SUS Submission (IPS/OPS)	99%		99.8%	99.8%	99.8%	99.8%	99.9%	100%	tbc	tbc				<99%		≥99%
	NHS Number Compliance	Completion of NHS Numbers in SUS A&E Submissions	95%		97.3%	97.4%	97.5%	97.5%	97.6%	98%	tbc	tbc				<95%		≥95%

* Local standard of 90% with a de minimis of 2 breaches per month or 6 per quarter
NHS Number Compliance is YTD

To: NHS CCG Accountable Officers
Trust and Foundation Trust Chief Executive Officers
System Resilience Group Chairs

CC: NHS England Regional Directors
NHS TDA Director of Delivery & Development
Monitor Regional Directors

14 July 2015

NHS England Publications Gateway Reference: 03614

Dear colleague

Improving and sustaining cancer performance

2014/15 was a challenging year for commissioners and providers. Performance against the cancer standards was generally strong, with certain areas making significant improvements in difficult circumstances. Despite this, performance against the cancer 62 day referral to treatment standard was consistently below the required 85% at national level.

We understand that operational performance standards can be challenging to meet in the context of current pressures. In some cases the pressure to meet them could lead to perverse consequences, and Sir Bruce Keogh's recent review of standards addressed that issue head on – making changes which are specifically designed to support you all in doing what is best for patients.

But when it comes to cancer standards, we know that waiting times have a very direct link with the quality of service we provide. We know that waiting for test results or treatment causes real anxiety for patients and their families. We know that many treatment options will only be effective if we employ them early enough. Ultimately, we know that delays in diagnosis and treatment are part of the reason that cancer outcomes in this country do not always compare well with our European peers.

We have made huge progress in addressing these issues over the past decade. Age-standardised mortality rates have decreased year-on-year and nine out of ten patients now rate their care as excellent or very good. It is critical that we work together to maintain and build upon these improvements.

Monitor, the National Trust Development Authority and NHS England have therefore agreed to lead a national delivery group for improving 62 day performance, which will work closely with the Cancer Waiting Times Taskforce (CWTT) and Intensive Support Team (IST). This reflects a recognition that, as with many areas of operational performance, poor 62 day performance and the required solutions will sit with a combination of commissioners and often multiple providers. This letter sets out the group's key streams of work.

We recognise that some regions have already been taking action to address performance issues and this group is intended to bring together this work under a national programme.

Eight key priorities

The CWTT led by Dr Kathy McLean and Mr Sean Duffy have identified 8 key priorities for local health systems to implement as a matter of urgency – please see Annex A for details.

These priorities offer practical actions to help providers and also support CCGs with effective commissioning of cancer services.

They have been identified to ensure that effective cancer resilience planning is undertaken in the current financial year.

All acute Trusts will be asked to complete a self-assessment of compliance with the 8 key priorities and return a plan to achieve full compliance, (or explanation of planned non-compliance), by the end of August 2015.

We believe the system will benefit if these priorities are supported by a strong assurance process. However, there are no quick fixes and as such we need to be realistic. These priorities should not be assured as a “tick box” exercise, but assurance should be used as a tool to get to a better position where we are able to deliver and sustain excellent care to our patients.

Cancer delivery plan

In addition to the 8 key priorities, a cancer waits action plan has been devised by the National Tripartite in response to the challenges we currently face and has the support of the Secretary of State for Health.

The key now is to ensure the recommendations set down in the plan – as outlined below – are fully embedded.

Improvement Plans

All Trusts will be segmented as poor/high concern/low concern/good based upon current and recent performance data.

All poor or high concern Trusts will be expected to produce an Improvement Plan by the end of August for review and sign off by its Regional Tripartite.

Trusts rated as good are likely to be followed up to discuss which additional operational measures have proved to be beneficial to performance so that this learning can be shared across other local health systems.

We will be significantly increasing the capacity of the Elective IST so they can support the production of these Improvement Plans.

Performance Reporting

To support this, all Trusts and Foundation Trusts will be expected to produce weekly PTLs for the 62 day standard.

Submissions from Foundation Trusts should be made via UNIFY2, so that information can be shared with commissioners. This will be coordinated through CCGs using the already established TDA weekly UNIFY PTL collection for NHS Trusts and which will be shared with FTs for use from week commencing 20 July.

Patients who have breached the 62 day standard will be externally monitored in the same way that 18 week breaches are monitored externally.

We will ask the CWWT to provide us with advice on the appropriate “backstop” measure which will then be operationalised into routine monitoring systems as we move forward.

Regional Tripartites will liaise with commissioners to remind them that the Remedial Action Plan process should be used where Trusts are not delivering the 62 day standard. NHS England will review the relevant sections of the national NHS Contract to ensure that the withholding regime for this standard reflects the importance of reliable delivery.

Capacity Planning

Each local health system will be required to prepare a cancer capacity plan setting out how it will deal with the projected increase in cancer demand. We will write to you again to set the detailed requirements and the required timeline for the production of local system capacity plans. We will also work on developing guidance to support this planning process.

System Resilience Groups

The remit of System Resilience Groups (SRGs) will be explicitly expanded to cover the 62 day cancer standard given the need to drive better and sustained performance.

Confirmation that the remit of SRGs explicitly now includes 62 day standard will be formally communicated in NHS England's SRG Winter assurance letter 2015/16 which is due to go out later in July.

Review breach allocation policy

We appreciate this is a particular issue for some providers, although we should bear in mind that "shared" cases only account for less than a third of breaches. It is also clear that deterioration in performance of shared cases has been exactly the same as non-shared cases. The ALB delivery group will look to commission a review of the current breach allocation policy by the CWTT to report back by end of August 2015.

Focus on endoscopy

Long waits for endoscopy procedures has become an increasing problem. Each system with long waits will be required to clear its backlog as a matter of urgency.

To support this work *InHealth* are mobilising a Programme Management Office to facilitate this process and help providers to clear the endoscopy backlog.

This will be operational from 1 August 2015, and will utilise a range of NHS and Independent Sector providers who are able to offer capacity.

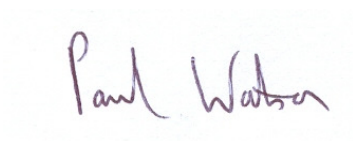
Further work is also being undertaken to look at a number of Trusts to understand local and national challenges and what might be done to help reduce waiting times and improve performance.

Next steps

The 62 day standard is one of the most important operational standards in the NHS. It has a strong relationship with the determinants of good cancer outcomes and positive patient experience. Delivering it is a key priority and we hope that the steps outlined in this letter – particularly the increased support available from the IST, Cancer Waiting Times Taskforce and Endoscopy PMO – will support you in doing what is needed in your own areas.

If you have any queries in the meantime, please do not hesitate to liaise with your relevant local contact.

Yours sincerely,



Paul Watson
NHS England



Lyn Simpson
NHS TDA



Adam Sewell-Jones
Monitor

Cancer Waiting Time Standard: Eight Key Priorities

- The Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards.
- Boards should receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.
- Every Trust should have a cancer operational policy in place and approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.
- Every Trust must maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.
- Each Trust should maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.
- A root cause breach analysis should be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching). These should be reviewed in the weekly PTL meetings.
- Alongside the above, a capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) should be carried out. There should also be an assessment of sustainable list size at this point.
- An Improvement Plan should then be prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.

BOARD OF DIRECTORS	
Meeting Date and Part:	31st July Part I
Subject:	Quality Report
Section:	Performance
Executive Director with overall responsibility	Paula Shobbrook, Director of Nursing and Midwifery
Author(s):	Joanne Sims, Associate Director Quality & Risk Ellen Bull, Deputy Director of Nursing
Previous discussed at:	To be discussed at HAC 30th July 2015
Action required: The Board of Directors is asked to receive the report which will be reviewed at the Healthcare Assurance Committee on 30 th July 2015.	
Executive Summary: This report provides a summary of information and analysis on the key performance and quality (P&Q) indicators linked to the Board objectives for 15/16. The Trust level dashboard provides information on patient safety and patient experience indicators including: <ul style="list-style-type: none"> • Serious Incidents • Safety Thermometer – Harm Free Care • Patient experience performance 	
Related Strategic Goals/ Objectives:	See list of current goals/objectives agreed by Board
Relevant CQC Outcome:	Safe, Caring, Effective, Responsive & Well Led
Risk profile <ol style="list-style-type: none"> Have any risks been reduced? No Have any risks been created? No 	

Quality & Patient Safety Performance Exception Report - June 2015

1. Purpose of the Report

This report accompanies the Quality/Patient Performance Dashboard and outlines the Trust's performance exceptions against key quality indicators for patient safety and patient experience for the month of June 2015

2. Serious Incidents

Seven Serious Incidents (SI's) were confirmed and reported on STEIS in June 2015.

3. Safety Thermometer

All inpatient wards collect the monthly Safety Thermometer (ST) "Harm Free Care" data. The survey, undertaken for all inpatients the first Wednesday of the month, records whether patients have had an inpatient fall within the last 72 hours, a hospital acquired category 2-4 pressure ulcer, a catheter related urinary tract infection and/or, a hospital acquired VTE. If a patient has not had any of these events they are determined to have had "harm free care".

NHS SAFETY THERMOMETER	14/15 Trust Average	14/15 National Average	15/16 Target	Apr	May	June
Safety Thermometer %Harm Free Care	90.68%	93.80%	95%	92.56%	92.51%	89.1%
Safety Thermometer % Harm Free Care (New Harms only)	97.18%	97.59%	98%	96.78%	97.86%	98.9%

	April 2015	May 2015	June 2015	
New Pressure Ulcers	12	6	3	
New falls (Harm)	2	2	1	
New VTE	0	0	0	
New Catheter UTI	2	2	1	

	Jan 2015	Feb 15	Mar 15	April 15	May 15	June 15
Risk assessment compliance						
• Falls	86%	88%	88%	90%	89%	90%
• Waterlow	91%	91%	91%	91%	96%	94%
• MUST	74%	76%	81%	83%	87%	90%
• Mobility	87%	88%	89%	89%	92%	91%
• Bedrails	88%	90%	89%	92%	93%	94%

4. Patient Experience Report

4.1 Friends and Family Test (FFT)

National Comparison using the NHS England data base for May 2015 data sets

RBCH In-Patients and Day Case Family and Friends Test ranking

	April 2015	May 2015
FFT Ranking	3 rd (with 13 others out of 167 hospitals)	3 rd (with 18 others out of 170 hospitals)
Our score: Number of patients who would recommend	98%	98%
Our response rate based on activity	13.8%	18.3%
Number of participating Trusts	167	170
Top score	100%	100%
Lowest score	85%	79%

The table above shows the Trust 3rd out of 170 hospitals with an FFT score of 98% of patients recommending the Trust. The same score as 18 other hospitals in the 170 sample and is top quartile nationally.

Comparison with NHS England data, shows RBCH compliance rate of 18.3% is low. Further support and clinical engagement has been requested and is evidenced in June data (table 4.2) indicating a raise from 7% to 25% for Day Case patient responses facilitated by the return of the FFT band 2 post in the patient experience team.

The table below represents the top 3 FFT scores by percentage of those who would recommend a Trust and the number of hospitals that attained that score for in-patient's results on the NHS England website.

National ranking

FFT % (% of those who would recommend)	Rank	No. of Trusts with this score
100%	1	8
99%	2	17
98%	3	19* (including RBCH)
There are 126 Trusts with scores below that of RBCH ranging between 97% - 79%		

Emergency Department (ED) - Family and Friends Test ranking

The table below shows the Trust 8th out of 140 hospitals with an FFT score 92% of patients recommending the Trust. The same score as 7 other hospitals in the 140 sample.

RBCH ED Family and Friends Test ranking

	April 2015	May 2015
FFT Ranking	6th (with 11 others out of 139 hospitals)	8th (with 7 others out of 140 hospitals)
Our score: Number of patients who would recommend	94%	92%
Our response rate	5.1%	7%
Trusts sample size	139	140
Top score	100%	100%*
Lowest score	61%	61%

* 100% score based on 6 FFT returns (0.1% response rate)

The table below represents the top 8 FFT scores by percentage of those who would recommend a Trust and the number of hospitals that attained that score for ED results on the NHS England website.

National ranking

ED FFT % (% of those who would recommend)	Rank	No. of Trusts with this score
100%	1	1
98%	2	4
97%	3	4
96%	4	8
95%	5	6
94%	6	10
93%	7	7
92%	8	8* (including RBCH)
There are a further 92 Trusts below RBCH with scores ranging between 91% - 66%		

Using the NHS England data, the Trust with a May compliance rate of 7% in ED places the Trust 109th from a sample of 140 Trusts. National compliance rates in ED's range from 47.4% to 0%. Plans for further support and clinical engagement are underway.

4.2 In Month FFT responses results and compliance (June 2015 data)

There is minimal variation with the total FFT scores for submission areas with the previous month, and a decrease in the number of patients who would not recommend the Trust in OPD areas, Maternity and ED.

Please note there are no extremely unlikely to recommend from any in patient wards (except ITU / SSU), as shown in the table below.

Extremely unlikely responses for ED, Maternity, inpatient, outpatient and day case areas (June 2015).

Ward / Area	No. Ext. Unlikely	% Ext. Unlikely	% Ext Unlikely against months Total activity
ED	25	20%	0.7%
Short Stay Unit (SSU)	1	1.0%	0.5%
ITU	1	25%	20%
Day Surgery Unit	2	2%	na
Chest Clinic (Thoracic)	1	50%	na
Eye Unit Out-patients	1	0.8%	na
Orthoptics	1	0.8%	na
Outpatients General	1	0.6%	na
Ortho Outpatients	2	0.9%	na
Pathology RBH	1	12.5%	na
Pharmacy RBH	2	11.8%	na
Pre-assessment	2	1.2%	na
X-ray	1	0.6%	na
Physio Xch	1	1.5%	na

The table below shows the proportion of 'Unlikely and Extremely Unlikely to Recommend' FFT responses from across the *Whole Trust* - For internal Monitoring only

Unlikely & Extremely Unlikely Responses	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
No of FFT responses for all areas Trust wide Unlikely or Extremely Unlikely to recommend	48	59	49	35	65	65
% Unlikely or Extremely Unlikely to recommend	1.6%	2.1%	1.8%	1.5%	2.0%	1.6%

This table indicates a decrease in those who would not recommend the Trust based on 3970 FFT returns from a sample of 4156 FFT cards completed.

4.4 Patient Opinion and NHS Choices: June Data

8 patient opinion comments were posted in June; Themes were; 5 expressed satisfaction with the service they received and 3 negative comments regarding poor care, information and special dietary food services. These are disseminated appropriately for action.

5. Recommendation

The Board of Directors is asked to note the report which is provided for information and assurance.

BOARD OF DIRECTORS	
Meeting Date and Part:	31 July 2015 – Part I
Subject:	Financial Performance
Section:	Performance
Executive Director with overall responsibility	Stuart Hunter, Director of Finance
Author(s):	Pete Papworth, Deputy Director of Finance
Previous discussion and/or dissemination:	Finance Committee and Trust Management Board
Action required: The Board of Directors is asked to note the financial performance for the period ending 30 June 2015.	
Summary: Activity during June was marginally above budget across all points of delivery, resulting in an aggregate increase in month of 2%. Whilst this brings the year to date activity volume in line with the initial plan, additional elective activity continues to off-set reduced emergency department attendances. Despite activity being in line with budgeted levels; the Trust reports an adverse financial position as at 30 June. The Trust budgeted a net deficit of £137,000 in month, against which an actual deficit of £147,000 was reported. This represents an adverse variance of £10,000, and takes the year to date adverse variance to £212,000. Immediate and decisive action must be taken to ensure that costs are contained within the agreed budget. Where appropriate, directorate management teams are currently preparing detailed financial recovery options for consideration and approval. Income has over achieved by £22,000 to date, with reduced private patient income off-set by additional NHS patient and non-patient related income. Expenditure reports an over spend of £235,000 to date, driven mainly by additional high cost drugs and devices; most notably in relation to cardiac CRT devices. Agency staffing costs remain very high, off-set by under spends from vacant posts. The Trust has welcomed the Department of Health's support in establishing consistent national controls to help NHS provider organisations control temporary staff expenditure effectively; and is in the process of refining internal policies and processes to maximize the benefit of this. Cost improvement schemes to date have delivered savings of £1.286 million, against a target of £1.352 million. Action is in hand to recover this shortfall, and in addition to this a number of new schemes have been identified and are progressing which will result in an over achievement against the initial target.	

Capital spend reported a small over spend in month, bringing the year to date over spend to £118,000. This reflects the timing of agreed capital commitments and the forecast for the year remains in line with the agreed capital programme.

The Trust Continuity of Services Risk Rating remains at 3, in line with the agreed plan. The Trust has responded to Monitor's Consultation in relation to proposed changes to the Financial Risk Ratings, and awaits the outcome of this consultation to understand the implications. At this stage, it is expected that with effect from 1 August, the Trust will fall within the 'risk and investigation' category under the proposed new ratings.

**Related Strategic Goals/
Objectives:**

Goal 7 – Financial Stability

Relevant CQC Outcome:

Outcome 26 – Financial Position

Risk Profile:

No new risks have been added to the Trust risk register, and none have been removed or reduced.

Reason paper is in Part 2

N/A

THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST
FINANCIAL PERFORMANCE FOR THE PERIOD TO 30 JUNE 2015

KEY FINANCIALS	2014/15 YTD ACTUAL £'000	CURRENT YEAR TO DATE				IN MONTH			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %	PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
NET SURPLUS/ (DEFICIT)	(2,395)	(4,425)	(4,637)	(212)	5%	(137)	(147)	(10)	7%
EBITDA	1,073	(700)	(916)	(216)	31%	1,144	1,130	(14)	(1%)
TRANSFORMATION PROGRAMME	1,341	1,352	1,286	(66)	(5%)	760	689	(71)	(9%)
CAPITAL EXPENDITURE	3,679	4,335	4,453	(118)	(3%)	1,669	1,694	(25)	(1%)

ACTIVITY	2014/15 YTD ACTUAL NUMBER	CURRENT YEAR TO DATE				IN MONTH			
		PLAN NUMBER	ACTUAL NUMBER	VARIANCE NUMBER	VARIANCE %	PLAN NUMBER	ACTUAL NUMBER	VARIANCE NUMBER	VARIANCE %
Elective	16,686	17,093	17,431	338	2%	6,165	6,240	75	1%
Outpatients	82,898	83,026	83,519	493	1%	29,944	30,647	703	2%
Non Elective	8,153	8,260	8,308	48	1%	2,723	2,818	95	3%
Emergency Department Attendances	22,304	22,190	21,732	(458)	(2%)	7,315	7,371	56	1%
TOTAL PbR ACTIVITY	130,041	130,569	130,990	421	0%	46,147	47,076	929	2%

INCOME	2014/15 YTD ACTUAL £'000	CURRENT YEAR TO DATE				IN MONTH			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %	PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
Elective	17,008	16,881	16,820	(60)	(0%)	6,182	6,171	(11)	(0%)
Outpatients	7,774	7,648	7,636	(12)	(0%)	2,536	2,535	(1)	(0%)
Non Elective	13,598	13,995	14,007	13	0%	4,588	4,621	33	1%
Emergency Department Attendances	2,127	2,428	2,405	(23)	(1%)	800	790	(10)	(1%)
Non PbR	16,227	18,054	18,181	127	1%	6,535	6,584	49	1%
Non Contracted	6,999	6,345	6,246	(99)	(2%)	2,271	2,163	(107)	(5%)
Research	459	444	506	62	14%	160	179	19	12%
Interest	37	24	40	16	66%	9	15	7	77%
TOTAL INCOME	64,229	65,819	65,841	22	0%	23,082	23,060	(22)	(0%)

EXPENDITURE	2014/15 YTD ACTUAL £'000	CURRENT YEAR TO DATE				IN MONTH			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %	PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
Pay	40,523	42,237	42,102	135	0%	13,890	13,958	(68)	(0%)
Clinical Supplies	8,735	8,763	9,005	(242)	(3%)	2,709	2,855	(146)	(5%)
Drugs	7,088	7,206	7,644	(439)	(6%)	2,520	2,625	(105)	(4%)
Other Non Pay Expenditure	6,169	7,744	7,364	380	5%	2,667	2,314	353	13%
Research	457	462	524	(62)	(13%)	156	175	(19)	(12%)
Depreciation	2,363	2,354	2,363	(9)	(0%)	785	788	(3)	(0%)
PDC Dividends Payable	1,290	1,479	1,477	2	0%	493	492	1	0%
TOTAL EXPENDITURE	66,624	70,244	70,478	(235)	(0%)	23,220	23,207	12	0%

STATEMENT OF FINANCIAL POSITION	2014/15 YTD ACTUAL £'000	CURRENT YEAR TO DATE			
		PLAN £'000	ACTUAL £'000	VARIANCE £'000	VARIANCE %
Non Current Assets	160,873	174,765	175,239	474	0%
Current Assets	65,815	77,673	79,775	2,102	3%
Current Liabilities	(28,694)	(43,072)	(45,865)	(2,793)	6%
Non Current Liabilities	(5,215)	(18,837)	(18,837)	0	0%
TOTAL ASSETS EMPLOYED	192,779	190,529	190,312	(217)	(0%)
Public Dividend Capital	78,674	79,665	79,665	0	0%
Revaluation Reserve	72,999	74,608	74,608	0	0%
Income and Expenditure Reserve	41,106	36,256	36,039	(217)	(1%)
TOTAL TAXPAYERS EQUITY	192,779	190,529	190,312	(217)	(0%)

CONTINUITY OF SERVICE RISK RATING	2014/15 YTD ACTUAL METRIC	CURRENT YEAR TO DATE			
		PLAN METRIC	ACTUAL METRIC	RISK RATING	WEIGHTED RATING
Debt Service Cover	0.81x	(0.44)x	(0.58)x	1	1
Liquidity	46.0	38.1	37.6	4	2
CONTINUITY OF SERVICE RISK RATING	3				3

BOARD OF DIRECTORS	
Meeting Date and Part:	31 st July 2015 - Part 1
Subject:	Workforce report
Section:	Information
Executive Director with overall responsibility	Karen Allman
Author(s):	Karen Allman
Previous discussion and/or dissemination:	
Action required: The Board of Directors is asked to: Note the content of the report.	
Summary: The report shows the performance of the Trust by care groups across a range of workforce metrics: Appraisal, Mandatory Training, Turnover and Joiner rates, Sickness and Vacancies. This month's report includes updates on the sickness absence call pilot, the staff survey action plan, and the 2015 Q1 Staff Impressions FFT survey.	
Related Strategic Goals/ Objectives:	To listen to, support, motivate and develop our staff
Relevant CQC Outcome:	Outcomes 12, 13 & 14 - Staffing
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

WORKFORCE REPORT – JULY 2015

The monthly workforce data is shown below, both by care group and category of staff. A revised Trust target of 100% appraisal compliance (as per the Board discussion in March) and 3% sickness absence have been set and performance has been RAG rated against these targets.

Care Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June			At 30 June	
Surgical	4.5%	69.4%	78.0%	4.56%	14771	10.6%	16.0%	2.5%
Medical	2.2%	57.4%	78.0%	4.05%	18749	18.2%	12.9%	10.5%
Specialities	10.7%	74.6%	77.0%	3.65%	10140	12.0%	11.5%	5.5%
Corporate	7.7%	50.0%	76.0%	3.91%	12406	12.7%	10.9%	6.5%
Trustwide	5.8%	65.8%	77.5%	4.05%	56066	13.9%	12.8%	6.8%

Staff Group	Appraisal Compliance		Mandatory Training Compliance	Sickness		Joining Rate	Turnover	Vacancy Rate (from ESR)
	Values Based	Medical & Dental		Absence	FTE Days			
	At 30 June			Rolling 12 months to 30 June			At 30 June	
Add Prof Scientific and Technical	7.6%		71.0%	3.27%	1401	11.9%	14.9%	9.7%
Additional Clinical Services	1.3%		79.0%	6.40%	15520	23.1%	13.4%	4.4%
Administrative and Clerical	9.8%		78.0%	3.44%	10535	12.2%	14.3%	6.5%
Allied Health Professionals	5.5%		84.0%	1.82%	1645	11.6%	11.2%	1.0%
Estates and Ancillary	1.4%		73.0%	5.80%	6805	13.2%	20.3%	9.0%
Healthcare Scientists	7.8%		91.0%	3.05%	644	19.4%	21.0%	5.1%
Medical and Dental		65.8%	62.0%	1.14%	1778	8.1%	6.7%	4.7%
Nursing and Midwifery Registered	6.7%		81.0%	4.36%	17738	11.1%	10.1%	9.6%
Trustwide	5.8%	65.8%	77.5%	4.05%	56066	13.9%	12.8%	6.8%

As noted previously, Turnover in Corporate Directorate and Estates & Ancillary and Administrative & Clerical staff groups include the transfer of 29 Commercial Services staff to Poole ESR.

1. Appraisal

As previously advised, appraisal compliance was reset to zero with the introduction of the new values based appraisal.

The number of appraisals reported is below trajectory but it is thought that figures are under-reported due to delays in uploading completion into ESR. The importance of this part of the process has been reiterated.

2. Essential Core Skills Compliance

Overall compliance has increased to 77.5% (76.5% for May), continuing the steady upward trend over the last few months with most subjects seeing increases, particularly for eLearning subjects, demonstrating that the VLE is working well. However, the overall rate of increase is disappointing and compliance remains below the level required. Work continues within the Education & Training Department to offer support to those departments showing lower compliance.

Compliance in the face-to-face subjects (Fire, Conflict Resolution, Resuscitation, Moving and Handling) is steadily increasing, with higher numbers of participants and less DNA s, but still lags behind the e-learning subjects, particularly for Fire and Conflict Resolution which both show low levels of compliance at 61%.

The Doctors and Dental staff group have increased from 54% to 62% since February 2015. Additional communication and support has taken place to increase this further as Doctors still remain the least compliant staff group. Healthcare Scientists are the staff group with the highest compliance at 91%.

New subjects added to the ECS Needs Analysis are showing good increases: Dementia tier 1 is at 58.6% and tier 2 (face to face session) is at 32%. Safeguarding Adults level 2 launched in February 2015 and is already at 41%, further evidence that eLearning subjects are ensuring better completion of learning.

A survey collecting feedback on the VLE is soon to be launched and a summary of the feedback will be available for the next Board paper. Furthermore, a SWOT analysis has been completed by the ECS Group, the results of which will be collated with the survey feedback and an action plan written.

3. Sickness Absence

The Trust-wide sickness rate has remained static at 4.05%.

The Surgical care group continues to be red-rated, although with a very slight reduction to 4.56% (May 4.62%) The Medical care group has slipped to red this month at 4.05% up from 3.95% in May.

By staff group, 3 areas remain red-rated:

- Additional Clinical Services: 6.40% (unchanged)
- Estates & Ancillary: 5.80% (5.78% in May)
- Nursing & Midwifery: 4.36% (4.31% in May)

Absence Call Pilot:

The new pilot for sickness absence reporting as referred to in last month's Board paper commenced on 15th June. The Absence Call service provides additional support and advice to staff who are experiencing an episode of short term sickness absence and also, if appropriate, challenges reasons for the sickness. The pilot is seen as an additional tool and not intended to replace management intervention.

Care First will provide a quarterly report and project end report at six months. This will also review the sickness rates within these areas, looking for improvement and whether there have been any potential savings from backfill of posts.

The scheme will be reviewed at Workforce Committee and within the Transformation workstream.

4. Turnover and Joiner Rate

The joining rate shows a very slight decrease to 13.9% from 14% last month but continues to exceed the turnover rate of 12.8%.

5. Vacancy Rate

The vacancy rate is reported as the difference between the total full time equivalent (FTE) staff in post (including locums and staff on maternity leave) and the funded FTE reported by Finance, as a percentage of the funded FTE. Trust-wide our vacancies are 6.8% of funded posts, down slightly from 6.9% last month, although there were increases for Medical and Corporate staff.

6. Recruitment

Focus on recruitment remains - we had a successful stand at the RCN National Congress in Bournemouth at the BIC from the 21st - 25th June. We also attended the RCN job fair in Birmingham on 2nd /3rd July, however this was much less busy with less contacts than other similar events.

7. Staff Survey

Following the 2014 staff survey, Care Groups and Directorates developed their own action plans but the corporate action plan is updated below for information.

Action point	Update on action taken	Date
A Care Group specific report to be made available to all Directors of Operations and Heads of Nursing, to enable the development of individual action plans for half yearly reviews.	Reports have been prepared for each Care Group and the Corporate areas, highlighting areas of good performance and concern. Care groups and corporate areas have developed their own actions plans and report at half-yearly reviews.	Completed March 2015
The full report to be made available to Directors of Operations and Heads of Nursing for benchmarking purposes.	The full Picker report and national reports have been sent to Directors of Operations and Heads of Nursing.	Completed March 2015
The Workforce Strategy and Development Committee and the Valuing Staff and Wellbeing group to review the corporate actions plans at their first meeting following release of the staff survey results.	Presentations have been taken to the Workforce Committee and Valuing Staff and Wellbeing Group, with action plans for comment.	Completed May 2015

Results to be communicated to staff via various media, e.g. a Health and Wellbeing event, leaflet and corporate communications.	A Staff Survey leaflet was produced and sent to Care Groups and Corporate areas with Staff Survey reports. A Health and Wellbeing event has taken place and information made available through communications and on intranet.	Completed May 2015
A Corporate plan is developed for the main points of concern, as described above	Completed, see below.	March 2015
Corporate actions		
Action to be taken against staff who exhibit physical violence against others.	Staff Impressions survey Q1 [see item 10 below] included additional questions relating to physical violence by staff. Reports by 4 staff advising of incidents - hair pulling, pushing and chair shaking. Work is underway to raise the profile of reporting concerns of all kinds, which will be communicated to staff via various media with the help of the communications team.	August 2015
Health and Wellbeing initiatives for staff to include fitness to work and mental health awareness.	A programme of events has been drawn up, with promotion of fitness sessions (Pilates, 'fit for work' and Zumba), also a new Weight Watchers class commenced in July 2015. Mindfulness sessions are being held in some areas and promotion has taken place for a free evening mindfulness session.	On-going
Physical violence from patients/service users, their relatives or others to be firmly addressed.	Actions discussed with Security Manager.	Follow-up required
Health and Safety training sessions to be monitored and poor attendance to be reported to Directorates for follow up.	Online – monitoring to take place.	Ongoing
Launch of new Appraisal system in 2015, with robust follow-up for managers who fail to complete appraisals for staff.	New appraisal training completed and progress being made towards all staff receiving new behaviours based appraisal.	November 2015

8. Education & Training – Time to Lead (TTL)

Themes from the recent presentations are currently being collated and once completed a decision will be made on the next steps for TTL. Some evaluation forms are still awaited from delegates; once all of the information is received a formal report will be produced and shared with the Board.

9. Safe Staffing

Safe Staffing figures are reported as per the national guidance for acute ward areas and demonstrate the actual fill rates of registered and unregistered nurses against the planned template.

Areas of variance are reported by exception.

For June 2015 on aggregate, the Trust fill rate of actual against planned was as follows:

- RN/RM fill rate days 93.8%
- HCA fill rate days 104.5%
- RN/RM fill rate nights 100.6%
- HCA fill rate nights 118.6%

Surgical Care Group - Variances by exception :

- Ward 14 have intentionally not filled all shifts due to reduced service need.
- Ward 17 have had a long-term special for a complex patient, each shift at the request of consultants.
- Ward 18 have required a couple of specials.
- Other surgical ward areas have mitigated risk each day.
- Ward 7 show a low fill rate of trained staff for the day shifts. This is due to the template not yet being aligned with their requirements; it is showing more qualified nurses than is required to maintain safety, therefore until the template is corrected we will show a reduced fill rate.
- Derwent is also showing under template fill rate; this is due to the reduction in service need and a corresponding reduction of staff required.
- Day Surgery lower fill rates reflect vacancies. This figure should improve over the next two months as posts have now been recruited into.

Medical Care Group - Some areas in older peoples medicine and medicine have had higher than planned HCA shifts, mainly at night. This reflects the specials required for patient safety.

One of the cardiac wards has a higher than planned usage of qualified and unqualified on days, this is being validated by the Care Group Head of Nursing.

Specialties Care Group - No significant variances.

The Nursing Agency Authorisation Protocol has been developed, disseminated and implementation has commenced. This is part of the Monitor guidance on managing Agency Usage which all Foundation Trusts have been requested to voluntarily comply with. A suite of work to support this is underway as part of the wider workforce transformation project.

10. Staff Impressions

The 2015 Q1 survey, which included questions on violence at work, closed at the end of June. We have now been collecting and reporting on Staff FFT data and our additional engagement measure for a year. An overview of results is shown below, and a presentation is attached (*Appendix 1*) from our survey provider Lepidus which shows improvement across the board, and a decrease in those that would not recommend the Trust.

1. Completion Rates

	Numbers	Completion %
Q1 2014	739	16.3%
Q2 2014	421	9%
Q4 2014	573	12.8%
Q1 2015	544	12.16%

2. Staff FFT Results

RBCH	Recommend Trust as a place to work	Recommend Trust as a place for treatment
Q1	60%	73%
Q2	65%	77%
Staff Survey	64%	71%
Q4	65%	83%
Q1 2015	68% (8% increase)	84% (11% increase)

3. Engagement

RBCH	Is your overall experience mainly good or mainly bad? (Mainly Good)
Q1	86%
Q2	87%
Q4	88%
Q1 2015	92%* (6% increase)

*Lepidus advises that a score of 90% or above indicates an engaged workforce.

4. Additional Questions

For Quarter 1 2015 (June 2015) we focused questions on experiencing physical violence at work, following the outcome of the Staff Survey.

Q1. In the last 12 months have you personally experienced physical violence at work?

Yes	No
7%	93%

Q2. How often have you suffered physical violence at work?

	%
Not experienced violence	92
Once	1
2-3 times	2
4-5 times	1
More than 5 times	2
No response	3

Q3. Who was it by? Please tick all that apply.

	%
Not experienced violence	92
Patient	6
Relative/Carer	1
Colleague	0
My Line Manager	0
Other Manager/Senior Manager	0
No response	2

Q4. Did you receive adequate support from colleagues and/or managers following the incident(s)?

	%
Not experienced violence	92
Mainly Yes	4
Mainly No	2
No response	2

Q5. Have you witnessed others experiencing physical violence at work?

	%
Yes	12
No	84
No response	3

Q6. Do you know how to report an incident of physical violence at work that you have been involved in or witnessed?

	%	Numbers
Yes	80	436
No	17	91
No response	3	17

This shows there are still individuals in the Trust who would not know how to raise a concern. There is work in HR to revise the Public Interest Disclosure (Whistleblowing) policy and to raise awareness through a screensaver and poster campaign on the different methods of raising issues.

We also need to develop an action for all line managers to ensure the cascade of this information reaches all staff.

5. Additional Comments

5.1 Experiencing violence at work

In the free text comments there are 4 incidents referred to which relate to violence from staff. We cannot identify where these occurred. They refer to pushing, hair pulling and banging chairs together.

There are 57 comments about violence from patients and these are predominantly due to dementia, confusion and intoxication. There is a suggestion that these incidents are underreported.

There are 40 comments giving ideas for improvement, including introducing a process and protected time for proper debriefing following incidents to increase learning.

5.2 Recommend the Trust as a place for Treatment

296 (77%) of the comments are positive. These are based on personal experiences, belief and pride in the clinical services and the hard work of our staff.

However there are 40 comments stating that their recommendation would depend on the ward or service that a patient would need to go to.

5.3 Recommend the Trust as a place to work

There are 245 (54%) positive comments about why the individuals would recommend the Trust as a place to work. These include a good team, nice environment, access to development, opportunities to progress and a supportive environment.

There are 164 (36%) negative comments about why our staff may not recommend our trust to their friends and family as a place to work. These include the work based pressures and stressful environment, lack of resources and staff, and unsupportive or poorly skilled managers.

There are 10 comments which specifically refer to bullying.

There are 13 comments in which people state they would not recommend the Trust as a place to work because of the car park and exit issues.

5.4 Anything else

This is a useful question as it allows staff to tell us anything they want without being directed by the survey.

- There were 22 comments relating to behaviour. This is towards each other, towards the patients, and from management to staff. There were also 8 comments about bullying.
- 23 comments related to resources in terms of staffing levels and facilities.
- There were 35 comments giving views and ideas for how to improve.

6.0 Suggested next steps

- Consider the need for a review of violence experienced from patients. If so, a lead would need to be identified.
- Senior representatives of the Trust - Executive Directors plus a Clinical Director and a Director of Operations - to read the anonymous comments made by our staff over the last year in the Staff Impressions survey.
- On-going communication about how the car park and exit issues are being addressed, with a specific acknowledgement of the impact this has on how staff feel about the Trust.
- Role modelling of Trust behaviours by all leaders at all levels, and challenging of demonstrations of poor behaviour (as part of appraisal process and as part of general leadership).
- Specific activity related to re-launch of whistleblowing policy and the raising concerns communication campaign.



2015/16 Staff Impressions/FFT Survey

Qtr 1 Headline Results and Benchmarking

Jul 2015



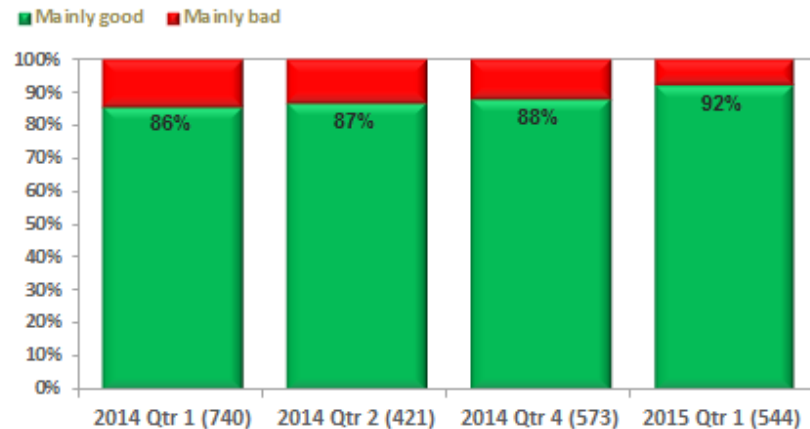
Contents

- Staff Morale
- Staff FFT
- Response Rate

Please note that some Trusts are still collating paper responses. An * denotes Trusts who are still to present final results.

Staff Morale

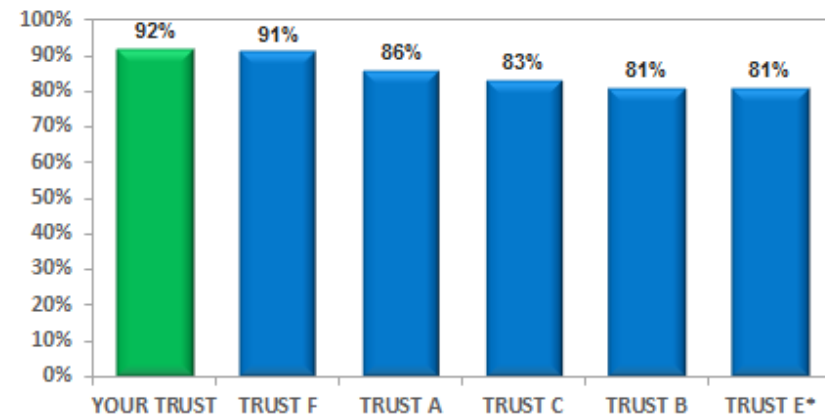
Overall 2014 Qtr 1 vs Qtr 2 vs Qtr 4 vs 2015 Qtr 1



Thinking about your overall experience of working at our Trust, is your impression...?

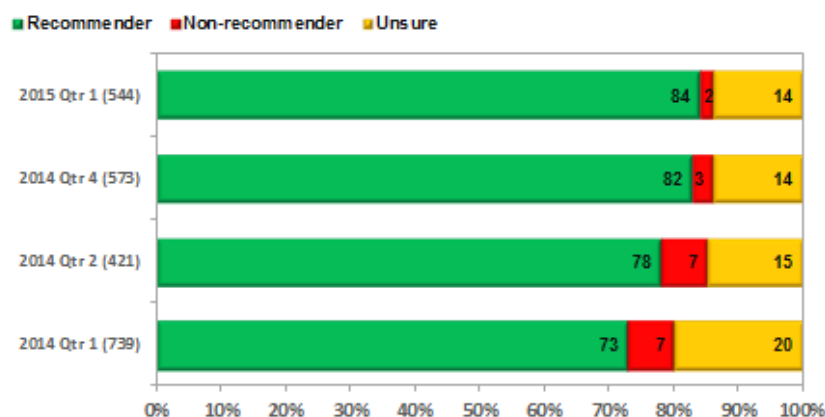
Staff Morale

Benchmark 2015 Qtr 1



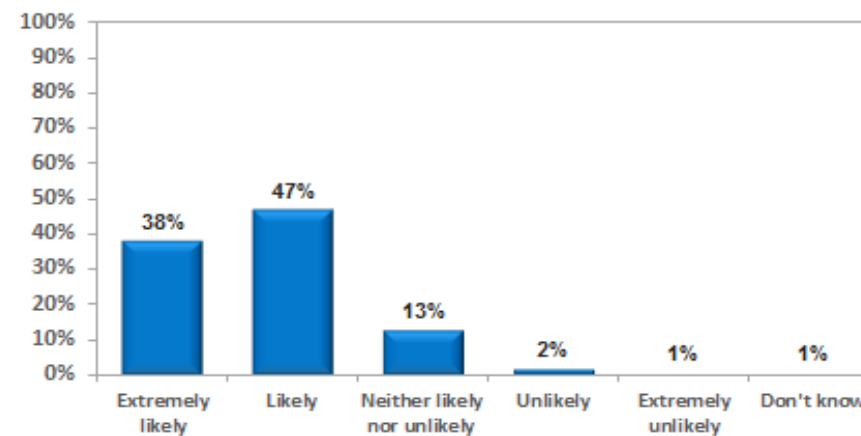
Service FFT

Scores 2014 Qtr 1 vs Qtr 2 vs Qtr 4 vs 2015 Qtr 1



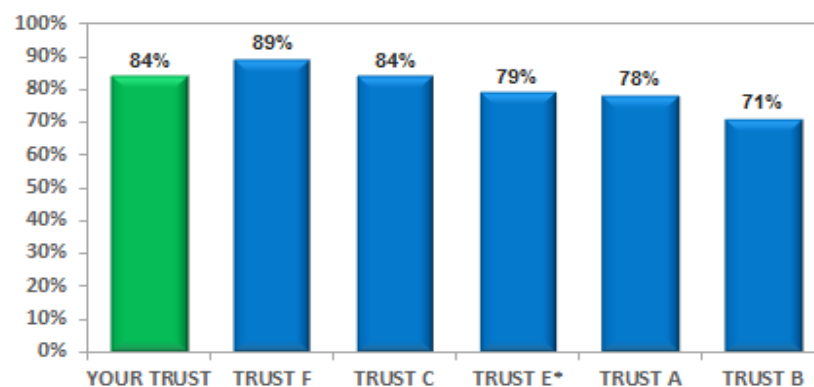
Service FFT

Ratings 2015 Qtr 1



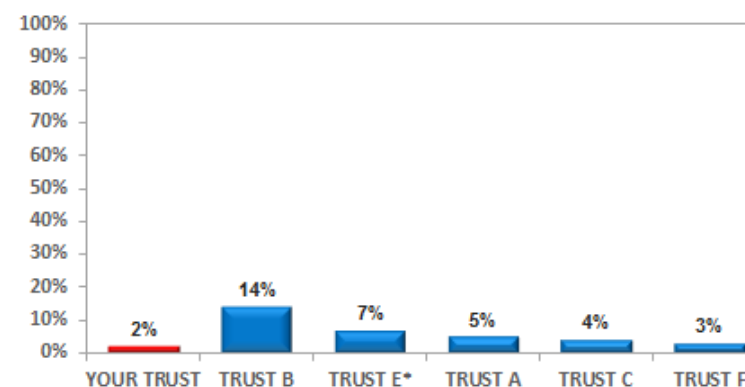
Service/Care FFT

Benchmark Recommenders 2015 Qtr 1



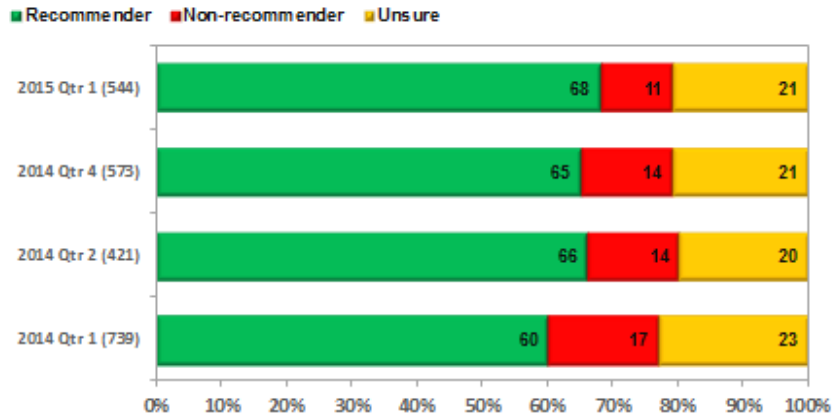
Service/Care FFT

Benchmark Non-Recommenders 2015 Qtr 1



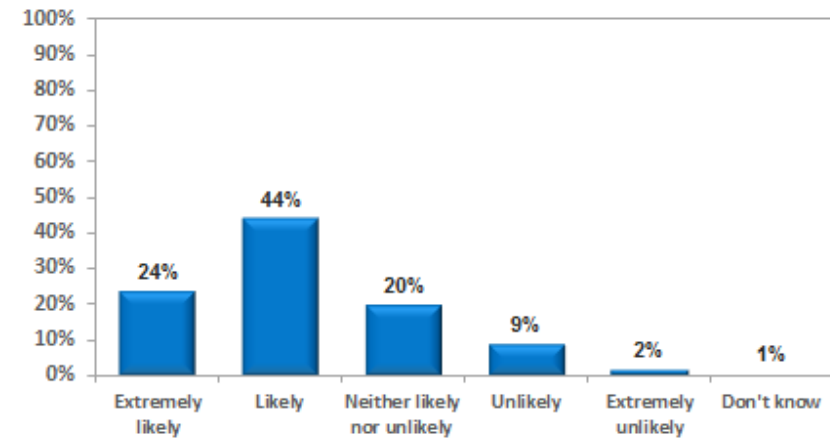
Workplace FFT

Score 2014 Qtr 1 vs Qtr 2 vs Qtr 4 vs 2015 Qtr 1



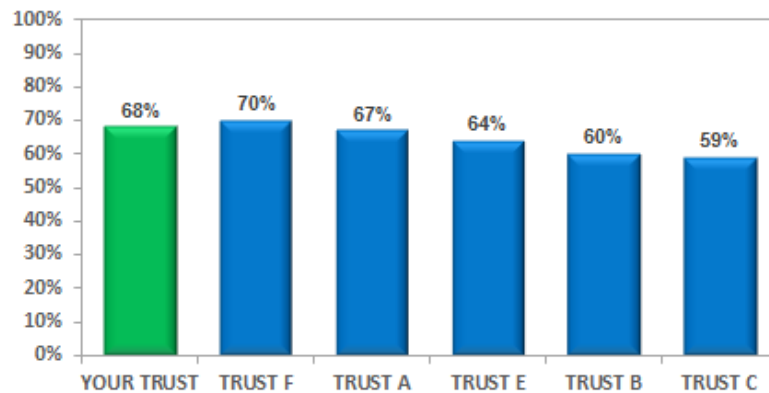
Workplace FFT

Ratings 2015 Qtr 1



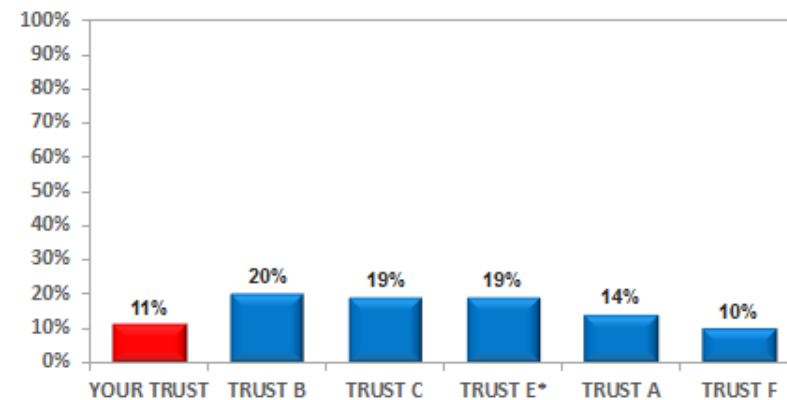
Workplace FFT

Benchmark Recommenders 2015 Qtr 1



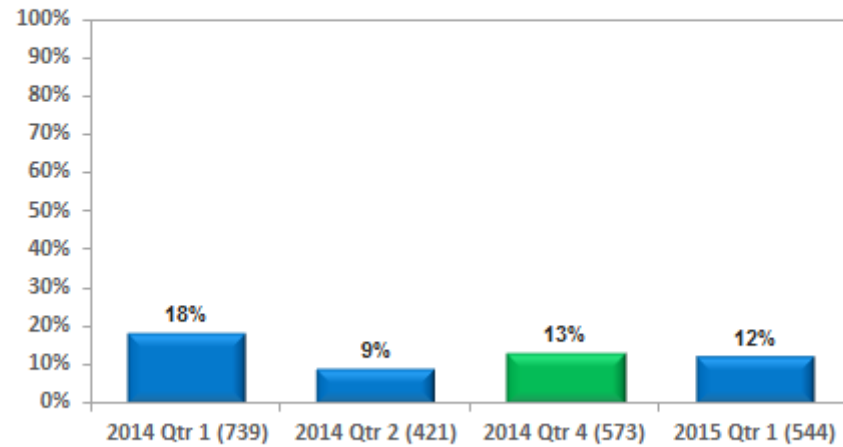
Workplace FFT

Benchmark Non-Recommenders 2015 Qtr 1



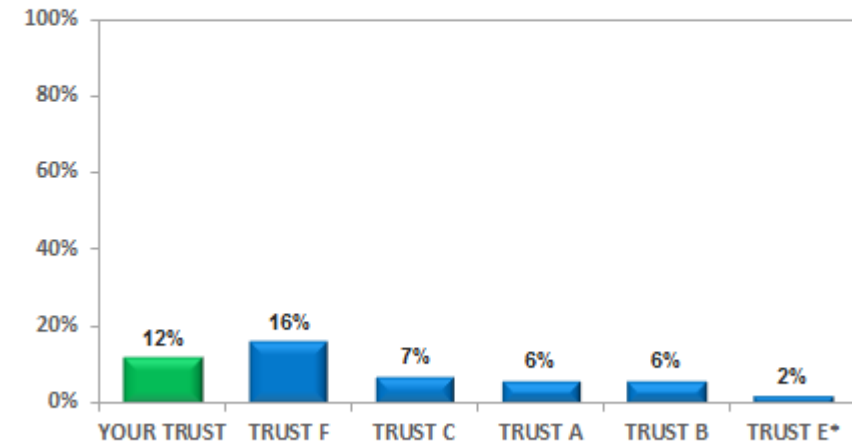
Response Rates

Overall 2014 Qtr 1 vs Qtr 2 vs Qtr 4 vs 2015 Qtr 1



Response Rates

Benchmark 2015 Qtr 1



BOARD OF DIRECTORS	
Meeting Date and Part:	31 st July 2015 Part 1
Subject:	VLE Essential Core Skills Training
Section:	Performance
Executive Director with overall responsibility	Basil Fozard, Medical Director
Author(s):	Basil Fozard, Medical Director
Previous discussion and/or dissemination:	Board of Directors May 2015
Action required: For information.	
Summary: Poor performance on compliance on Consultant Essential Core Skills has been previously raised. <ul style="list-style-type: none"> i. MD and Corporate Education Manager meeting 09.07.15. ii. ECST advice sheet emailed to all Consultants (attached). iii. Guidance for monitoring ECST sent to all DM's, DOO's and CD's (attached). iv. Appraisal output checklist confirms ECS training is up to date (attached). 	
Related Strategic Goals/ Objectives:	To offer patient centered services by providing high quality, responsive, accessible, safe effective and timely care.
Relevant CQC Outcome:	12
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? ii. Have any risks been created? No 	
Reason paper is in Part 2	

Appraisal Output Check list v.5.0 (July 15)

Name:	Appraisal Meeting Date:	
Domain 1: Knowledge, Skills and Performance		
Indicator	Present	Comment
Is the doctor's full scope of practice described inc PP? ¹		
Is there sufficient supporting information from all roles and places of work?		
Knowledge and skills are up to date		
Participation in CPD activities – query GMC compliancy ²		
Engagement in Quality Improvement Activities including notes audit		
Working within limits of competence & refers appropriately		
<i>Where relevant:</i>		
Commentary on research		
Commentary on teaching/ training experience		
Commentary on effective management work		
Domain 2: Safety and Quality		
Commentary on participation in systems of quality assurance and improvement – query GMC compliancy ²		
Confirmation that all Significant Events/ SUIs, AIRs and mortality have been presented and reflected upon		
Confirmation that proper supervision is given to staff for whose performance they are responsible		
Domain 3: Communication, Partnership and Teamwork		
Commentary on 360 colleague and patient feedback		
Date of the last 360 feedback		
Commentary on communication with colleagues		
Commentary on effective teamwork		
Commentary on any compliments received		
Domain 4: Maintaining Trust		
Any evidence of honesty and integrity from the 360 feedback		
Confirmation that all complaints have been presented and reflected upon		
Complaints have been responded to fully and promptly		
Confirmation of probity and health		
Additional requirements		
eMortality where applicable		
Attendance at Governance half days		
Confirm Essential Core Skills Training is up to date including NICE IV Fluids Training		
PDP		
S M A R T		
Appraiser statements		
The 5 appraisal output statements need to be 'agreed' or 'disagreed' by the appraiser		
Sign off		
Appraisee/ Appraiser GMC Number		

Appraisal Output Check list

Outcome

[illegible]

Signed

Mark Goodwin
Associate Medical Director

Date _____

References:

1. To include any role in which the doctor's license to practice is used e.g. Private practice, sports events, locums etc and for PP the scope of work is equivalent to that undertaken in NHS. There are no active complaints/ SUI/ any litigation.
2. GMC Supporting Information for Appraisal and Revalidation
[http://www.gmc-uk.org/static/documents/content/RT -
Supporting information for appraisal and revalidation - DC5485.pdf](http://www.gmc-uk.org/static/documents/content/RT-_Supporting_information_for_appraisal_and_revalidation_-_DC5485.pdf)

Essential Core Skills Training

Top three questions and answers.....

1. How do I find out what I need to do?

- Log on to the Virtual Learning Environment
- Within the Trust via a PC or Lap top click on the BEAT VLE icon on the desktop
- From home you can access using the URL www.rbch.vle.nhs.uk from a desktop, laptop, tablet or android phone
- Enter your assignment number (on payslip) as username and DOB in exactly this format including capital for first letter of month 30-Dec-1981 as your password
- You will then be presented with a gauge which will show a RAG system as to the subjects you need to complete
- Click on those that are red to access the learning

How do I complete the e-learning?

- For elearning subjects you will be presented with two options – to take the assessment or to complete the module of learning.
- It takes minutes to complete the assessment if you do feel you have the required level of knowledge to skill the learning within the module.
- You have a few attempts to get all the questions correct.
- Once completed your gauge and record will automatically turn green and you will be compliant for the set period of time for that subject

How do I book on face to face sessions?

- There are four face to face requirements; Conflict resolution, Resus, Medicines Management and Fire Updates.
- If these are red on your VLE when you click on them you will be redirected to the log in page for ESR
- You then need to search for the relevant subject the VLE tells you to in ESR and book on to a up coming face to face session.
- If you have lost your log in details for ESR please request these from IT Help Desk

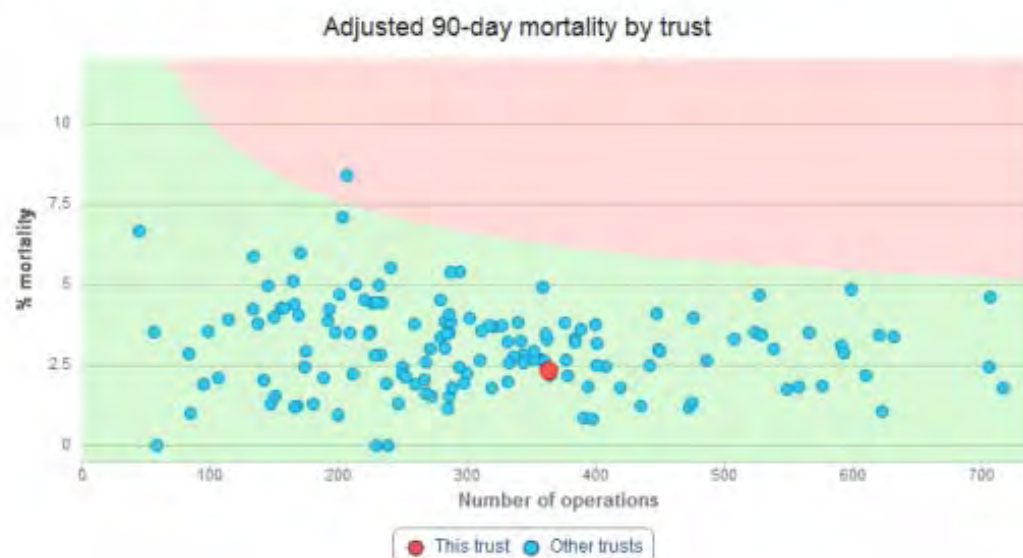
Contact Education and Training for more info on ext 4158

BOARD OF DIRECTORS	
Meeting Date and Part:	31 st July 2015 Part 1
Subject:	Surgeon Outcomes
Section:	Performance
Executive Director with overall responsibility	Basil Fozard, Medical Director
Author(s):	Basil Fozard, Medical Director
Previous discussion and/or dissemination:	N/A
Action required: Information was requested on how to assess individual surgeon outcomes.	
Summary: Individual surgeon outcomes are accessible on the internet and can easily be found on a Google search. http://www.acpgbi.org.uk/surgeon-outcomes/the-royal-bournemouth-christchurch-hospitals-nhs-foundation-trust/	
Related Strategic Goals/ Objectives:	
Relevant CQC Outcome:	
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	

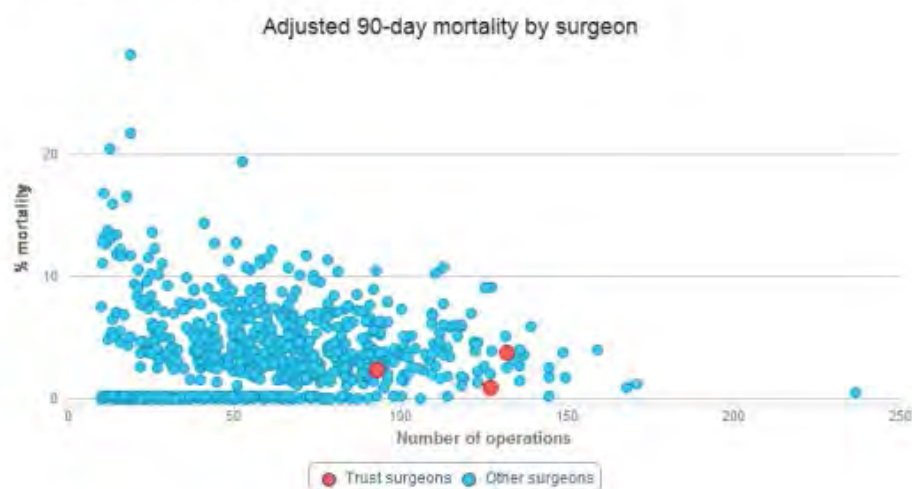
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

The THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST incorporates Royal Bournemouth General Hospital.

Mortality by trust



Mortality by surgeon



Name	Procedures	Deaths	Adj. 90-day mortality rate	ACP surgeon *
Fozard, Basil	127	1	0.88	No
Howell, Robert	93	2	2.36	Yes
Lawrance, Richard	132	5	3.75	Yes

■ ACPGBI surgeon

* This denotes whether this surgeon is a member of the *Association of Coloproctology of Great Britain and Ireland*.

BOARD OF DIRECTORS	
Meeting Date and Part:	31 st July 2015 - Part 1
Subject:	Emergency Department Improvement Plan
Section:	Performance
Executive Director with overall responsibility	Richard Renaut, Chief Operating Officer
Author(s):	Alex Lister, Directorate Manager
Previous discussion and/or dissemination:	Previous discussion at Board
Action required: The Board of Directors is asked to: Note the plan and support the recommendations	
Summary: Overview of the actions underway to improve Emergency Department 4 hour performance.	
Related Strategic Goals/ Objectives:	1. to offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care
Relevant CQC Outcome:	4. Responsive 5. Well-led
Risk Profile: i. Have any risks been reduced? N ii. Have any risks been created? N	
Reason paper is in Part 2	N/A

Emergency Department Update

1. Summary

The Trust is required to ensure that all patients attending the Emergency Department (ED) are seen, treated and discharged or admitted within 4 hours of arrival. This is a whole Trust, and indeed whole health and social care system responsibility, because it is a very good measure as to how well the emergency care system is operating.

The Trust has not achieved this standard for each of the last four quarters. Despite improving performance in the last quarter (Q1 15/16) the 95% level was not achieved (Trust achieved 93.2%). This paper focuses on what the Emergency Department (ED) can do to improve this it's part of the performance, as wider system issues will be discussed elsewhere.

Monthly 4 hour performance during 2015 has been as follows:

January	89.84%
February	91.59%
March	95.87%
April	91.58%
May	94.69%
June	93.46%
July (as at 23 rd)	97.74%

Achievement of the 95% target is affected by a multitude of factors:

- Health system issues in primary care prior to arrival, e.g. availability of GP or out of hours appointments
- Within ED (discussed in this paper)
- Within the Trust – hospital flow and bed availability to admit in to
- Within the community and social care services related to complex discharges and delayed transfers of care.

Analysis of 2015/16 Trust performance identifies that in 7 of the 13 weeks of Q1 95% performance was not achieved within ED itself, making it impossible for the Trust to achieve 95% for the quarter.

The Trust has a hospital wide programme of improvement related to in hospital flow: “5 daily actions.” The Older Persons Medicine Directorate is delivering an improvement programme in partnership with health and social partners to address complex discharges and delayed transfers of care.

This paper will present actions currently being undertaken within the Emergency Department to achieve and sustain Emergency Department performance against the 95% performance indicator.

2. Context and Current Performance

The Trust is required to externally report its overall performance against the 4 hour target. This includes all patients attending the Emergency Department, and combines the patients attending the Ophthalmic Emergency Department (ARC).

Breaches are reported at Trust level, and are validated daily and attributed to one of fifteen reasons. If a patient remains in the department for twelve hours after a decision to admit this is a Serious Incident and investigated accordingly. This has not occurred in 2015/16.

The table below isolates and compares ED only performance to Trust Performance. This is achieved by:

- Removing Ophthalmic attendances
- Removing breaches who had been seen and referred to an inpatient speciality 210 minutes (3 ½ hours), but subsequently breached due to lack of bed availability.

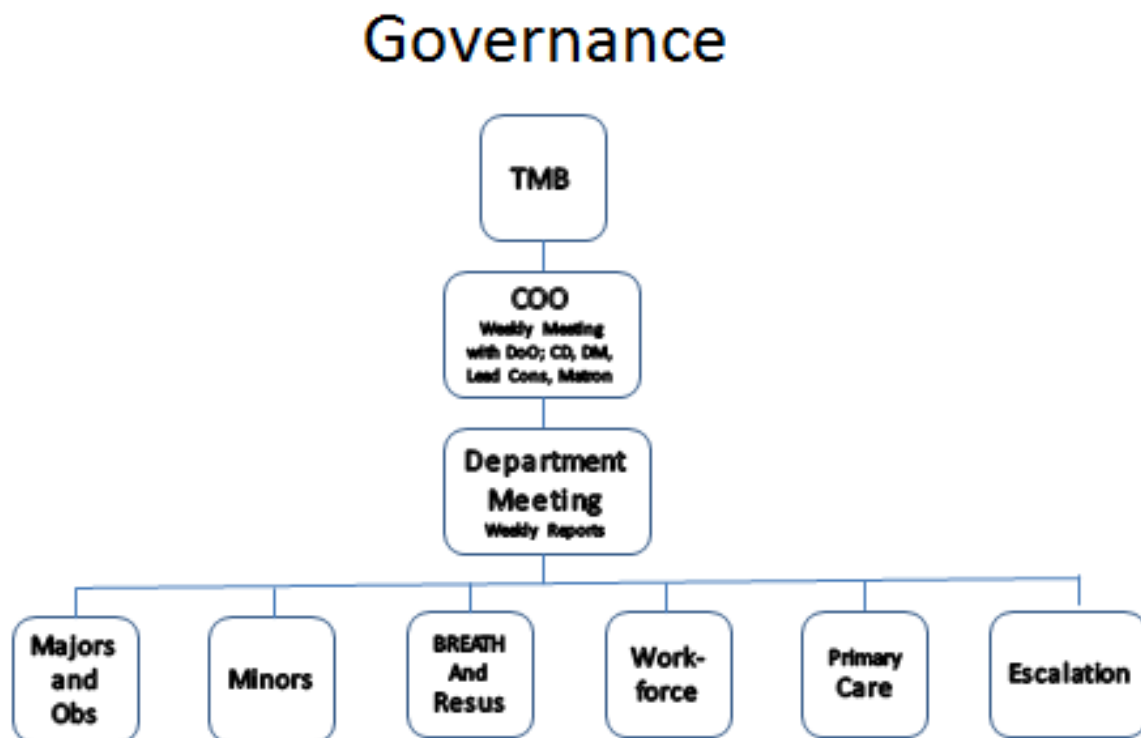
The table identifies that after an initial run of high performance in January to late March against the 3.5 hour ED only performance, the impact of delayed ED decision making was the single most important factor affecting performance in 7 of the first 13 weeks in the current financial year.

DATE	TRUST ATTENDANCES (inc Eye Unit)	TRUST PERFORMANCE	BREACHES			
			TOTAL > 4 HOURS	ED Attends (excl eye unit)	ED Breaches (all not reported as bed breach)	ED Performance (exc bed breaches)
WE 7/12	1641	89.21%	177	1360	156	88.53
WE 14/12	1605	92.77%	116	1315	93	92.93
WE 21/12	1596	86.59%	214	1321	108	91.82
WE 28/12	1538	90.51%	146	1319	89	93.25
WE 4/1	1539	82.52%	269	1292	154	88.08
WE 11/1	1459	93.90%	89	1155	53	95.41
WE 18/1	1475	92.41%	112	1189	56	95.29
WE 25/1	1437	92.28%	111	1156	38	96.71
WE 1/2	1515	89.04%	166	1214	39	96.79
WE 8/2	1550	96.13%	60	1248	29	97.68
WE 15/2	1582	89.32%	169	1271	63	95.04
WE 22/2	1590	89.56%	166	1289	61	95.27
WE 1/3	1584	91.29%	138	1267	96	92.42
WE 8/3	1605	96.45%	57	1275	15	98.82
WE 15/3	1546	98.45%	24	1239	14	98.87
WE 22/3	1592	97.61%	29	1286	31	97.59
WE 29/3	1636	94.32%	93	1299	68	94.77
WE 5/4	1704	88.56%	179	1380	150	89.13
WE 12/4	1656	87.50%	211	1359	147	89.18
WE 19/4	1624	94.27%	93	1334	53	96.03
WE 26/4	1586	94.58%	86	1270	61	95.20
WE 3/5	1645	91.85%	134	1320	106	91.97
WE 10/5	1660	97.65%	39	1336	20	98.50
WE 17/5	1684	94.71%	89	1367	65	95.25
WE 24/5	1622	95.56%	72	1303	48	96.32
WE 31/5	1698	91.34%	147	1430	124	91.33
WE 7/6	1612	91.19%	142	1293	114	91.18
WE 14/6	1729	93.18%	118	1414	88	93.78
WE 21/6	1717	97.90%	36	1355	23	98.30
WE 28/6	1761	93.81%	109	1429	93	93.49
WE 5/7	1780	93.82%	110	1450	90	93.79
WE 12/7	1796	98.05%	35	1468	28	98.09
WE 19/7	1687	98.22%	30	1384	10	99.28

3. Analysis and Actions

There are a number of factors that have impacted performance, some unique such as doctor changeover immediately before the 4 day Easter weekend (for which forward plans are already in place for similar extended holiday periods). Others factors are an increase in late evening surges of patient numbers, above historic patterns of presentation, causing bottlenecks and delays within the ED itself.

Targeted working groups have been re-established with consultant and senior nursing leads and feed into weekly executive led check and challenge meetings as described in the governance structure below:



These focus on the key areas identified in the “Monitor Action Plan” which is updated regularly.

4. Majors/Obs and BREATH/Resus

BREATH (Bournemouth Rapid Evaluation and Treatment Hub) commenced as a pilot in January 2015 and saw immediate success (see ED 3.5 hr performance). It was substantively funded in budget setting and commenced extended service hours to 10:00 – 22:00 with effect 22nd June 2015, once staff had been recruited.

The BREATH steering group has reformed with additional representation from the Clinical Site Team and Ambulance Trusts. New SoP's are being drafted and the learning from the first six months of the service has directed areas for development, and those adding less value. Service models are to be formalised and maintained.

Increasing use of the now trained Majors Assisting Practitioners (MAPs) into the evening as a twilight shift (from August) will also provide additional decision making support at this key time in preventing overnight waits and breaches.

5. Minors

In minors the Emergency Nurse Practitioner (ENP) service has seen challenges to service due to extended sickness; this situation is now resolving.

The ENPs will lead the implementation of See and Treat and associated minors pathways which will strengthen the minors work stream and builds on both ownership of the 4 hour target and the overall leadership in the area.

Signposting will be implemented in place of triage. This was successful in a 2 week pilot earlier this year but is intense on senior resource in the model implemented. Focused training will take place to ensure that experienced band 5s are able to confidently and robustly signpost, with support from ENPs agreed as a second review if required.

There has been some estates work that has been suggested that will improve the minors process and this is currently being worked up.

6. Primary Care

New-wave was discontinued at the end of June. Since then we have employed GPs on zero hours contracts to provide the equivalent service on Saturdays and Sundays. At this point we have not provided any additional cover during weekdays and continue to monitor whether this impacts performance or capacity.

We are refreshing links with the out of hour's service provided by SWAST to ensure pathways are agreed and robustly used. We are also looking at more formal referral onto the weekend walk-in service at Boscombe.

7. Workforce

Detailed analysis is being undertaken to correlate the waiting time position against medical staffing numbers (by seniority) and attendances by hour. This will inform both workforce planning and escalation planning and triggers. However the challenge remains the actions that are triggered, particularly out of hours. Identifying and mobilising appropriate resource to respond in event of a surge, in a way that is cost effective, is something that requires further thought, and a whole Trust engagement, and will be discussed at September's TMB. Learning from other Trusts is also being undertaken, including Ipswich, which has had one of the most consistent 4 hour performances of any DGH in England.

From August the F2 rota has been adjusted to provide an additional 2 hours service in the evening where surges are recognised as a challenge.

The recently appointed 7th consultant arrives in August which facilitates group job plan discussion. There are strong applicants for the post of 8th consultant, interviews planned for 28th August.

Job planning of the expanded consultant workforce will seek to optimise department cover with prospective job plans. Middle grade recruitment remains challenging with substantive vacancies.

This work is being progressed in house. External support with workforce design has not been progressed currently, but remains an option for future consideration.

8. Escalation

There is increasing evidence from Trusts that are successfully achieving the 4 hour standard on a consistent basis that a Trust wide response to escalation triggers in the Emergency Department will strongly support achieving target.

There is a suite of policies and escalation plans that have been under development for some months and is red RAG rated on the Monitor plan because they are overdue. The Emergency Department will complete this work with relevant stakeholders and submit to TMB in September to agree these.

Examples from other Trusts include flexing medical and surgical doctors working on the wards, rapid clerking, quicker access to critical care or surgical assessment unit, and if the triggers are earlier in the day, about re-deploying staff, calling in flexible working staff and focused attention to 5 daily actions to improve flow.

9. Recommendations

It is recommended that that Board:

- Note the current performance;
- Note and support the action plan;
- Note and support the governance arrangements in place to monitor the plan and ensure corrective action is in place for exceptions.
- Support the development and implementation of Trust wide escalation actions for surges in demand affecting the Emergency Department.

BOARD OF DIRECTORS	
Meeting Date and Part:	31 July 2015 - Part 1
Subject:	Clinical Service Review Update
Section:	Strategy and Risk
Executive Director with overall responsibility	Tony Spotswood
Author(s):	Tony Spotswood
Previous discussion and/or dissemination:	TMB, Board of Directors
Action required: Board is asked to consider the emerging CSR picture and agree action s appropriate to inform and support the process	
Summary: The paper confirms the reasons for the delay in proceeding to consultation	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	All
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

Clinical Services Review

The purpose of this paper is to update the Board on on-going discussions regarding the Clinical Services Review.

Dorset CCG has taken the decision to defer formal consultation on its proposals until early in the New Year. The reasons for this centre on:

- A wish to complete further work on the out-of-hospital model of care and confirm how this relates to and complements the in-hospital model.
- A need for greater assurance on the part of NHS England that the necessary work has been completed to allow public consultation to proceed
- The need to complete outstanding work. That will allow a full and informed option appraisal relating to future decisions on the designation of the emergency and planned care sites

The CCG has indicated that given the volume of services affected by the consultation, the decision on whether or not to consult will need to be agreed first by the National Investment Committee, a committee operating on behalf of NHS England. The CCG has also expressed an intent, should it consult, to do so on a preferred option for the provision of emergency and planned care services. It is therefore critical that a robust, objective and transparent process is followed to examine the relative benefits of RBH and Poole Hospitals operating as the planned care and emergency sites using the six criteria already agreed. Richard Renaut will provide the Board with the latest update on the likely capital costs of developing each site as the emergency and planned care sites. The Board will wish to have a clear explanation of the options appraisal process in considering its support for the preferred option.

Finally, the Board should be aware of the current uncertainty with regard to the allocation of capital to support implementation of the CSR. We have asked Dorset CCG to ensure that capital would be available to bid against, prior to launching the consultation. In view of this uncertainty we need to consider a 'Plan B' an alternative approach to addressing the wider service and financial challenges that impact on how care is provided going forwards. The joint proposal to submit a vanguard bid to support the development of an acute joint venture vehicle in Dorset is one facet of this approach. The Board will be briefed separately on this during its meeting.

This report is provided for information.

Tony Spotswood
Chief Executive

BOARD OF DIRECTORS	
Meeting Date and Part:	31 July 2015 - Part 1
Subject:	Trust Strategy
Section:	Strategy and Risk
Executive Director with overall responsibility	Tony Spotswood
Author(s):	Tony Spotswood
Previous discussion and/or dissemination:	TMB, Board of Directors
Action required: Board to receive the Trust's Strategy 2015-2020	
Summary: A detailed Trust Strategy responding to the Dorset Clinical Services Review, Five Year Forward View and the wider Quality, Financial, and Manpower challenges facing the NHS	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	All
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

Trust Strategy

Appended is the Trust's Strategy, which is being launched both within the Trust and externally during August. Since the Board and Council of Governors seminar, the Strategy has been updated to reflect the inclusion of our Research and Development strategy, comments from Clinical Directors and the addition of new forward QI priorities agreed by TMB.

An 'easy read' version of the strategy is being developed for staff, our members and external stakeholders. A series of staff conversations/presentations will be held to discuss the key elements of the strategy and help ensure a deeper understanding with the Trust. This will be led by the CEO and members of TMB.

Separately an external advisor has been appointed to help support the development of a clear and detailed Workforce Strategy building on the information already contained within our Strategy. The advisor will work closely with Karen Allman, who has lead responsibility for this, and be assisted by an advisory group which comprises Karen, Basil Fozard, Paula Shobbrook, Derek Dundas and myself. This work will be completed by the end of September.

The Board is invited to comment on the Strategy and process for wider dissemination.

Tony Spotswood
Chief Executive

*excellent care for every patient,
every day, everywhere*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



Trust Strategy 2015/20



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Introduction

The Trust's 2015/20 Strategy sets out our **plans and ambition** to enhance and **continually improve the quality of care and outcomes** we provide to our patients. The potential **future development of the Trust as a major emergency centre** for residents living in Dorset and west Hampshire aligns with the wider strategic reconfiguration of hospital and out-of-hospital care being led by the Dorset Clinical Commissioning Group. The proposed future model of care for Dorset residents is one that we have helped co-create with partner organisations and has been clinically led.

In looking forward we have taken account of the following key factors which have influenced and shaped our proposals:

- the need to provide **safe, compassionate, high quality care to all of our patients**
- the **growing elderly population** with changing health needs who place greater and new demands on our services
- the importance of **strengthening out-of-hours provision** and offering consultant delivered care 24 hours a day, seven days a week - Sir Bruce Keogh
- the evident benefits of providing **rapid access to care** minimising waits for assessment, investigation, diagnosis and treatment and the importance of **providing more integrated provision** across hospital, primary and community services
- **the pivotal role our staff play** as healthcare professionals and leaders and the direct impact they can have on quality improvement, patient experience and outcomes. This is why a critical part of this strategy focuses on our work to develop our **leadership capacity and capability** and further strengthen our **organisational health**
- the continued national **shortage of some staff** in some specialist areas which combined with the financial constraints provide a vital impetus to reconfigure and centralise some services
- the **wider financial challenges**, with demand for healthcare presently outpacing increases in local and national health and social care funding necessitating the creation of new models of care which ensures that services are of high quality, financially sustainable and viable
- the need to consider **new models of care and organisational form** which sustain the **continued viability of key services** and underpin the drive to **create centres of excellence in both emergency and planned care** - *Five Year Forward View*
- finally, **changes in technology** and the importance of supporting and facilitating both **local innovation** and the wider **adoption of best practice** to inform, shape and guide the delivery of safe, high quality care to our patients.

Executive summary

This strategy describes a range of bold and exciting plans to strengthen and improve the care and services we provide to the residents of Dorset, west Hampshire and surrounding areas.

We have set out our plans to develop the Royal Bournemouth Hospital as the main emergency centre for Dorset. Christchurch Hospital will operate as an extended community hub offering a wide range of community, diagnostic, outpatient, ambulatory, nursing home and primary care services for local people.

The reconfiguration of clinical services proposed by the Dorset Clinical Commissioning Group (CCG) provides an opportunity to introduce new models of care which we welcome and support. Our strategy directly addresses the need to adapt and change services. It is anticipated that the Clinical Services Review will be fully implemented in 2018/19 and our focus for the next three years, therefore, remains on strengthening the provision of existing services, working closely with partners and continuing to meet the needs of our patients and doing so within the framework of increasing financial constraint. We will expand our work on quality improvement and extend the use of this methodology to drive down unwarranted variations in care and embed best practice approaches to meeting the needs of our patients. We will encourage greater patient involvement in the design of our services and want to use the feedback from both patients and our staff to inform our work.

Our vision is to be the most improved hospital by 2017 and within this strategy we describe how we will achieve this. Our strategy sets out the work we are engaged in and will continue with to develop and embed a model of collective leadership. This has at its heart a focus on developing a culture which promotes greater staff engagement and ensures that all staff are able to contribute to continually improving patient care. The workforce challenges we, and other organisations face

need to be addressed through the adaptation of existing roles; the introduction of new roles and more innovative ways to recruit staff. It remains critically important that we continue to focus on how we retain and develop our staff so that everyone is able to give of their best. In conjunction with local commissioners we have set out plans to improve waiting times for access to all services and describe how we plan to improve patient care and generate **improved efficiency in how we deliver that care** through better use of information technology and IT systems enabling us to integrate information with partners in primary and secondary care.

Our Estates Strategy sets out plans for the development of the Royal Bournemouth Hospital as an emergency centre. It also describes the redevelopment of Christchurch Hospital. These plans need to be taken forward within a financial context that means we will need to adopt and embed an approach that offers value for money and seeks to drive out waste in order to ensure the funds allotted are used to support the ongoing provision of front-line services. As part of this work we will consider our future organisational form and whether different forms are necessary going forward in order to protect and enhance the services we provide to our patients.



Why does the present model of care need to change?

The challenges explained above provide an important context for why services need to change. We have seen a dramatic improvement in the care we provide over the last 10 years. Life expectancy has increased by 4% and patients have better outcomes following cancer and cardiac treatment/intervention. Waiting times are considerably shorter and patient satisfaction is higher. Conversely demand for care and treatment is rising exponentially. The numbers of patients presenting at our Emergency Department rose by 7% last year and the number of patients requiring emergency admission rose by 10%. The Trust, for the first time in its history, posted an operating deficit in 2014 of £5.2m and has set a deficit plan for 2015/16 of £12.9m. We plan to arrest this trend and ensure services are put on a sustainable financial footing. These trends need to be set within a wider context where the health system for Dorset as a whole projects a funding shortfall of over £200m by 2021, if existing patterns of provision are maintained.

In summary our focus is:

- **continuing to improve the quality of our care, patient experience, safety, and outcomes** through an **unrelenting focus on quality improvement** helping **reduce preventable harm and mortality**
- establishing **new models of care** which **strengthen emergency and planned provision** and enable Consultants to provide care 24 hours a day, seven days a week
- ensuring **sufficient well-trained staff** to support the delivery of enhanced models of care
- **promoting wider integration** of service to ensure patients have a better experience, across the interface of primary, secondary, community and social care
- ensuring our services are **financially sustainable and affordable** to local commissioners.
- realising opportunities for **local innovation, delegated decision making** and **clear autonomy** at a clinical level

This all means that we will continue to evolve, improve and develop how services are provided. We describe within this strategy what changes are proposed and how they will help strengthen the ongoing care we will provide to our patients.

It is anticipated that the strategic reconfiguration of service will be implemented in 2018/19. In the lead up to this our focus will continue to be on how we improve the quality of our care and doing so within the confines of the resources made available to the NHS.



Our vision, mission and values

Our vision

Our vision and aspiration is to be the most improved hospital in the UK by 2017.

Our mission

Our mission, developed by our staff, is to provide excellent care for patients reflecting the care we expect for our family.

This means:

- **Putting patients at the heart of everything we do**
- **Working together to improve care**
- **Being responsive to patients' individual needs**

Our values

The behaviours, culture and ethos which guides our work and interaction with both patients and colleagues is underpinned by the following core values, all of which have been shaped by our staff.



Communicate

- say it, hear it, do it

Improve

- change it

Teamwork

- share it

Pride

- show it



These values provide an important back-cloth and underpin the organisational development work described on pages **x** and **y**.

Strategic objectives

The key **strategic objectives** we have set are:

- to **continue to improve the quality of care** we provide to our patients ensuring that it is **safe, compassionate and effective**, driving down **reductions in the variations of care**, ensuring that it is informed by and adheres to **best practice and national guidelines**. Our priorities includes the provision of **harm-free care, reducing avoidable mortality** ensuring patients are **cared for in the correct setting** and that our **patient satisfaction** levels are within the upper quartile or better for the NHS
- to continue to **drive improvements in patient experience, outcomes and care** across the whole Trust. We will use our QI methodology to support this work
- to **support and develop our staff** so that they are able to **realise their potential** and **give of their best** within a culture that **encourages engagement, welcomes feedback, is open and transparent**
- developing our services as the **main emergency care hospital for Dorset and west Hampshire residents**
- ensuring patients have **rapid access** to all of our services focusing on the provision of **timely diagnosis and treatment** with waiting times exceeding national standards
- ensuring our services remain **financially sustainable**, services are provided within budget and resources are used wisely, cutting waste and thus allowing the maximum funding to flow to front-line patient care



Clinical strategy

- our journey to date

We provide **high quality district general hospital and tertiary services** to a **catchment population** which ranges between **370,000 and 1.2m**. The following inpatient services are provided to the conurbation of Bournemouth, Christchurch, east Dorset, west Hampshire, and the New Forest:

- General Surgery
- Urology
- Breast Surgery
- Colorectal Surgery
- Upper GI Surgery
- General Medicine
- Gastroenterology
- Diabetes and Endocrinology
- Clinical Haematology
- Rehabilitation
- Specialist Palliative Medicine
- Stroke
- Respiratory Medicine
- Rheumatology
- Dermatology
- Midwifery Birthing Centre
- Gynaecology
- A broader range of Outpatient Specialties is shown in Annex A

Additionally the following services are provided not only to this catchment population, but also to residents of Poole and the surrounding areas:

- Urology
- Orthopaedics
- Ophthalmology
- Complex GI Surgery

We provide the following services to a larger conurbation encompassing Dorset, parts of Wiltshire and west Hampshire:

Vascular Surgery

Elective care provided to the population of east Dorset, west Hampshire and the New Forest. Emergency care provided to the whole of Dorset, Salisbury and southern Wiltshire

Complex Upper GI Surgery

For example, oesophagectomy procedures provided to the whole of Dorset and west Hampshire

Urology

Provided to east Dorset, west Hampshire and the New Forest with complex robotic surgery offered to the whole of Dorset

Interventional Cardiology and Electrophysiology

Elective services provided to east Dorset, out-of-hours emergency intervention provided to the whole of Dorset, complex EP provided for the whole of Dorset

Interventional Radiology

Elective care provided to the population of east Dorset, west Hampshire and the New Forest. Emergency care provided to the whole of Dorset, Salisbury and Southern Wiltshire

Our Accident and Emergency service

treated 86,748 patients in 2014/15. Of these over 70,000 patients attended the main Emergency Department and more than 15,000 patients attended the Eye Casualty. There remains close interplay between the services provided at the Royal Bournemouth Hospital (RBH) and those offered at Poole Hospital with some consultants working on both site, enabling local residents to have ready access to a broad range of outpatient services at their local hospital. As an example, patients attending RBH can see an oral surgeon, ear, nose and throat surgeon, and a consultant



neurologist, all of whom deliver inpatient care in Poole Hospital.

Visiting consultants also attend from Southampton University Hospital Trust ensuring additional specific input into multi-disciplinary team meetings to advise on the care of patients undergoing complex procedures.

An extensive range of Radiology services are available at RBH including world leading technology in CT and MR; a broad range of Pathology services are offered encompassing Haematology and Blood Sciences, Blood Transfusion, Microbiology, Histopathology, Immunology, Cellular Pathology and Phlebotomy. Biochemistry services are provided via Poole Hospital. The Royal Bournemouth Hospital is also the site for the Dorset Prosthetic Limb Centre.

The number of patients treated by the Trust has risen by 30% over the last seven years. In 2014/15 we treated:

- 32,999 patients as **emergency admissions**
- 10,806 patients were admitted for **inpatient elective treatments**

- 59,265 patients received **elective treatment** as a **day patient**
- 9,085 patients received care as a **day attendee**
- 112,858 patients had a **new outpatient consultation**
- 254,913 patients had a **follow up consultation**

In addition, there were in excess of **750,000 radiological and pathological tests** provided to patients.

The role of **Christchurch Hospital** is changing. Five years ago there were over 200 inpatient beds occupied by patients requiring long-stay elderly care and rehabilitation. As new approaches to care have helped reduce the time patients spend in hospital, and community and rehabilitation services have been enhanced and strengthened, so Christchurch Hospital has taken on a new role. There are no longer any inpatients beds other than those providing specialist palliative care. The hospital currently provides a broad range of outpatient services, day hospital services, rehabilitation, NHS dentistry, phlebotomy, X-ray and specialist palliative care services.

Clinical Services Review

The Clinical Service Review led by Dorset CCG and involving over 300 local clinicians as well as members of the public has identified new models of in-hospital and out-of-hospital care which the CCG will consult on in August 2015. The **new models of in-hospital provision** centre on:

- the development of a **major planned care hospital** with an urgent care centre
- the creation of a **major emergency hospital**
- a **planned care and emergency hospital located in west Dorset**

A broad outline of each of the three models is shown below. The concentration of emergency services for east Dorset at a single location Monday-Friday in hours, and for the whole of Dorset out-of-hours, addresses directly the need to strengthen these services through the provision of consultant-delivered care, 24 hours a day seven days a week. It also responds directly to Sir Bruce Keogh's review: *Transforming Urgent and Emergency Services in England*, published in 2013.



shaping your local NHS

Out-of-hospital care.

A major reconfiguration of out-of-hospital care is also proposed with the development of two large hubs in the east of Dorset, one at the major planned care hospital site and the other at a community hospital location. Given the development underway at Christchurch Hospital and the large geographic population it serves, it is ideally placed to develop as one of the larger hubs offering a range of primary care, outpatient and community services. Within the west, five to seven local hubs are to be developed, based around existing community hospitals with one such hub potentially located on the acute site in west Dorset. The smaller hubs will serve a population of 60,000 and the larger hub a catchment population of 125,000. A local hub will typically provide primary care services to a catchment population of 30,000 and the larger hub these services to 40,000 people.

Major planned care hospital summary of services

Major planned care hospital summary of services	
Urgent and emergency care	<ul style="list-style-type: none"> ▪ 24/7 Urgent Care Centre (as part of Dorset's A & E network) - GP led with consultant input in networked arrangement with integrated GP out of hours services ▪ Sub-acute medical admissions ▪ Rehabilitation beds
Planned and specialist	<ul style="list-style-type: none"> ▪ High volume low complexity planned and day case surgery ▪ Enhanced planned recovery unit ▪ Planned medical interventions/admissions e.g. chemotherapy ▪ Outpatients and diagnostics
Maternity and paediatrics	<ul style="list-style-type: none"> ▪ Antenatal and postnatal care ▪ Children's therapies and outpatients
Long term conditions & frail older people	<ul style="list-style-type: none"> ▪ Integrated frailty service ▪ Primary and community care services on site ▪ Step up, step down beds ▪ Mental health care services (not inpatient beds)

Indicative no. of beds: ~180 to 300

Planned care and emergency hospital summary of services

**Services provided 24/7 across Dorset on a networked basis*

Urgent and emergency care	<ul style="list-style-type: none"> ▪ Consultant led A&E with 14/7 consultant presence* ▪ Hyper-acute cardiac Monday to Friday, 8 hours a day* ▪ Non-interventional cardiac – 12/7 in line with 7 day a week working* ▪ Hyper-acute stroke service 14/7* ▪ Stroke unit and stroke rehabilitation ▪ Emergency surgery 14/7* ▪ Acute medical admissions*
Planned and specialist	<ul style="list-style-type: none"> ▪ Level 3 Critical Care* ▪ High volume low complexity planned and day case surgery ▪ Interventional radiology - Monday to Friday, 8 hours a day* ▪ Outpatients and diagnostics
Maternity and Paediatrics	<ul style="list-style-type: none"> ▪ 24/7 consultant led cover with approx. 60 hours per week on labour unit and 128 hours on call at night (either resident or at home if within 30 minutes)* ▪ Alongside midwifery led unit ▪ Neonatal care* ▪ Develop paediatric assessment unit 16/7*
Long term conditions & frail older people	<ul style="list-style-type: none"> ▪ Integrated frailty service ▪ Primary and community care services on site ▪ Mental health care services (not inpatient beds)

Indicative no. of beds: ~320 - 360

Major emergency hospital summary of services

Urgent and emergency care	<ul style="list-style-type: none"> ▪ 24/7 consultant delivered A&E with trauma ▪ 24/7 hyper-acute cardiac, stroke ▪ 24/7 consultant delivered emergency surgery in line with NCEPOD* recommendations ▪ Acute medical admissions ▪ 24/7 Gastrointestinal bleed rota
Planned and specialist	<ul style="list-style-type: none"> ▪ Level 3 critical care ▪ High complex low volume planned care ▪ 24/7 interventional radiology ▪ Outpatients and diagnostics
Maternity and paediatrics	<ul style="list-style-type: none"> ▪ High risk obstetrics with 24/7 consultant presence for maternity ▪ Alongside midwifery led unit ▪ Inpatient consultant delivered paediatrics 24/7 ▪ Neonatal Intensive Care Unit level 3
Long term conditions & frail older people	<ul style="list-style-type: none"> ▪ Integrated frailty service ▪ Mental health care services (not inpatient beds) ▪ Primary and community care services on site

**National Confidential Enquiry into Patient Outcome and Death*

Indicative no. of beds: ~900 - 1,100

The proposals in outline are shown below.

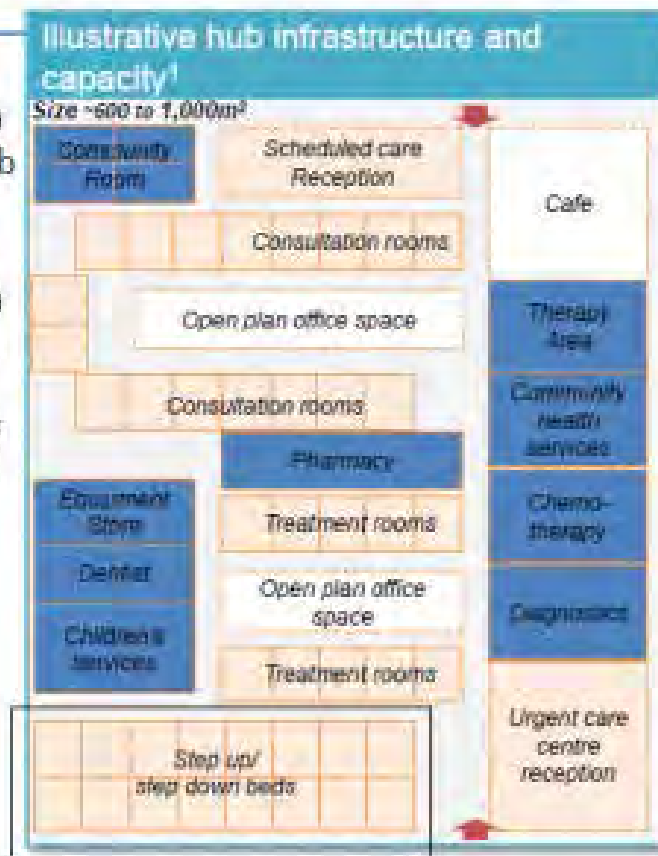
Proposal is to develop hubs to support the delivery of services at scale



Illustrative purposes only

Illustrative example of a hub

- Providing 'hub' services for a catchment population of 60,000 at a local hub and 125,000 at a larger hub
- Providing primary care services for catchment population of 30,000 at a local hub and 40,000 at a larger hub
- All the hubs will require multi use of rooms and utilisation for 10 hours a day, 7 days a week, including pharmacy and GP services
- Larger hubs would include step up/step down beds





The benefits for patients

These changes will enable ongoing improvements in the services we and the wider health community offer. Broadly the benefits for patients include:

- **better outcomes for patients by reducing morbidity and the number of preventable deaths**
- **enhancing the patient experience** while in hospital and subsequently when receiving community and/or social care
- **improving access to services** by offering both primary and secondary care services 24 hours a day, seven days a week
- **reducing the number of patients that need to be admitted to hospital** for their care, with greater emphasis on education and self care
- increasing the **focus on prevention**
- **bringing skills and expertise** together to create **centres of excellence** for both planned and elective care
- improving opportunities for **innovation and enhancing research and development contributions**
- closing the projected financial gap of over £200m for the health community and ensuring local Trust **services are financially sustainable**

The future role of the Royal Bournemouth and Christchurch hospitals

The Clinical Services Review signals **two possible future roles for the Royal Bournemouth Hospital (RBH)** as we move towards implementation of its key recommendations. We will either develop as a planned care site in which case there will be a significant contraction in facilities and services at RBH or we will develop as the main emergency centre for Dorset and west Hampshire residents. In considering these options from a patient perspective, we believe that **the interests of the residents of Dorset and west Hampshire are best served through RBH developing as the main emergency hospital.**

The reasons for this are multifold.

- The importance of **concentrating vital emergency and non-elective services close to the largest population centres**. The Bournemouth and Christchurch localities comprise 237,600 residents. In contrast the Poole locality comprises 149,010 residents. This is underscored by the fact that the hospital presently **serves the highest concentration of residents aged over 85 in England**. Christchurch, for example, has 31% of residents aged over 65; this compares with 21.6% in Poole.
- Detailed time travel analysis shows that **access to care for the majority of the population is best served by the location of district general hospital emergency services at RBH**. Critically, those patients that require out-of-hours emergency care transferred from west Dorset are readily able to access RBH within 60 minutes. Indeed, the most acutely unwell patients treated within Dorset already receive emergency care for acute conditions (heart attack and emergency aneurysm) at RBH.
- The **established track record of providing high quality emergency care**; for example the **mortality rates and cardiac outcomes are already among the best in the country.**

- **Bournemouth**, as a location, is **important in maintaining wider network services with health systems outside of Dorset**. As an example the Vascular Network with an emergency hub based at RBH works effectively because of its location and a shift in location is likely to result in break-up of the service.
- **Value to the taxpayer** is important. It is clearly evident that developing RBH as the emergency centre will be **the most cost-effective option for the Dorset health system** both in terms of ongoing revenue costs and the capital spend required to establish up to 1,100 beds necessary to support the development of the emergency centre.
- **How quickly the proposed changes can be implemented** will be critical to securing important benefits for patients. The **modern design of the RBH site allows for rapid expansion** ensuring that the new facilities can be put in place quickly. In tandem with this, the Trust is working closely with Bournemouth Borough Council and Dorset County Council to support **further improvements to the road network** that will open up new direct links between the hospital and the A338 and a further expansion of the A338.

Critically the development of RBH as the main emergency centre will allow Poole Hospital to develop both as a specialist centre continuing to provide radiotherapy and as a planned care centre.

What changes are planned to support the development of RBH as a major emergency centre?

The redevelopment of RBH as the main emergency site for Dorset will necessitate the relocation of the following inpatient services to the Royal Bournemouth site:

- **obstetrics and neonatology** to be relocated from Poole (3)

- **inpatient paediatrics** relocated from Poole (4)
 - **trauma services**
 - **oncology**
 - a small range of cancer, major head and neck and oral/maxillo-facial surgery
- (3) It is anticipated that up to 300 high-risk women from west Dorset will give birth in the Obstetric Unit on the main emergency site.
- (4) Out-of-hours emergency admissions for the whole of Dorset will occur at this site.

In addition a **range of existing services based on the RBH site will need to be expanded** to serve the whole of the east Dorset population and, where shown, the whole of Dorset and west Hampshire, out-of-hours. These are:

- **Accident and Emergency** Department services with a substantial enhancement of the existing service to offer 24/7 consultant-delivered care
- **emergency admission for medical and elderly care patients** including stroke
- emergency surgical patients including out-of-hours with provision to serve the whole of Dorset
- **complex low volume elective surgery**
- **inpatient haematology**
- **critical care**

While the focus of the main emergency site is orientated towards provision of emergency and non-elective care there are **a range of elective services** that will need to be **co-located with these services**. These include:

- **all inpatient urology**
- **all inpatient vascular surgery**
- **all elective Cardiology procedures**
- **complex elective general surgery and gynaecology**

The reason for this is it is not logistically practical to split these services and offer them on the main planned care site.



In order to provide reasonable access to patients in west Hampshire, Christchurch and Bournemouth, it is further proposed that services such as **day-case haematology, oncology, paediatric ophthalmology, and a small range of other day-case surgery is maintained on the main emergency site.** Similarly it will be important to provide a range of one-stop outpatient services on this site complementary to the broader range of emergency care. A substantial radiology presence will be critical and as a minimum a hot lab. Work is currently underway with Poole Hospital and Salisbury Hospital to consider further options for the provision of pathology services. This work will conclude in early 2016.

Under this scenario the following inpatient and day-case services would be relocated from RBH to Poole Hospital:

- Elective Orthopaedics
- Elective Ophthalmology
- Elective General Surgery
- Day-case Urology
- Day-case Vascular Surgery
- Diagnostic Endoscopy (some endoscopy provision will be retained on the emergency site which will offer an emergency bleeding rota 24 hours a day, seven days a week)
- Rheumatology and Dermatology day-case provision
- Dorset Prosthetic Limb service will also relocate to Poole Hospital

It is anticipated that these changes, subject to consultation, will be implemented from 2018/19 onwards.

RBH as a planned care site

Should Dorset CCG, NHS England and West Hampshire CCG determine that it wishes to see RBH develop as the planned care site, this will create a very different role for the Trust going forward. The **following services would be relocated from RBH to Poole Hospital:**

- Accident and Emergency services
- Major and emergency General Surgery
- Elective inpatient and non-elective Urology
- Inpatient and emergency Vascular Surgery

- Interventional Radiology
- Elective and Emergency PCI
- Electrophysiology and Complex Pacing
- The Midwife run Delivery Unit
- Complex Gastroenterology
- 90% of medical emergency admissions and general medical elderly care patients
- Inpatient Haematology
- Acute Stroke services
- Critical Care

In total, more than 40,000 patients requiring emergency and complex elective intervention/treatment would need to be transferred to receive their care at Poole Hospital.

What services would be offered at RBH as a planned care site?

High-volume low complex surgery including day-case surgery, elective orthopaedics, ophthalmology and 10% of the acute medical take which will be managed on an ambulatory basis will remain on the RBH site. A new urgent care centre will be created, run by GPs offering 24/7 urgent care services. **High-volume, low complex general surgery, ENT, and gynaecology will be transferred from Poole Hospital.** It is anticipated that rheumatology and dermatology services will be centred on the planned care site.



Additionally, the Trust anticipates the **relocation of some inpatient community hospital beds** to help **develop a frailty unit, step-up and step-down facilities and ongoing rehabilitation**. This bed base is likely to be between 60 and 80 beds in size with additional outpatient facilities. Under this scenario we would anticipate **shrinking the total bed base by, in the order of, 500 beds**.

It is also envisaged that the planned care site will be used to develop out-of-hours primary care services and, under this scenario, discussions will take place with local GPs about the potential to develop a primary and acute care system (PACS) approach.

Future role of Christchurch Hospital

There is an ongoing close correlation between the future role of RBH and that of Christchurch Hospital, should RBH develop as the main emergency site.

Through development of a joint venture with Quantum, construction work is underway to redevelop Christchurch Hospital as a **community hub** providing an extended range of services to the population of Christchurch, Highcliffe, New Milton and the wider

conurbation. New facilities and services include the development of a 60-bed nursing home facility, the construction of **x** units of assisted living accommodation, the provision of a local pharmacy, and the establishment of a GP surgery on site with purpose built facilities. The Trust also proposes in 2017/18 to replace the existing Specialist Palliative Care Unit with a new expanded facility supported by McMillan Caring Locally. A new Day Hospital and outpatient facilities are also being developed. The total investment in Christchurch Hospital is over £30m and the work will be completed in 2016/17.

Should RBH develop as a planned care site, it is anticipated that the range of outpatient and diagnostic services located at Christchurch Hospital will reduce; with a focus on primary and community service provision.

Future changes to existing clinical services provided by the Trust

Here we summarise some of the planned and potential changes to existing services, influenced by changes in technology, demand and new ways of working. While some of these will occur prior to the full implementation of





the Clinical Services Review (CSR) proposals, others describe how services will evolve in the lead up to and implementation of the CSR.

Medical Directorate A&E-15

The Medical Directorate encompasses the medical specialties of **gastroenterology, respiratory medicine, acute medicine, diabetes and endocrinology** as well as the **Emergency Department (ED)**. A recent focus of our work has been the strengthening of services at the front door of the hospital with an expansion in medical and nursing input to these areas. This has enabled and supported the development of new pathways of care, more ambulatory provision, and new models of assessment such as the Bournemouth Rapid Evaluation and Treatment Hub (BREATHE). In turn this has led to more patients being managed effectively without recourse to admission and the release of resources elsewhere within the Trust to care for the most acutely ill.

The creation of an emergency hospital for Dorset offers the opportunity to develop further specialist medical care and treatment. Specifically we envisage the emergency site being developed to cohort high acuity

medical specialty patients in gastroenterology, respiratory medicine, diabetes and endocrinology in order to **deliver specialised 24/7 consultant-delivered services**. This would dovetail well with the development of services for acutely unwell patients who require complex and emergency endoscopic and interventional radiology procedures also necessitating the continuing presence of acute surgery on site. We already offer the most specialised services in Dorset for gastroenterology, diabetes and endocrinology and have established links with other specialised centres nationally. We anticipate this being developed further through an operational network that would allow us to develop **shared pathways** across sites to optimise the use of collective resources across the county and reduce the variations in care. The concentration of expertise on one site naturally allows the rapid availability of specialists to care for other patients within the hospital and is a model which is now being developed within our gastroenterology service.

Ambulatory care will continue to be developed as the optimal future model for most patients, apart from the very acutely unwell, with specialised input to the front door and

specialist advice, rapid access to consultant-delivered care with high quality patient care promoted through the use of ambulatory medicine. The expansion of acute medicine through combining existing teams across the two sites will facilitate the establishment of 24/7 cover by acute medicine for the medical take. This would allow the expertise that acute medicine can deliver to offer patients the highest quality, readily accessible, specialised care on admission. Specialty in-reach within 24/7 would allow patients access to a specialist expert opinion within the shortest of timeframes.

In tandem with this we are also seeking to improve further **community working**, especially across the specialties of respiratory medicine and diabetes, with a view to promoting further admission avoidance, care closer to home and more integrated care as well as 24/7 advice to primary care as well as inpatients.

Full implementation of the CSR proposals will necessitate a significant expansion of the bed base for medicine within the main emergency hospital. It is anticipated that the existing RBH bed complement will need to increase by approximately 85%. The integration of specialist teams will be a critical feature of developing an outstanding specialty based service for west Hampshire and Dorset residents offering some specialist care across the whole of Dorset while serving the population of east Dorset and west Hampshire seven days a week.

It is anticipated that approximately 10% of the existing medical take will continue to occur in the planned care centre with the principal focus being on the delivery of ambulatory care with the more acutely unwell patients being admitted to the main emergency site for east Dorset.

The creation of an emergency hospital allows for a significant strengthening of the Emergency Department services across east Dorset. The **aim** is to **provide consultant-delivered care 24 hours a day, seven days a week**. This will, however, require a further expansion in the consultant workforce. The department will continue to provide network

support to the urgent care centre to be run by primary care clinicians on the planned care site. It is anticipated that approximately 30% of patients that currently attend Emergency Departments will still be seen and treated appropriately on the planned care site.

A larger, more modern Emergency Department will need to be developed to act as a hub for pre-hospital care with the emphasis on establishing a framework for the trauma service to become the **major trauma unit**. This will include establishing a paediatric emergency service as part of the main acute Emergency Department. Our focus will also be to develop even stronger links with primary care and other allied health services to ensure patients are in the right place for their care and the appropriate management of their condition. The development of nurse practitioners caring for those patients with minor injuries as well as more major cases will help facilitate an efficient, rapid turn-around, nurse-led minor injuries unit. This is intended to ensure that we maximise the use of resources for the critically ill and injured patients. It is envisaged that the establishment of a new Accident and Emergency Unit will occur during 2018/19. In the lead up to this time we will continue to focus on providing high quality care to our patients seven days a week.

Cardiology

Our previous strategy paved the way for a significant expansion in the range of cardiology service provided to RBH. Patient outcomes from a range of interventional procedures including percutaneous coronary intervention are among the best in the UK with the unit continuing to improve all aspects of a comprehensive cardiology service.

We anticipate as a consequence of the implementation of the CSR, the **rapid integration of cardiology services** particularly in the east of Dorset prior to the development of a single main emergency site. This will mean the **centralisation of invasive cardiology** on a single site in the east, and is anticipated as early as 2016/17. Within this context a number of important and exciting developments in cardiological provision are proposed and described in greater detail below.



PCI and PPCI

- Continued improvement in the primary PCI service including the development of patient pathways in conjunction with South West Ambulance Service (SWAST) leading to a **reduction in the time between the call from the ambulance service that a patient is en route to the hospital and the insertion of a balloon to allow the opening up of arteries.**
- The consolidation of the on-call service for consultants providing PCI service across Dorset securing contributions from Salisbury and Dorset County hospitals in offering a **county-wide out-of-hours PPCI service.**
- A natural extension of the working day and the development of seven day working leading to extended PCI provision resulting in more flexible working and reduction in length of stay particularly for non-elective patients.
- The **improvement and consolidation of the clinical data systems** supporting analysis and provision of elective PCI services.

Front door service for 7/7

We plan to **improve access to cardiology opinion and for** ambulatory care options for cardiological conditions. In conjunction with this, access will also be improved to outpatients tests, CTCA and stress imaging. To aid the rapid assessment and treatment of patients, cardiac nurse practitioners and specialists nurses will work in more **generic roles** within the Emergency Department and work is underway that will lead to further integration of the Rapid Access Chest Pain Clinic with other front-door accident and emergency services providing a **comprehensive seven day service.**

For those patients admitted to our wards, we will continue our work to improve discharge planning and extend the use of nurses and pharmacists to allow multi-professional criteria led discharge pathways to be fully established.

Imaging

In conjunction with local commissioners, we plan to **extend the existing imaging capacity for ECHO, trans-oesophageal ECHOs, CTCA and cardiac MRI.** The planned integration of services between Bournemouth and Poole will help extend the range of expertise available to support this. In addition, proposals are currently being considered for the acquisition of a dSpect stress nuclear imaging facility. The imaging service also plans to achieve BSE reaccreditation status in 2016/17.

Heart failure

Recent appointments in heart failure, including the expansion of consultant and specialist nurse input, enables the Trust to secure some vital improvements to the heart failure service with **better integration with community services** including the **provision of open access ECHO**. Ongoing work to develop an integrated service will be a major feature of the Trust's work during the period 2016-2018.

Arrhythmia service

We plan to **establish a 24/7 arrhythmia service**. Recent consultant appointments allied to the proposed integration with the Poole-based service and physiologists will help establish this. However it will need to be provided on a network based approach which will likely result in a large network being established with partners outside of Dorset.

Other priorities within cardiology include further development of the clinical and commercial research opportunities, creating a Dorset-wide information system to support cardiology including access between primary and secondary care, further refining the number of catheter laboratories and the beds required to provide for emergency services, securing and supporting the development of the cardiology workforce including medical nursing and cardiac physiology staff and realising the opportunities for improved procurement to help underpin the provision of services.

Proposals are also being considered to expand and develop the suite of private patient services available, to complement NHS provision. This includes the potential to develop in collaboration with an external partner dedicated private patient facilities.

Surgical services

Our surgical services incorporate the **delivery of elective and emergency care for sub-specialist areas of Upper Gastrointestinal (Upper GI), Surgery, Colorectal Surgery, Vascular Surgery, Urological Surgery, Breast and Endocrine Surgery and Gynaecological Surgery**.



The Upper GI/Colorectal Surgery services are responsible for elective care and for the management of emergency surgical (acute) patients. Sir Bruce Keogh's report in 2013 reinforced the importance of emergency surgical care being delivered by appropriately skilled consultant medical staff 24/7. **A consultant-delivered emergency care service** has been provided at RBH since September 2014. Further consultant appointments within the next six months will **add resilience to this service** and, importantly, will also enable the level of ambulatory emergency care to be enhanced above the current 20% threshold by ensuring rapid access to consultant opinion. We also aim to **relocate the Ambulatory Emergency Care adjacent to the Surgical Admissions Unit** to improve the flow of patients within the hospital and as a consequence improve their

experience while in hospital. The additional appointments also enable improved efficiency of theatre utilisation with more flexible scheduling and provide a greater opportunity to back-fill lists thus enabling the continuing reduction in the waiting time for elective surgical procedures.

For **vascular surgery**, RBH acts as the hub for emergency and more complex care working in conjunction with consultant colleagues from Salisbury and Dorset County hospitals which serves the whole of Dorset, west Hampshire and the southern Salisbury population. Following the consolidation of emergency vascular services in line with the national strategy our next step is to focus on the **further development of major elective care** within the hub operating as the centre for all major elective vascular aneurysm repairs, working in close collaboration with the vascular services on the spoke sites which will focus on outpatient and more ambulatory day care treatment. Following implementation of the CSR it is proposed to introduce new hybrid vascular theatres. Additionally, we propose the development a one-stop ambulatory therapeutic intervention for the management of varicose veins with the majority of venous endotherapy being provided on an outpatient basis. We also propose to drive forward further vertical integration of venous ulcer therapies with pathways now being developed for the management of these patients within the community and this service will develop during 2016/17.

Our **urology service** serves the population of Poole, Bournemouth, Christchurch and west Hampshire with the most complex surgery also performed on site for patients who live throughout Dorset. There has been considerable technological advances within urological surgery and **robotic-assisted prostatic surgery is now well embedded** with concomitant reductions in morbidity and length of stay. We need to further **develop our role as the Urological Cancer Centre for Dorset** by streamlining pre-operative pathways, progressing the enhanced recovery programme and mapping capacity to demand. Further emphasis is being placed on the reduction of length of stay for patients particularly those awaiting prosthetic surgery

who will benefit from the recent introduction of template biopsy clinics. The consultant workforce is being expanded to both reduce further waiting time for elective procedures, and also ensure that a comprehensive and robust 24/7 consultant-delivered urological emergency service can be provided for patients. We will similarly expand our private patient provision offering patients a choice; income generated will go towards underpinning the continued provision of NHS services.

The development of **women's health services** at RBH will be aided through the transfer of services to the new **Jigsaw Building which will be open from September 2015**. These new facilities will aid planned changes in the delivery of both breast and gynaecology services. In particular, facilities will allow the full establishment of **one-stop diagnostic breast clinics** providing clinical and radiological assessment during one visit. The Breast Team will also be expanded. A breast physician is to be appointed to ensure that we provide women with timely access to diagnosis and treatment. These changes will provide a greater resilience both to the breast service and to the melanoma service.

Within **gynaecology** it is similarly planned to establish **more one-stop clinics** with clinical and diagnostic services being provided at the same visit. There will be a further migration of some **existing day case procedures to outpatients procedures** particularly in areas of interventional colposcopy and hysteroscopy. There will be a continued fusion of services between Poole Hospital and RBH with emphasis on 24/7 consultant-delivered care within the Early Pregnancy Unit at the vanguard of providing clinics at the weekends. An equally important strand of our work is the focus on **retention and recruitment of surgical nursing staff** and the development of well led medical, nursing and business management to the directorate.

Full implementation of the CSR proposals will help further consolidate the provision of out-of-hours acute surgical care across the whole of Dorset. Close working and collaboration already exists with surgical colleagues in Poole and west Dorset with regard to Upper GI surgery and the development of a single

site for emergency general surgery will **enable sub-specialist consultant care to be provided 24 hours a day, seven days a week.**

Orthopaedics



Our elective orthopaedic service is the fifth largest in England. It has an excellent reputation for providing high quality care and offers a comprehensive range of elective orthopaedic interventions. The consultant medical staff who provide this service are also responsible for the trauma service at Poole Hospital. Elective orthopaedic services post implementation of the CSR will be located on the planned care site. The key priorities outlined below therefore focus on the continued provision of orthopaedic services at RBH until implementation of CSR.

- Further strengthening of the interface between the orthopaedic service and primary care through the development of sub-specialty groups to help advise GPs, strengthen communication and develop improved referral patterns. This work includes the orthopaedic management service.
- The importance of considering how orthopaedic capacity is ring-fenced within the hospital and the further use of the Derwent as a dedicated facility for orthopaedic care.

- The need to develop further the orthopaedic revision knee and hip arthroplasty service in lieu of the needs within the community, building on recent additional appointments.
- The strengthening of discharge arrangements and closer working with both social care and the older people's service to enable appropriate review of patients while in hospital.
- An unrelenting focus on quality improvement, management of pathways, sub-specialty working and outcome measures. This work will be combined with a further focus on theatre efficiency and continued improvements in productivity.
- Ongoing improvements in communication with patients, other hospital teams, GPs, including a strengthening of the consent process.

Finally, there is a need to review and improve the outpatient accommodation available to orthopaedic patients recognising the high volumes of patients being seen in the department.

Ophthalmology

We offer an excellent, comprehensive ophthalmic service provided by a dedicated team of highly skilled professionals operating from purpose-built facilities. The **challenges** the ophthalmic service face include:

- **increasing demand** due to the rising elderly population and higher birth rates
- the high volume of patients with **long term conditions** associated with old age particularly **glaucoma and macular degeneration (AMD)**



- **medical workforce challenges** which will necessitate different approaches to providing the workforce going forwards
- the **accelerated introduction of complex and/or expensive new drug treatments** eg lamellar keratoplasty, glaucoma surgery and injectable drugs for AMD

In response to these and other challenges we have identified some important actions necessary to underpin the continued provision of high-quality ophthalmic service:

- Innovate:** we want to find new ways to deliver care through virtual clinics, IT solutions, optometry and nurse-led shared care. Care provided by consultant-led multi-disciplinary teams. Continuing to be at the forefront of new technology and treatments, for example new drugs for dry AMD, new scanning techniques, new laser technology supported by our generous charity The Friends of the Eye Unit.
- Integrate:** we want greater integration (not competition) with primary care providers by leading training and governance of GPs and optometrists, to provide increased low complexity ophthalmology care in the community.
- Educate:** continuing to excel in the provision of training to Wessex junior doctors, expanding the role of advanced nurse practitioners in nurse-led injection clinics, oculoplastics and emergency care. Surgical skills courses with our state-of-the-art simulator.
- Collaboration:** increasing our support and role in cross-specialty research, for example haematology/oncology trials; providing community optometrists with support for prescriber's certification; joint paediatric consultant appointment with Dorchester; providing out-of-hours emergency care Dorset wide.

The **potential for treatment of dry AMD within the next five years will be the greatest logistical challenge** and will dwarf the introduction of treatment for wet AMD in 2007, which has seen outpatient numbers in the macula service rise exponentially. Cataract surgery demand will continue to rise putting constant pressure on the RTT target. Patient expectation will rightly increase in this era of

preventable sight loss and we plan to be able to respond to these challenges in conjunction with local commissioners and this will require a further increase in the medical workforce as well as the development of new roles.

Finally, we plan to extend the number of sites at which patients can receive ophthalmology treatment offering surgery at the emergency and planned care sites, with outpatient provision at community hub locations.

Haematology RBH0233

Haematology can be categorised into **clinical and laboratory** provision. For clinical haematology the anticipated outcome of the Dorset CSR is the development of a **single east Dorset inpatient haematology unit and autologous transplant unit**. This will result in the establishment of a new joint facility with Poole and Bournemouth medical and nursing teams amalgamating to provide this single east Dorset service. There will be a single junior doctor and consultant on call haematology service developed as a result reinforcing a consistent approach to patient care and management. In addition we will need to ensure the **larger joint transplant unit gains JACIE accreditation**. We also wish to consider **ambulatory care for autologous transplant patients**.

At RBH the new Jigsaw haematology/oncology day unit opens September 2015. This will allow **expansion of specialist haematology clinics and increased clinical trial work**. The newly refurbished Aseptic Pharmacy Unit will also enable increased clinical trial work in haematology. We are also planning to **expand**



the homecare delivery of drugs programme and initiate haemato-oncology drugs review programme to make cost savings and ensure **patients continue to get the best possible and current anti-cancer medications**. These changes will occur during 2016/17.

Increasing homecare and **community chemotherapy provision** are also a priority within our five year strategy as pilot studies have shown these to be very popular with patients and reduce the need to attend hospital and therefore the risks of infection.

Patient driven **outpatient follow up for some haematological conditions** (e.g. lymphoma) are being piloted around the region and this is also something we plan to develop to obviate the need for unnecessary journeys to hospital and improve patients quality of life/survivorship. In addition we will commence a **pilot outreach transplant clinic at Dorset County Hospital** in 2015 to similarly reduce unnecessary travel for our transplant patients and improve the quality of their life.

In the next five years the Haematology Department will have embraced pathology integration. This is an exciting opportunity to gain efficiencies through collaborative work for an innovative and stream lined service. It will challenge the way pathology is currently delivered but will modernise the service and provide for greater efficiencies. We anticipate the proposed joint venture with Poole and Salisbury hospitals to be fully operational within three years. Within this project, the **Specialist Integrated Haematology Malignancy Diagnostic Service (SIHMDS)** will deliver fully integrated reports for the diagnosis of all haematology cancers including lymphoma. The SIHMDS will incorporate state-of-the-art molecular diagnostics both in house and with collaboration with the national genomic centres. In addition, it will continue to have a research arm and comprehensive quality programme.

Pathology service

The provision of pathology services will as signalled earlier change radically over the next five years. Increased technology through the introduction of **result requesting and reporting, near patient testing** and the **fundamental redesign of the pathology service** are all important priorities. Hospitals require responsive hot laboratories, other testing can be provided on a more remote basis. The joint venture work with partner organisations underway now will enable an integrated service to be provided by 2017/18.



End of life care

We provide an outstanding specialist palliative care service. Our plans include the **replacement of the current Specialist Palliative Care Unit** with a new enlarged facility taken forward jointly with Macmillan Caring Locally. The new specialist facility will be located at Christchurch Hospital and is scheduled to be developed in 2017/18.



Our plans include further work with partner organisations to fully integrate the hospital and out-of-hospital palliative care services. Presently too many patients experience limited or little choice as to where they spend their final weeks and days. More patients want to spend their final days at home with their family or in a supported external setting, away from the hospital. Working with Dorset Healthcare Foundation Trust and Dorset CCG we want to secure an expansion in the range of support available to allow patients this choice.

Midwifery services



The midwifery birthing service has recently been relocated to **new purpose-built facilities** in a secluded part of the RBH site. This transfer has proved immensely popular with both women attending the delivery unit, their spouses, staff and midwives working in the unit. Increasingly midwifery services need to be considered and managed as a **single integrated entity across east Dorset**. Despite providing no obstetric care, we are responsible for over half of all antenatal and postnatal care provided to women across the east Dorset conurbation. **Locally, consultants employed by RBH provide vital input to the Obstetric Unit at Poole Hospital** and it is planned that this continues. More emphasis is also now being placed on supporting more women to give birth at home. Full implementation of the CSR proposals will see midwifery birthing facilities being **co-located within east Dorset with the main obstetric service thereby minimising transfer times** should women who choose to birth in the midwife delivery unit need to be transferred for

obstetric intervention. All women will, however, **continue to have a choice as to whether they birth at home, in a midwife unit, or in an obstetric unit.**

Older people's medicine



Our older people's services have changed radically over the last two years with the focus on **developing a centre of excellence** for the care and management of older people with a multiplicity of health needs. The aspiration of the team is to provide an inspirational place to work, to **develop and deliver a first class nationally and locally respected service** through expertise in treatment, care and rehabilitation, collaborative working, demonstrating compassion in working together with patients, families, carers and community services.

Our ambitions

- To further expand our medical workforce and develop enhanced nurse and therapist roles to support the strengthening of the multi-professional approach to the care of older people.
- To sustainably deliver a **high quality best practice stroke service** at Sentinel Stroke National Audit Programme level with all SSNAP domains at level B or better. Short term this includes full implementation during 2015 of the stroke out-reach service to ensure **all stroke patients have the necessary best practice assessments and treatments** in the required time scales including CT scan, water swallow, screen, thrombolysis, and ensure the earliest possible transfer to the Stroke Unit.
- Embedding the five daily actions to **improve patient flow** within the hospital and ensure that **patients are in the correct wards**

for their specialist needs, care and treatment. These five daily actions are early decisions on discharge; timely provision of discharge medication; senior review of patients to enable discharge; the transfer to specialty bedded wards from the Acute Medical Unit and a focus on appropriate length of stay.

- To **redesign our discharge service** to ensure a fully pro-active approach to planning not just the care, but the aftercare of patients and their discharge
- To continue our work with Social Service colleagues, GPs, and Dorset Healthcare Foundation Trust to support the **embedding of discharge to assess** and enable the redesign of the frail elderly pathways. This work includes fully embedding the **Discharge to Assess model and the trusted assessor role**, collaborative working with local GPs to develop and **implement hospital based locality liaison leads** and closer working with Poole Hospital to agree **standardised pathways and models of care for the frail elderly.**

The input of patients and carers in constantly providing feedback about the care received is essential. We want to **develop further our patient engagement work** to ensure that patients are fully involved in the **evaluation, redesign and improvements that will aid their care.** We will continue and extend our work with Bournemouth University to provide **specific academic learning opportunities** aligned to **best practice and national guidelines** for older people's care; we are working to develop further opportunities to promote research and to translate that into the care we provide on a daily basis to our patients.

One facet of the development of older people's services is the role that **specialist nurses and therapists play in providing multidisciplinary care.** We plan to introduce new older people's nurse practitioner and nurse specialist roles to ensure ongoing provision of high quality robust and sustainable seven day services. Further work is required with local authorities to consider the development of **more support within the community to aid the rehabilitation**

of patients once they leave hospital and so reduce the reliance on nursing and care home provision.

In tandem with Dorset CCG and local authority partners we aim to explore and then implement greater provision of **step-up and step-down facilities** to minimise the time patients have to spend in hospital once their acute health needs are met.

Recruitment into older people's services continues to pose challenges both locally and nationally. Our work centres on the development of new roles and the development of relevant competency frameworks to support and incentivise more nurses working in the elderly care environment. We also wish to develop closer links with nursing homes and support the maintenance of patients in their homes by creating closer links between primary and secondary care to support rapid intervention and minimise the need for patients to be brought into hospital.

As the CSR gains traction so we would wish to consider the **expanded use of Christchurch Hospital as a hub for specialist musculoskeletal services.** Older people's services will continue to be provided on both the planned care and main emergency sites into the future.

Specialist services

Our specialist services encompass orthodontics, **Dorset Prosthetics Centre, dermatology, rheumatology, Sexual Health Department, environmental controls and pharmacy.** These services operate within



a clinical directorate structure committed to providing professional excellence, integrity of living, learning and practising with the highest ethical and clinical standards. Our primary focus for each of these clinical areas is the development of **new clinical pathways**, and the **implementation of NICE recommendations**. The **future of the sexual health service** will be determined by the outcome of the tendering process currently underway for sexual health services run by Dorset County Council. The Trust has combined with local NHS and third sector partners to offer a range of new and different services complementing existing sexual health services and await the outcome of the tender process in the Autumn of 2015. The new contract will be operational from January 2016 and if we are not successful we will need to work with local commissioning partners to secure the continued provision of HIV services for the Dorset population. Tendering of services also impacts on the Dorset Prosthetics Centre. The Steepers tender for the provision of prosthetic components is due for renewal in December 2016 and internal bid will be produced to compete for this service.

Within **dermatology**, clinical work is underway to **engineer different pathways and roles** with more of the dermatology service being provided in future through specialist nurse roles and in partnership with local GPs. Work is underway to develop a culture of open communications that **fosters a sense of community** with the federation of local general medical practices. This includes developing **new ways of integrating services in an outpatient setting** in relation to dermatology and rheumatology with the aid of new technology, for example photographic patient triage. As CSR work develops we anticipate transitioning to **managed clinical networks** which will allow greater integration of services, help reduce variation and approach, and further drive up standards. It also has the potential to create a lead provider model for services across Dorset.

It is anticipated that **orthodontics, the Dorset Prosthetic Centre, dermatology**, and if we retain the **Department of Sexual Health** will primarily be located within the planned care centre to operate on a hub and spoke basis.

There is a continuing commitment to advance services through **closer integration of education, research and collaboration**. Strengthening innovation by increasing research portfolios through trials particularly in rheumatology and the Department of Sexual Health is also a key feature of our work in 2016/17 and 2017/18. The introduction of both **electronic prescribing** and **order communications** will have a profound impact on pharmacy services by streamlining existing processes and allowing consolidation of pharmacy support within areas including the Frailty Unit where the pharmacists role as an independent prescriber working closely with multidisciplinary teams has been critical to expediting the early discharge of patients. Pharmacy services will continue to evolve and the outsourcing of outpatient prescribing and the development of homecare provision will be key features of the changing nature of the pharmacy service.

Radiology

Our **radiology service** is a centre of excellence and is central to so much of the care we provide. This is reflected in the recent significant expansion in radiological investigation, intervention and scanning facilities. Developments in both cancer and cardiac care mean that radiology is a critical service in providing diagnosis and treatment to these and many other patients. We currently have some of the **most advanced CT technology in the world**. Some rationalisation of radiological provision has already taken place; **the vast majority of interventional radiology is undertaken locally in Bournemouth** where there is also specific expertise for cardiac imaging. In contrast Poole Hospital is the sole provider of nuclear medicine and PET and provides the vast majority of the paediatric radiological service.

Should RBH develop as the main emergency site for Dorset we will need to ensure **a full paediatric radiology service is available**. One of the benefits of providing this service locally is the ready and quick access to Southampton where paediatric surgery is required. Given the current extensive range of acute care provided at RBH, **we are well placed to develop our facilities as the**



main emergency hospital going forward.

Conversely, should RBH be identified as the planned care site there will be a need to relocate a range of services to Poole as the main emergency site and the corresponding shift of the Breast Screening Unit in expanded form to RBH. In this scenario, interventional radiology would predominantly be provided at Poole Hospital but with some elective services to be provided locally.

In the short term an additional CT scanner will be established within the Emergency Department to help support the management of patients with conditions such as stroke, to ensure ready access to imaging, onward treatment and admission to the Stroke Unit.

We are keen to work with **primary care and community colleagues** to help advise on and input to the development of new imaging facilities within the community. We envisage community hospitals and hubs performing X-rays and ultrasound scans operating within a central communication system in liaison with the Trust to ensure integrated provision of imaging services. With the development of the planned care site we envisage the provision of direct access for CT and MR.

More generally the imaging facilities in Dorset lend themselves to the development of a **network or pan-Dorset imaging service** with joint picture archiving, order communications, unified pathways and governance structures. We are keen to work with partner organisations to secure this. This in turn would enable the accreditation of all sites complying with the Imaging Services Accreditation standard. An increased network will also allow us to use reporting resource effectively to cover leave, sickness and develop sub-specialty expertise including joint working to secure appropriate out-of-hours support for the emergency site.

There is a clear need to **develop an Interventional Radiology (IR) network** to mirror the vascular network now in place. The establishment of the network involving organisations in Dorchester and Salisbury will pave the way for an expansion of the working day. The aim is to achieve this in 2016. The **role of IR will continue to expand** in a number of ways:

- there is increased demand in CT for CT angiography, CT guided IR procedures e.g. (RFA) more biopsy/drainages performed by IR
- increased demand for MSK intervention eg fluoro/CT guided pain blocks, vertebroplasty

- hybrid CT for IR procedures - vascular and urological interventions in a theatre environment, cryoblation/TACE treatments

There is also a need in the medium term to introduce the following:

- **emergency IR availability at Poole** to include postpartum haemorrhage, GI bleeding, colonic stenting, trauma-related bleeding (all dependent to some extent on acute services review but improved cover will be required at Poole irrespective of any final decision re geography)

- **elective IR provision**, particularly for cancer-related procedures, eg insertion of long-lines, palliative stenting, and pleuro-peritoneal shunts
- **neuro/stroke imaging** - access to 3T scanner, on the site of 'acute stroke unit'. Implications of 'clot retrieval' in acute stroke = urgent CT cerebral angiography and transfer to University Hospitals of Southampton

These developments need to be supported by local commissioners.

The diagram below describes how services at both RBH and Poole Hospital will evolve in implementing the CSR.

RBH Green	Poole Purple
<p>Paediatrics (equipment/facilities/reporting) Obstetrics (facilities/Jigsaw already built) NeuroRadiology - acute TIA/stroke</p> <p>IR (in place - current BC for extended day) Cardiac MR/CT (in place) ED capacity (in place - should be!) Endoscopic US/ERCP (in place) 24/7 CT (in place)</p>	<p>IR suite (x one - Oncology/emergency Obstetric)</p> <p>PET-CT (in place) Radiotherapy planning (in place) Paediatrics (in place) Obstetrics (in place) Breast Screening Unit (in place) 24/7 CT (in place)</p>
Poole Green	RBH Purple
<p>IR suites (two+ suites - emergency and oncology) Cardiac MR/CT capacity/optimisation CT capacity - third CT (emergency and oncology) Endoscopic US/ERCP NeuroRadiology - acute TIA/stroke</p> <p>Paeds (in place) Obstetrics (in place) 24/7 CT (in place)</p>	<p>Breast screening unit expansion</p> <p>IR elective (in place) OP/elective scanning capacity (third CT) 24/7 CT (in place)</p>

Anaesthesia Directorate

Our Anaesthesia Directorate is responsible for **anaesthesia, theatre services, critical care, pre-assessment, the management of a 36 hour stay ward, acute pain services and sterile supply services**. The short term goal is to provide a more suitable theatre environment to cope with the increased capacity and skill set required to deliver a full range of surgical services. This has, and will require the **ongoing recruitment of non-medical theatre staff (scrub and anaesthesia) and the training of these staff to meet our patient's needs**. An ongoing programme of recruitment will also be supported to bolster our medical workforce in responding to anticipated retirements and to ensure that the medical manpower is sufficient that we can continue to deliver services safely and maintain an important training role for junior doctors.

There is a pressing need to simplify our over-complicated theatre template; this will entail **moving to a standard four and eight hour theatre** list and these changes will be co-ordinated with systems to improve the utilisation and efficiency of our operating theatre suites. It is planned that these changes will be introduced in the early part of 2016.

The provision of consultant-delivered services seven days a week has long been a feature of the operation of critical care services; similarly

our emergency CPOD theatre already runs on a 24 hour/seven day week basis. One of the challenges we aim to address is how we best plan and organise our acute pain service in order to extend the hours it operates recognising that patients need these services seven days a week. Our **sterile supply service** operates from purpose-built factory-based facilities at Alderney Hospital. It has the capacity with further investment to provide services to other local hospitals and this is one option currently being considered alongside others including the relocation of the service to the RBH site. A decision on the future location of this service will be made during 2016/17.

Full implementation of the CSR will signal significant changes for the anaesthesia and critical care services in particular. A larger **critical care unit** will need to be developed on the emergency site and this will be assisted through the integration of existing teams working at Poole Hospital and RBH. Should the CCG decide to site the main emergency centre at RBH, investment will need to take place to **expand our facilities for the management of paediatric surgical emergencies**, and the current out-of-hours provision will need to be strengthened to meet the increased acute work that will flow to the emergency centre. RBH also remains well placed to provide a full range of elective surgical services should it be developed as the planned care site.



Our approach to quality

Our Quality Strategy has as its guiding principles the need to ensure patients are **safe**, that their care is clinically **effective** and their **experience** is the best it can be.

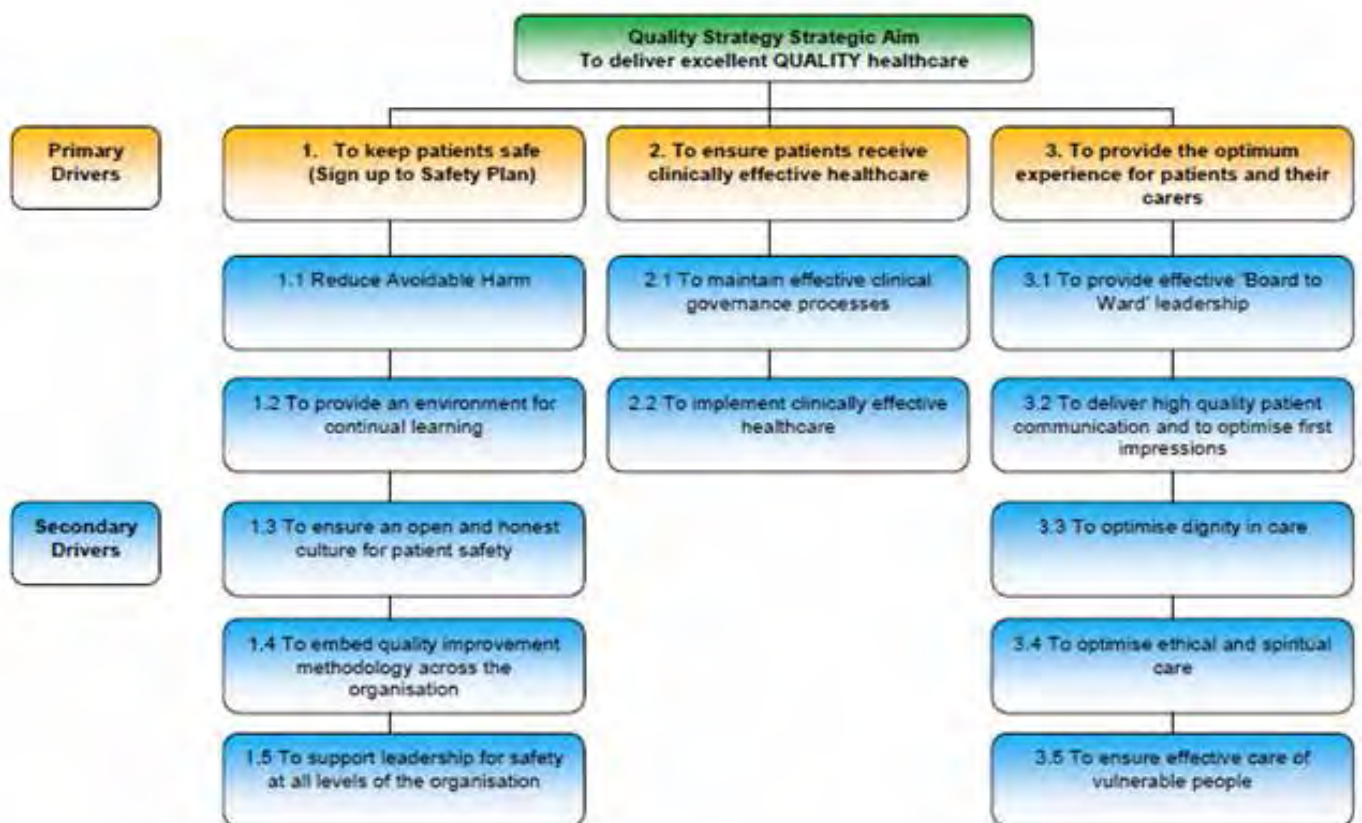
The work to deliver this ambition is described in outline below. Each of our primary areas of focus - safety, effectiveness and experience is underpinned by a detailed programme of activity described in further detail within our Quality Strategy.

The governance framework which supports our quality work is overseen by the Trust's Quality and Risk Committee and the Healthcare Assurance Committee which gain assurance through detailed reviewing of a series of ward, departmental and patient experience metrics.



"We will relentlessly strive to ensure everyone can SEE quality in everything we do."

The Trust Quality Strategy



We have developed a 'Sign Up to Safety Plan' to help give effect to our strategy, and in so doing our work is focused on delivery five important pledges.

Put safety first.

Commit to reduce avoidable harm in the NHS by half and make public goals and plans developed locally.

Continually learn.

Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

Honesty.

Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

Collaborate.

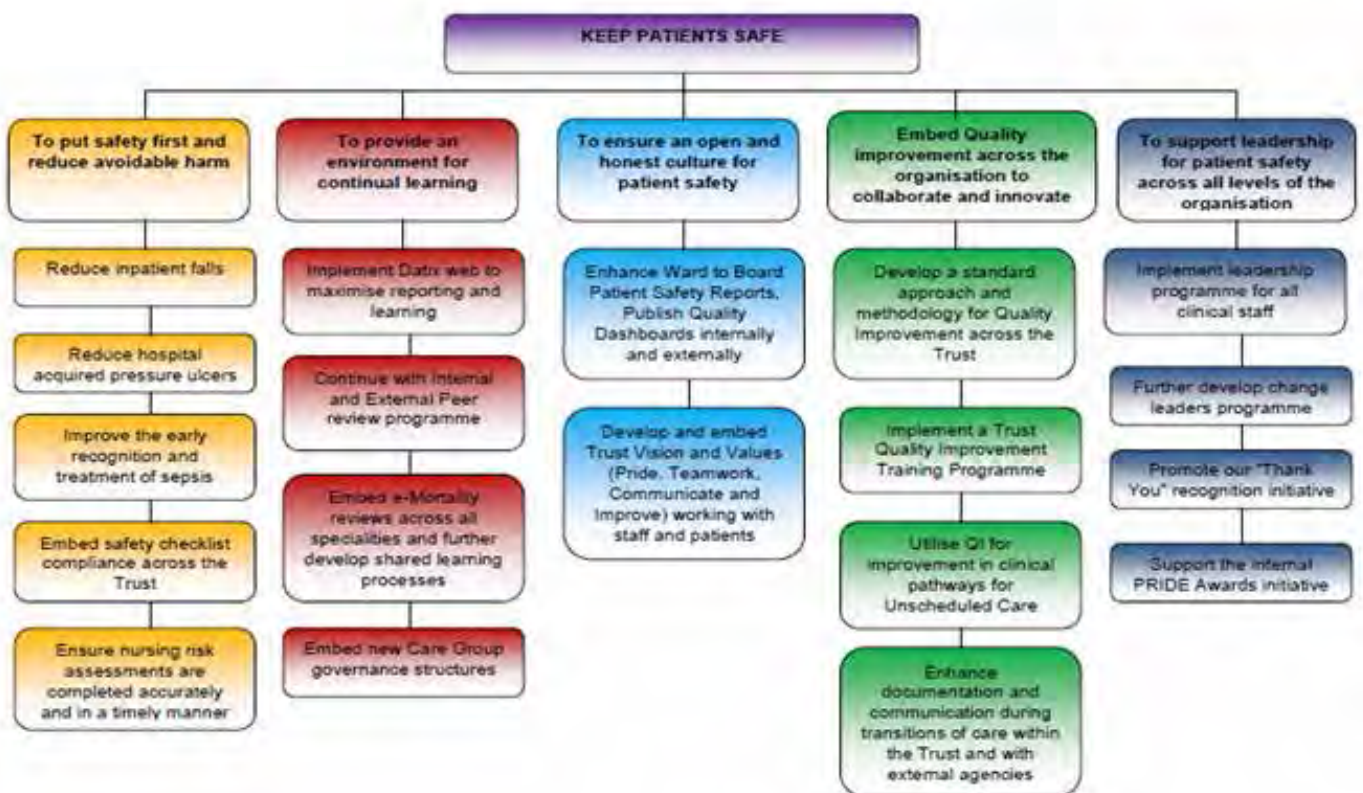
Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

Support.

Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

Our pledges have been delivered through careful evaluation of qualitative and quantitative reference data, feedback from staff, patients and our governors. The work underpinning this is shown below:

Sign up to Safety Plan



Our approach to quality improvement

Our **Quality Improvement Programme** has been developed to **engender a culture of continuous improvement and learning within the organisation - empowering staff and encouraging the development of clinical leaders.**



It is recognised that the future needs to look and feel different and we are about to embark upon a significant period of clinical and organisational change prompted through the Clinical Services Review. We therefore need a **sustainable programme of quality improvement that drives up standards and maintains them.** A programme approach will be adopted, with a proven methodology, led by the Executive Team and including clear senior clinical leadership and engagement. This will provide grip and assurance ensuring our intentions are being delivered.

We commenced our QI programme in May 2014 and this has developed rapidly to a central programme of work to **improve care, reduce variation, embed best practice and**

will increasingly focus on the effective and efficient deployment of resources helping shape our savings and reinvestment work to underpin services.

We are doing this by:

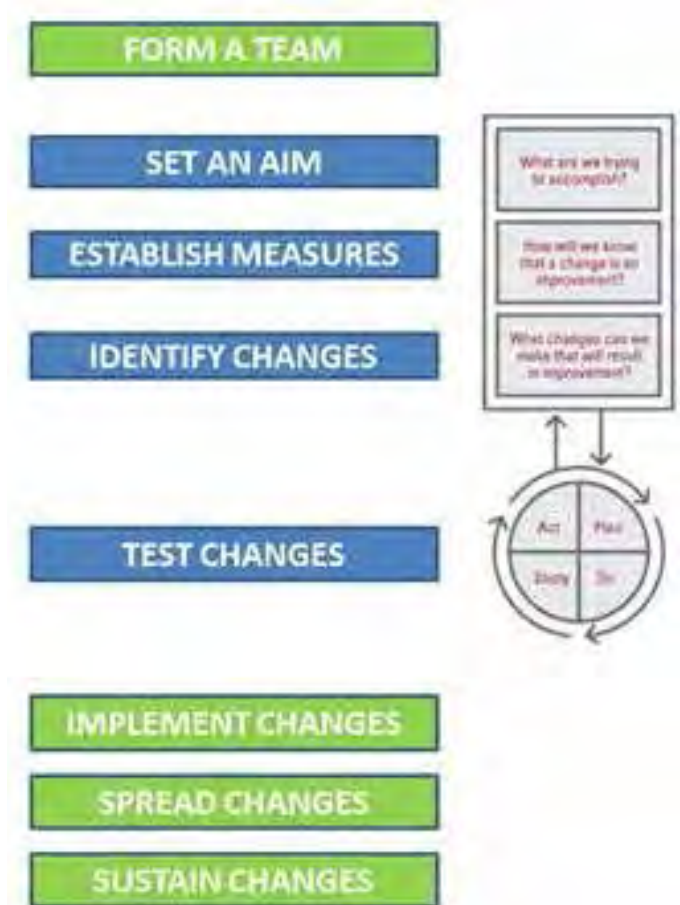
- delivering transformational change and quality improvement projects that result in a **safer and more caring hospital for patients**
- changing the way we do things so that **quality improvements are part of everything we do**, every day
- creating an environment where all **staff have a shared sense of ownership** and responsibility and feel enabled to make our hospitals among the best
- using the **energy and enthusiasm of our staff** and take the best ideas to improve quality and safety for our patients
- ensuring **as many as possible are involved in our improvement projects**
- being in a position where our patients are rating **our hospital as one of the best in the UK for safety, experience and effectiveness**
- **engaging and empowering** staff to deliver and sustain the changes needed in their workplace
- **developing the talent** of our staff at every level of the organisation
- providing our staff with the **improvement and change expertise** and skills enabling as many as possible to be involved in our improvement projects
- achieving a consistent message that **improving quality eliminates waste, reduces variation and improves efficiency**

Outcomes: What will success look like?

- 1 Better patient experience and feedback.
Patients feel confident about our services. Patients feel more involved and know what is happening to them.
- 2 Better working environment for staff.
Staff are less stressed and not under constant pressure. They are working within more ordered processes and protocols, with care based around internal professional standards and evidence based best practice. Our staff feel central to everything we are going - empowered, with the right skills and competencies to do their job effectively. In addition, they are clear about their accountabilities and responsibilities and feel valued for the contributions they are making to the organisation.
- 3 Performance and outcome metrics are improving.
We are inquisitive and interested in what we can do better, achieving upper quartile performance and benchmarking well across a range of outcome measures. We are viewed as an acute hospital capable of delivering significant improvements.
- 4 Delivering a cost effective and value for money service.
We are delivering our 2015/16 and 2016/17 efficiency and productivity plan. We are investing our resources wisely and in the most effective way.
- 5 Our health system is more integrated. We are seen as a catalyst for change and actively supporting better partnership working across Dorset and with our local partners. We have successfully built relationships and are moving together in a collaborative way. We have altered perceptions that we are 'arrogant and resistant to change'.

We adopted a standard improvement approach for quality improvement based on the Institute for Healthcare Improvement (IHI) model for improvement. This is shown below

RBCH Model for Improvement



This methodology 'gives skill', empowers, and encourages staff to continuously improve offering compassionate care at every level and doing what is best for patients.

All of our QI projects use appropriate quality improvement methods, including lean tools. Underpinning our approach is a change model (adapted from John P Kotter) to highlight the importance of:

- **increased urgency** with a strong vision and case for change
- building the **guiding team** with the right people, emotional commitment and right mix of skills to inspire people to move
- creating **short term wins** with aims that are easy to achieve and in bite-size chunks
- **communicating** for buy-in and empowering action by simplifying the message and removing obstacles to making the change happen and ensuring it sticks

We have introduced an academy for continuous quality improvement to help us identifying current change leaders, skills and expertise within the organisation.

The RBCH **Improvement Academy** is:

- providing short course programmes in **QI 'tools and techniques'**
- **removing the barriers** and blocks that inhibit their efforts
- **building on what is good** and promote the message that improving quality eliminates waste and improves efficiency
- **helping staff** test out new ideas for improving the quality of healthcare
- **growing** from within and help spread learning
- helping **embed core values** for RBCH

We have run staff training modules in introduction to improvement and what is LEAN?

Three of our doctors in training have received **Wessex Quality Improvement Fellowships** focusing on hospital flow (geriatrician support to surgical teams and best practice board and ward rounds) and fast track cancer referrals. In addition, seven of our doctors are currently participating in the Wessex SAS doctors Quality Improvement Programme.

In 2015/16 we are further developing our **rolling programme of QI** model for improvement learning and development for staff, including junior doctors. This will help us spot high potentials and encourage mentoring and coaching to 'grow our own' leadership capability.

We are delivering real benefits for patients via priority QI projects. These projects are clinically led and co-created with patients, focusing on achievement of national standards and where appropriate the development of new models of care. Each work stream has been accelerated with achievement of 'quick wins' to signal the pace of change.

Last year our key priority was unscheduled care. We focused on the redesign of our front door to a) increase clinical expertise b) provide more comprehensive ambulatory emergency care and c) ensure all frail older people are

reviewed by a geriatrician within 12-24 hours of referral.

We delivered the **following benefits** for patients:

- removal of AMU escalation beds
- a comprehensive ambulatory care service to increase access to same day emergency care and reduced admissions to traditional hospital bed base
- dedicated nurses to take GP calls and co-ordinate flow
- introduction of regular board rounds to more direct pull for older people and surgical ambulatory from ED
- increased medical cover at weekends and out of hours
- senior decision maker at front door with consultant available to take the call from the GP and ED (in hours)
- strengthened consultant input to the hospital at weekends with consultant ward rounds for care of elderly, AMU, gastroenterology, cardiology, surgical wards now in place 7/7 to reduce variation in week-end discharges
- strengthened physician input to patient care in the evenings by doubling the number of SPRs on duty until 11pm, increasing consultant physician input until 7pm and extending acute physician input into the Acute Medical Unit to 9pm
- appointment of GPs to work in AEC clinic (including weekends) to support winter resilience
- development of a short-stay ward (supported by designated social workers, discharge planning key workers and experienced therapists from the OPAL team) to facilitate discharges and ensure admission for up to five days length of stay is maintained
- introduction of interface geriatricians. Front door service for elderly care patients developed and supported by MFE consultant and the OPAL team, to ensure comprehensive geriatric assessment is received at the earliest opportunity and patients are treated on the correct elderly care pathway, commensurate with their needs

- a clear focus on patient flow, embedding daily whiteboard rounds in MFE, anticipated discharge dates and clear clinical criteria for discharge and admission into the right ward setting to deliver significant reductions in length of stay
- implementation of a transitional care ward for older people for patients waiting for placement, community hospital transfer for ongoing rehabilitation or patients waiting for intermediate care capacity

Table 1

Table 1 demonstrates our efficiency and productivity gain as a result of this quality improvement project. In summary, 0.96 overall reduction in our non-elective length of stay and associated reduction of 26,547 bed days. Medicine for the Elderly non-elective average length of stay reduced from 15 days (December 2013) to 12 days (December 2014).

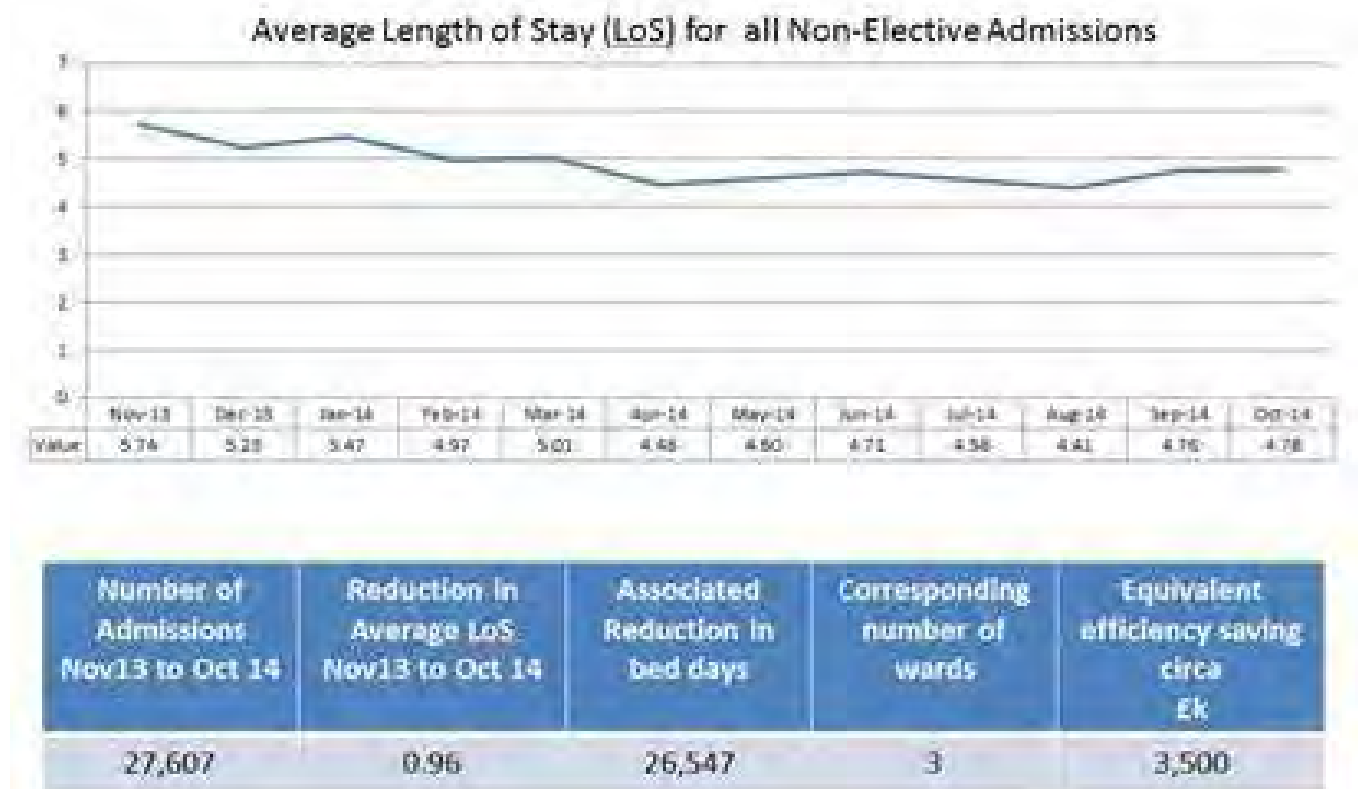


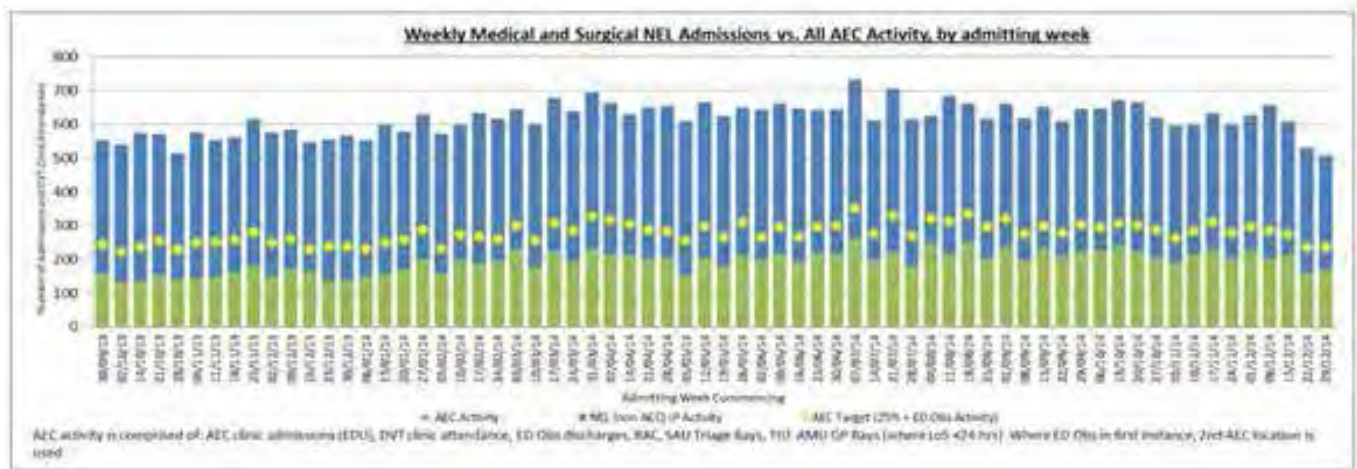
Table 2

Table 2 highlights our improvements in discharging general medicine non elective inpatients with a length of stay of two midnights or less (target 65%).

Non-Elective LOS	Dec 2013	Dec 2014
<12 hrs	27%	30%
<24 hrs	38%	41%
<36 hrs	46%	48%

Table 3

Table 3 highlights the percentage of patients with ambulatory care conditions seen in ambulatory care services. In 2013, our baseline was 12% against the national target of 25%. Our conversion rate to ambulatory care is now 35% (215 patients per week) excluding follow ups. We are planning a conversion rate of 45% as a stretch target for 2015/16



This year we have chosen to focus on a suite of five quality improvement projects:

Sepsis

Aim: To deliver the sepsis six to all patients with severe sepsis and / or septic shock within one hour by December 2015.

Hospital Flow

Aim: To improve patient flow throughout the hospital by implementing internal professional standards by March 2016, this includes discharge planning and implementation of the five daily actions:

- early discharge
- focus on preparation of medications
- senior review by medical staff
- reducing length of stay and ensuring early access to our wards from the admissions area

GI Cancer (two week waits)

Aim: To establish safe systems to deliver at least 93% compliance on two week waits for GI patients by March 2016, without detriment to other GI patients.

Checklists

Aim: To standardise and embed safe checklist practice and culture across all areas undertaking interventional and / or surgical procedures by September 2015.

Safe Emergency Laparotomy

Aim: To reduce mortality rate from emergency laparotomy surgery from 11.4% to 9% by March 2016.

During 2015/16 we are also committed to the Wessex Patient Safety Collaborative (Breakthrough Series) with teams participating in two stands of work - sepsis and transfers of care.

As we progress this work we will continue our focus on **reducing avoidable mortality and reducing variations in practice**.

The QI methodology will be used to underpin improvements in processes to create both greater efficiency in how we care for patients as well as focus on improving the quality of care - recognising the close correlation between the two.

The new priorities we have therefore set for the Trust focus on:

- Strengthening our substantive workforce, improving recruitment and retention and reducing our reliance on agency staff and the associated spend.
- Improving the responsiveness of our front door services to ensure as a minimum we regularly meet the 95% standard for patients to be treated within the Emergency Department or admitted
- Ensuring timely access for patients requiring inpatient cardiology care, by reducing the current length of stay and drawing patients through to the correct cardiology wards from elsewhere in the hospital
- Ensuring the timely discharge of patients from critical care eradicating delays in patients returning to specialty-based wards
- Improving the flow and throughput of patients within theatre, to ensure optimal efficiency
- Redesign of elective pathways to aid rapid access to planned care, including the provision of specialist advice to primary care



Our approach to leadership and organisational development

We are developing a comprehensive **leadership and organisational development** approach to guide our work to support the delivery of our Trust Strategy. Here we explain the approach we will take.

There is compelling evidence that **health care organisations secure better outcomes for patients where there is a collective approach to leadership.**

Collective Leadership

“All staff take responsibility for the success of the organisation in delivering continually improving, high quality and compassionate care”

Developing Collective Leadership
for Healthcare,
The King's Fund 2014

The evidence further affirms:

- **leadership** is the most important influence on culture
- **staff engagement** is one of the most important influencers of patient outcomes and experiences of being cared for - **patients receive better care when staff are engaged, motivated and well led**
- **quality improves** when all **staff are focused on continually improving patient care and forever reducing harm**
- **culture change** will not happen by accident, a **strategic approach** is critical to success



In summary our aim is to establish a collective values-based leadership approach which enhances the following key behaviours:

Collective, values-based leadership -

A leadership compact for RBCH board?

All leaders:

- Promote engagement, participation and involvement as their core leadership approach
- Promote appropriate staff autonomy and accountability
- Ensure staff 'voices' are encouraged, heard and acted on
- Encourage staff to be responsibly proactive and innovative
- Avoid domination, command and control except in crisis
- Take action to address systems problems
- Deal effectively with poor behaviour and performance
- Model compassion in dealing with patients and staff

The model we will use to give effect to this is:

Collective Leadership - a leadership model for RBCH?

- Leadership of all, by all and together with all
- Leadership the responsibility of all - anyone with expertise taking responsibility when appropriate
- Interdependent, collaborative leadership - working together to ensure high quality health and social care
- Leaders and teams working together across boundaries within and across organisations to ensure system success
- Requires that leaders prioritise success of patient care across the organisation/ system at least equally with their own area of operation

Creating a collective, values based leadership culture

How we propose to create the approach we want to establish and **embed collective leadership** to drive delivery of our strategy and secure the necessary cultural change within the organisation is summarised briefly below.

It is founded on:

- the establishment of collective leadership and a commitment to supporting a compassionate culture focused on continually improving and high quality care
- the creation of a leadership strategy (capability) that is recognised and owned by all staff and that will deliver the cultural change we want to see - to ensure patient safety and delivery of high quality care.

There will be three phases to this work:

1 Discovery Phase

- months 0-6 (complete March 2016)

- Collecting intelligence on strategy, vision, mission, future challenges, political context and opportunities
- Needed vs. existing capabilities
- Number of leaders, qualities, diversity, medical / clinical

2 Design Phase

- months 6-12

(complete September 2016)

- Required leadership capabilities - individual and collective
- Means to acquire, develop and sustain those capabilities

3 Delivery Phase

- months 12-24 and beyond (sustainable programme in place by December 2017 with a culture of continual improvement embedded in the / way we do things here)

- Leadership development - programmes and interventions
- Organisation development - culture, teams, boundary spanning, collaboration, dialogue
- Shaping leadership culture, organisational culture, embracing change

Our approach to workforce

Here we set out our approach to:

- the current and **future workforce challenges**
- the importance of maintaining **organisational resilience**
- how we **educate and develop our staff**

The workforce challenge

We have a number of workforce challenges. Some are across the wider NHS and encompass the **supply of appropriately trained clinical, medical and support staff** while others impact more specifically on this organisation. Our work is principally focused on ensuring we have a **highly motivated workforce** with the **right skill mix** to deliver the care and treatment required. This necessitates developing new and different competencies as we adapt existing roles in response to anticipated shortages and rationalisation of supply including the allocation of junior doctors to work in hospitals and the shortfall of professionals in areas such as histopathology, older people's medicine and accident and emergency services. The work will be informed by a **detailed workforce modelling**.

We will underpin the development of new and existing roles by a complementary focus on **innovative recruitment, development and retention**, exercising our ability to work collaboratively with health care partners and higher educational providers.

Critical to our future success will be the work we do to strengthen our approach to retaining and developing our existing staff. This is a key strand of work which will be developed further in tandem with our approach to collective leadership.

We propose to work closely with local healthcare providers in a co-ordinated approach including the **recruitment of potential staff from overseas** and the development and provision of careers and work experience opportunities for younger people.

We are currently experiencing difficulties in recruiting to the following areas, all of which are national priorities for recruitment:

- **emergency medicine**
- **older people's services and stroke**
- **theatre practitioners and ODPs**
- **histopathology**



A range of approaches are being pursued to strengthen recruitment in these areas together with development of extended roles and the development of new roles including pharmacists able to prescribe and physician assistants. We are also working closely with **Health Education Wessex** and developing supporting programmes and pilots such as the work already undertaken on the pilot of the **healthcare support worker**. A more **comprehensive workforce strategy** will be developed in the autumn considering the potential needs of the organisation within the context of the development of a single main emergency site for Dorset and the provision of the planned care site in east Dorset.

Notwithstanding this, it is critically important in terms of both recruiting and retaining staff that we maintain a **strong reputation as a good employer** and have the right organisational culture. Critical to this is the need for the **health and wellbeing of our staff** to be appropriately supported. Services that support this include **occupational health, effective people management and good management practices**. We train our managers to recognise work-related stress and will continue to actively support activities that help staff develop and sustain a healthy work/life balance. Enablers for this include **flexible working** arrangements, fostering an **open and supportive work environment, working in partnership** with Trade Unions and the roll out and development of the new **behavioural based appraisal framework**.



We work closely and collaboratively with a range of education, training and development partners including **Health Education Wessex, Bournemouth University and Bournemouth and Poole College**. We value the importance of education and training as a tool to develop our existing and future workforce and to support the delivery of high quality care on a

sustainable basis. The work will continue and be accelerated.

To support these aims our new **Blended Education and Training Department - BEAT** - was established in September 2014 and provides support and development to staff within the Trust.

BEAT play a crucial part in developing and retaining a high-quality and motivated workforce, ensuring staff are fit and safe to practice, are as effective as possible in their roles, and are up to date with the latest learning and best practice.

Sustainable and safe staffing and workforce productivity

To support the overall Quality Improvement Programme we are reviewing the arrangements for the use of temporary and agency staff. We need to reduce our **reliance on agency staff**, strengthening the quality of our services and improving our use of public funds. A sustainable approach to the use of bank and agency staff is being developed including the upgrading of the Trust **e-rostering solution** provided through the Cloud that providing a better system with enhanced connectivity and flexibility. In addition we are reviewing the use of medical and other locum/interim usage in the Trust and ensuring that appropriate checks and balances exist. Some other workstreams include:

- ensuring a **greater supply of NHS nurses** through the development of the RAN programme (Return to Acute Nursing) and the national Return to Practice programme
- developing links for the **recruitment of overseas nurses** to fill hard to recruit gaps
- sharing and developing internally best practice actions on **staff retention** and providing rotations and education opportunities and development
- supporting efforts to provide our staff with **more flexible working** including looking at shift patterns and developing better career paths for staff
- reducing **staff sickness rates** and the resultant need for agency staff by improving the health of our staff and providing effective support for the management of sickness absence

Our approach to Information Technology

We have developed a joint strategy in concert with our partners at Poole Hospital NHS Foundation Trust founded and developed on 27 projects to underpin:

- **safe patient care**
- **greater efficiency in our processes**
- **improvements to the working lives of our staff by using modern informatics**

A centrepiece of this is the drive to achieve paperless patient journeys by the development, procurement and implementation of linked clinical computer systems, presenting

all appropriate clinical information and functionality at the point of care seamlessly integrating with primary care systems. Additionally, we are implementing digital channels to help patients and carers feel more connected with the hospitals, take less effort in their healthcare transactions, respond to their concerns and improve their control of their personal care options.

The agreed architecture to support this is based on a clinical portal with best of breed systems. The table below summarises current and future intended progress:

Progress and headlines of next deliverables

Already achieved	Within the next two years
Interim Electronic Patient Record (EPR) jointly with Poole	Further embedding EDM
Electronic National Early Warning System	Electronic Nurse Assessments (from Nov 2014)
E-Mortality forms	Order Communications for Primary Care and Acute
Single Informatics Service delivering to PHFT via an SLA	Electronic Prescribing and Medicines Administration
Single Radiology systems between Poole and RBCH enabling seamless image sharing	Electronic letters emailed to patients
Electronic Document Management: Deployed to all specialties	Migrating to a modern EPR shared with PHFT to provide seamless access to all PHFT and RBCH clinical data
	Dorset Wide Health and Social Care Record



The benefits of this approach, which is fully provided for within our capital programme, centres on our aim to:

- **ensure information about the patient's current situation and relevant history is collected electronically at each point along the journey and made available instantly 24/7** to all appropriate clinical professionals to maximise safety and clinical quality
- **develop the potential use of IT system intelligence** in supporting and guiding clinical decisions according to best evidence, practice and safety
- **exploit the opportunities to improve links between organisations** to enable the vision of shared care between primary/secondary/tertiary and social care settings to be realised
- **engage patients, carers and current/future commissioners** of care by adding value through informatics innovations to make the trusts their first choice provider of acute care
- **help patients and carers** make an informed choice about their care options by providing information about the scope, quality and outcomes of our services
- **enable service improvements** particularly to improve the Trust's efficiency
- **achieve the commissioners' intentions and patient quality improvements** described in the **Commissioning for Quality and Innovation (CQUIN)** contract clauses and supporting our approach to providing more and rapid access to specialist advice for primary care



Performance for patients



Among the most important considerations for our patients is the ability to rapidly access care when it is required. Here we describe our work and commitment to improving access including:

- **waiting times for our Emergency Department**
- **referral to treatment (RTT) times for outpatients, diagnostics and procedures**
- **cancer diagnosis and treatment times**

These are part of the NHS Constitution, our regulatory and contractual requirements and core quality standard patients should expect. Each year sees significant growth in demand, as well as developing best practice. This chapter sets out our five year approach to meeting these challenges in each of these three areas.

Urgent and emergency care access

Taking a whole system approach including GP primary and community care, mental health and social care, is critically important. The **Better Together Programme** for Dorset provides the framework for greater integration of social and health. The Clinical Service Review (CSR) sets out an 'out of hospital' model of expanded primary care hubs and integrated localities, better able to manage elderly and chronic conditions. Sir Bruce Keogh's Urgent Care Review findings, especially the need for integrated urgent and emergency care in a locality, are central to our strategy. This in particular means we will work over the next five years to:

- develop a single, **integrated network spanning GP out of hours and extended hours services**, allowing patients a simple to access urgent care service
- develop a **GP practice on the RBH site** and 'single front door' approach for ED walk ins, and GP extended and out of hours
- support **integrated health and social care localities**, with a priority for Christchurch's elderly population
- have a **single Dorset health record**, allowing clinicians real time access to key information, including anticipatory care plans developed by local GPs for high risk patients
- join up the **support for local nursing and residential homes**, so the hospital and other parties are supporting residents far better, leading to better care and reduced inappropriate emergency admissions
- within the hospital we will continue to build upon our improved emergency care pathways described on pages 14 and 15 by:
 - **expanding further ambulatory** (day case) emergency care (AEC), providing diagnosis and treatment, without an overnight stay. AEC will be moving to seven days and increasing the range of conditions seen.

- **embedding good practice**, such as the five daily actions for inpatient ward care, to ensure 'flow' with the right patient in the right place at the right time
- **strengthening the 'front door'** by expanding ED and acute physician consultant numbers, immediate access to CT scanner, and clinical pathways improvement to allow quicker and more accurate decision making
- **continuing to move forward a seven day service**, building upon the excellent progress of the last two years, so medical, therapy, diagnostics and other services are fully functional regardless of the day of week. Specific focus on community seven day services and discharge will have the largest benefit
- to develop a nationally recognised **centre of excellence in older people's care**, both embedding best practice and innovating to remain at the forefront. Significant progress has been made over the past two years, in strengthening stroke services, and measurably improving the quality of inpatient older person's care. As well as continuing this progress we will further develop our research and development, teaching, and give a high priority to community based geriatrician support to GPs and others

Taken together these strands of work will allow us to use the current resources to better effect, so as to improve quality and outcomes, and meet the rising demand from an aging population, and a growing population with more long-term conditions.

We will as part of this, be active in **vertical integration**, combining with community and primary care to provide a seamless service. If fully successful this allows a shift from inpatient to community care, which is better for patients, and underpins the three to five year CSR strategy for out of hospital care.



Waiting times for outpatient clinics, diagnostics and treatments (referral to treatment)

At any one time there are over **20,000 patients at RBCH on referral to treatment pathways**, progressing through to their diagnosis and treatment. Ensuring all of these patients have timely and effective outcomes is central to our strategy. In line with the NHS Medical Director's guidance we will be focusing on patients on these pathways (clocks still running) and their individual stages of care e.g. to first clinic, to diagnostics, to operation if required etc.

Our strategy is focused around the following key initiatives.

- **Improving our theatre, outpatients and diagnostics productivity**, such that we can absorb growing demand within existing workforce and facilities, is the central, most important aspect. This fits well with our quality and financial improvement plans, as we can improve productivity at the same time as improve cost and quality by reducing delays, duplications and wastage. This will help our hardworking staff fulfil their full potential, because the systems and procedures can be made more effective. Key aspects of this work include:
 - **better capacity and demand planning and management**, stopping backlogs building and high cost 'catch up' work

- better and **more standardised pathways**, using 'lean' processes to reduce delays and wastage
- **improved IT** for booking clinics, diagnostics and procedures
- **improved coding and information** collection to ensure we have accurate data for planning and billing
- **new models of care**, including patient education and empowerment, reducing the need for follow ups and improving patient outcomes
- **greater joint working** with GPs and others to support advice and guidance and simple diagnostics in the community to ensure quality and integrated care, without the need for hospital trips
- **multi-skilling** to allow different staff groups to undertake tasks and improve value for money

In years three to five, the CSR will change the layout of services particularly at the very specialist and emergency level. Over the next three years our focus remains therefore on improving existing services.

Cancer services

The third key area of national and local expectation for **prompt, high quality care is for cancer** services. The clinical strategies chapter sets out how, through the CSR we can improve inpatient haematology, and by having a single east Dorset centre for complex, consultant led services, we can improve cancer outcomes, such as for cancer surgery. The trend for the last 15 years has been towards greater networks of care, sharing scarce expertise and resources to ensure excellent cancer care. This results in improved outcomes and saved lives.

Looking ahead to the next five years, we will develop our cancer strategy, including improving our access times for each stage of care.

- For fast track GP referrals we will plan for increased numbers, especially GI and skin patients and we are **redesigning pathways and processes** to achieve this.

- We will develop more **direct to test referrals pathways**, to allow GPs faster access to results for the patients, to more quickly rule out or diagnose cancer. Our CT development is key to this, along with developing endoscopy capacity.
- The Jigsaw Building for day case oncology and haematology, and women's health, will allow **more one-stop clinics**, in far better surroundings, to improve the effectiveness and experience for patients.
- Supporting both **prevention and secondary prevention** (for those who have beaten cancer) to remain healthy is a core part of our work. We will do this with partners, especially in public health and councils, GPs and voluntary organisations.
- The **expansion of screening** will be supported, especially for bowel cancer. This requires us to expand our endoscopy services, and improve our processes, work which is underway.
- We will **engage in the Wessex five year cancer strategy** development over 2015/16, and the work on the Dorset Cancer Alliance, so as to ensure we are maximising the joint effort of partners, and using the best evidence to make decisions.
- **Research and development** will continue to be a key part of our work to improve care, but also allow patients the option of cutting edge treatments. The development of person centred drugs, targeted to maximise their effectiveness, is an area we are well placed to develop over the next five years.

These specific priorities, along with the clinical strategies, and supported by workforce, IT, estates and capital and finances, form the backbone of our approach to the next five years.

As the NHS Forward View develops, so we will adapt for the local population we serve. We will also remain active in delivery of the core expectation around emergency, elective and cancer care services.

Future Organisational Form

There are a number of factors which will influence the **future organisational form** that underpins the delivery of services from the Royal Bournemouth and Christchurch hospitals. The increasing financial challenge for this and other neighbouring trusts highlights a clear potential that absent of a significant reshaping of the present models of care, the current organisational form is not sustainable into the medium term (three to five years).

The fundamental redesign of services driven by the Clinical Services Review (CSR) will create the need to **reshape organisational form**. Within east Dorset, services on one site will expand by up to 50% and on the other shrink by at least 50%. The creation of a main emergency site, and the interdependence it will have on staff from other organisations will lead to further consideration of a number of exciting options. These include:

- the potential to create a **single acute organisation for Dorset**, or the possibility of extending this further to a **single consolidated acute and community trust**
- the scope to develop both multi-specialty community providers and/or primary and acute care systems principally linked to the planned care site
- the potential to integrate hospital, community and social care

We recognise that our **organisational form is unlikely to be sustainable**. Work has therefore begun with other local providers in Dorset to explore the potential to develop an **acute vanguard project** designed to identify organisation forms that will enable the ongoing provision of high quality financially sustainable services. This work will include detailed examination of the potential to create a joint venture vehicle to allow future ongoing provision of clinical, non-clinical and support services. Those clinical services that could be included in such a venture include Emergency Department provision, cardiology, general surgery, stroke, vascular surgery, interventional radiology, obstetrics, gynaecology and paediatrics.

The clinical support services could include pathology where work is already underway, pharmacy and imaging. Non-clinical services could include most back office functions.

Any potential new organisational form would need to fully support implementation of the CSR proposals and safeguard the continued provision of high quality care. Longer term, there remains the potential, subject to the requirements of the Competition and Marketing Authority, to create a single provider of secondary and community health care services in Dorset and this could represent the optimal solution for viable provision of services in Dorset.

The vanguard application will be pursued in Autumn 2015.

Our approach to Research, Development and Innovation

The Royal Bournemouth and Christchurch Hospitals FT is the highest performing clinical research unit in Dorset with a dedicated infrastructure and team to support, oversee and facilitate research activity within the Trust. Prerequisites for clinical research include good clinical practice, well-trained and motivated teams and a strong underlying hospital infrastructure. The relatively high volume of clinical research activity is a clear marker of the presence and stability of these prerequisites.

Clinical trial activity predominantly focuses on adopted trials from the National Institute of Health Research (NIHR) portfolio. There is also significant commercial trial activity sponsored by pharmaceutical companies and industry. Both groups of activity represent an additional income to the Trust representing a combined turnover of circa £2.5m. Going forward we aim to continue the trend of expanding our research activity and seek to take advantage of the emphasis being placed on more commercial trial activity. During the last two years the clinical trial recruitment activity has increased, by way of example in 2013/14 a total of 1200 patients were recruited to NIHR portfolio studies and this increased in 2014/15 to 1776 patients. The Trust wishes to work more closely with the Wessex NIHR to ensure an appropriate flow of funds to support the ongoing planned expansion in research activity.

The strong and well established research and innovation infrastructure provides a firm platform on which to develop future activity. This is underpinned by clear and signalled support for the development of research through key areas of activity including Haematology, Cardiology, Orthopaedics, and Gastroenterology. It is, however, recognised that the uncertainty created by the Clinical Service Review and the future development

of sites including the Royal Bournemouth Hospital will create some uncertainty for the industry support in research. Nevertheless, it is important that we continue to work together with other local Trusts to develop research. The future pattern of research activity will broadly reflect the future configuration of services, for example the development of the Royal Bournemouth Hospital as an Emergency Centre would ensure that the Trust retains and develops further its Cardiology, Haematology and Stroke related activity. Conversely if the Trust develops as a Planned Care Centre it is likely to develop further research activity in specialties such as Rheumatology, Dermatology, Dementia and Neuro-degenerative diseases. The Trust is also keen to evaluate and consider how it can develop a clinical trials unit creating the ability to undertake further early phase pharmaceutical trials which include extensive pharmacokinetic studies. Christchurch Hospital and its development as a hub in collaboration with General Practice also provides the opportunity for more vertically integrated clinical services and therefore potentially a novel venue for research work.

During the lead up to implementation of the CSR we will continue to foster and develop relationships and clinical projects with partner organisations and external stakeholders including Bournemouth University Clinical Research Unit, the Wessex Academic Health Sciences Network and the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Wessex and Quintiles.

We are also developing a clinical innovation framework to help improve clinical productivity and support; a widespread adoption of new approaches to improving strengthening of care and clinical outcomes. There will be a specific focus on clearly defined repetitive systems for

specific clinical presentations mapped against quantified clinical outcome measures which enable:

- Improvement in the consistency of healthcare
- Analysis of the clinical worth of the interventions and treatments provided
- The easier embedding of new determined best practice, health technology, appraisals, NICE guidelines and research findings
- Easier embedding of clinical research of uncertain components of care
- Cost analysis of components of care pathways
- Exploration of potentially more efficient models of care or determining the processes are, in fact, optimal

The estate and our capital programme

Our estate portfolio is required to be flexible in its scale, scope and utilisation to support the evolving patient and clinical service requirements. In order to achieve this we have continued to invest in ways that optimise the efficiency and quality of the estate while simultaneously responding changes in demography and technological advances, all of which drive our strategy. The purpose of the estate strategy is therefore to enable the implementation of our strategic objectives.

Two significant capital schemes have been in recent development at the Royal Bournemouth Hospital (RBH) which will enable improved service delivery in purpose-designed facilities, and which will also have the collateral benefit of generating space capacity, and thereby facilitating spatial reconfiguration, in the main hospital building.



- **The new Bournemouth Birth Centre** opened in November 2014.



- **The Jigsaw Building** is due for completion in September 2015.

Additional space is also being freed up through the impact of the Electronic Document Management project in reducing space currently used for medical record storage, retrieval and archive. There is then scope for the further development of clinical capacity at RBH through both strategic reconfiguration and further new build development, as illustrated below:



Dorset Clinical Services Review (CSR)

CSR background

The Dorset CSR will be expected to define the Estate Strategy direction and priorities for the next 25 years, with the Royal Bournemouth Hospital becoming either the Dorset major emergency centre or a planned care centre.

Major emergency site scenario

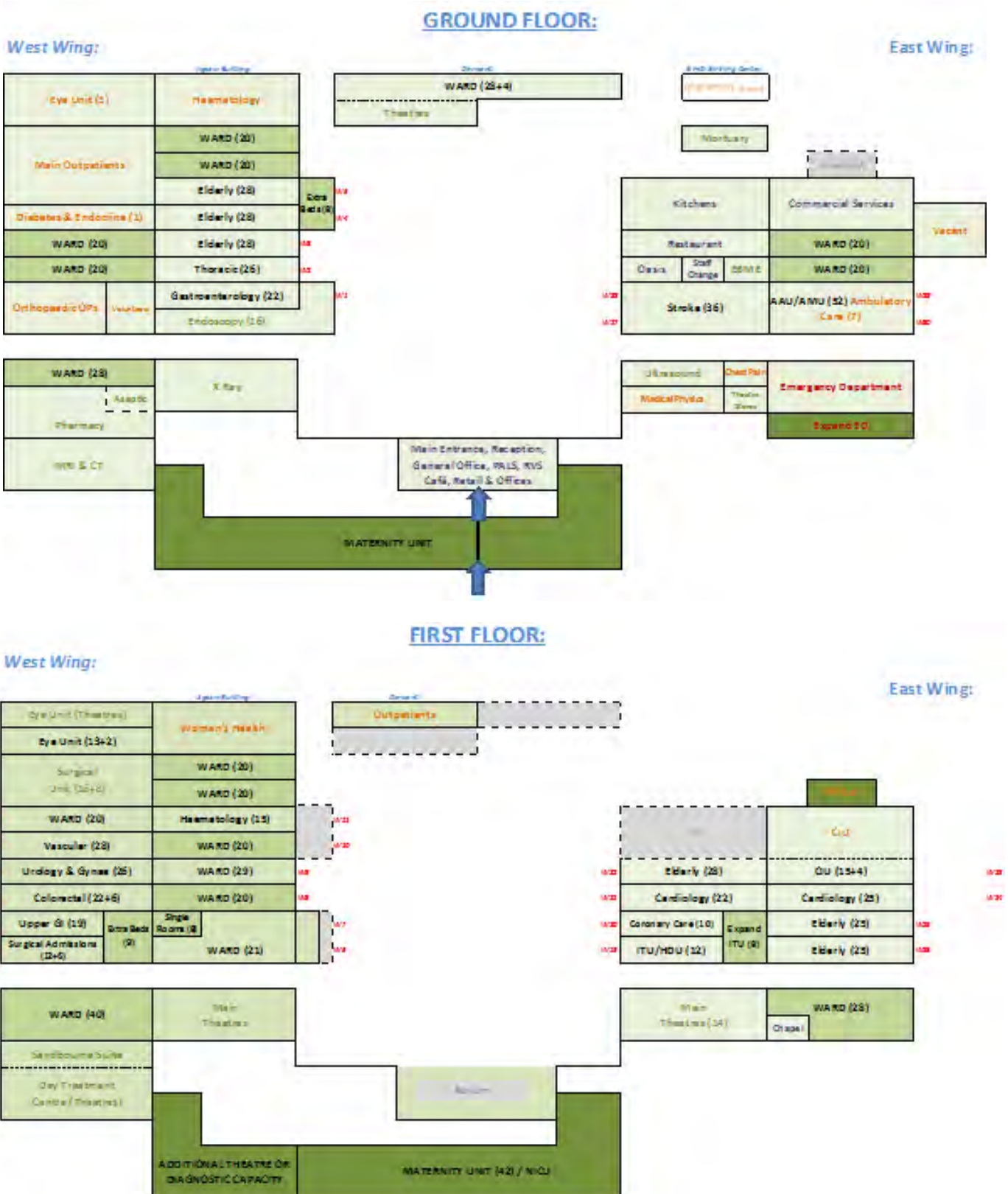
Under the RBH major emergency site scenario, the following services could be moved from the main hospital building to off-site locations (i.e. to the planned care site or elsewhere in the community), or to satellite locations on site, in order to create capacity in the main hospital building for the development of emergency services:

Vacated (to purple site, community, or elsewhere on site)

Elective Orthopaedics Elective Day Surgery Pathology Ward 8 (TIU) Ante Natal	Renal Orthodontics Sexual Health Rehabilitation Dorset Prosthetic Centre	Overnight Stay Ward Women's Health Thoracic Outpatients Ward 10 (Day case oncology) Various Administrative Functions
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Using the capacity created, the services below would enable the major emergency clinical model:

New	Expanded	Integrated support functions
Trauma Paediatrics Maternity (incl. NICU) Additional acute medicine and surgery	Expanded Bed Base Expanded ED Expanded Critical Care (ITU/HDU) More Main Theatres Capacity More Diagnostics Capacity	Pathology? Sterile Services Department?



Planned care site scenario

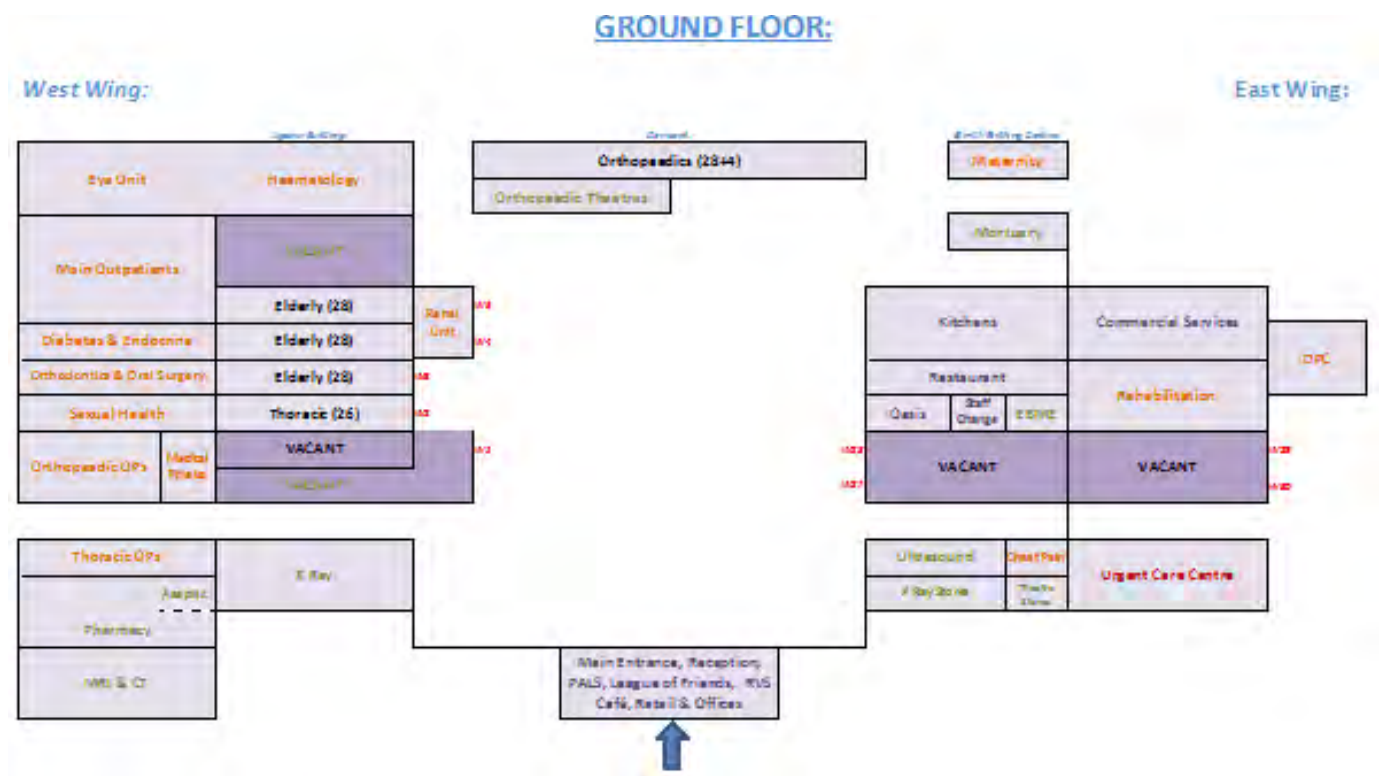
Under the RBH planned care site scenario, the following services would move from the RBH site to Poole Hospital as the major emergency site:

Vacated (to green site)		
Emergency Department AMU/AAU Critical Care (ITU/HDU) Stroke Cardiology Inpatient Haematology	Main Surgical Specialties: <ul style="list-style-type: none"> • Vascular • Urology • Gynaecology • Colorectal • Upper GI • Surgical Admissions 	? Pathology ? Sterile Services Department

Under this scenario, there would be a significant reduction in the RBH bed base and reduced acuity of the clinical activity taking place on site, leading to substantial vacant space:

New	Reduced	Expanded
Urgent Care Centre (in place of ED)	Significantly Reduced Bed Base Reduced Main Theatres Reduced Diagnostics?	Day Surgery Elective Procedures

Subject to further definition of the clinical model and functional content, an estates model for the delivery of the planned care site at RBH is as represented in the schematic below:



Subject to further clarification of the planned care site model by commissioners, the impact on RBH of this scenario would be the creation of significant vacant capacity, some of which would be for re-use as planned care services, but some of which may prove surplus to requirements. However, the scope for consolidation and disposal of surplus space is very limited, as there is no ability to dispose of this. This whole system financial model requires more work as the CSR process proceeds towards the strategic outline business case stage.



Christchurch Hospital

The continuing development of the Christchurch Hospital site remains a key component of our estate strategy.



Phase one is progressing and will deliver:

- new GP practice, pharmacy and X-ray department, and refurbished outpatients and other areas.
- nursing home and senior living developments (via joint venture with Quantum)

An OJEU notice has now been issued in respect of a Phase two development, which will deliver:

- new Macmillan Unit
- residential development (incorporating key worker housing)
- other commercial development (subject to bid approval)

- other potential clinical developments (variant bid)

Compliance, refurbishment and infrastructure

Alongside, and complementary to, the strategic development of the Trust estate portfolio, it remains a key priority to **ensure ongoing backlog maintenance**, refurbishment and adaptation of the building stock and associated infrastructure with a view to ensuring safety, compliance and fitness-for-purpose. Annual allowance will continue to be made in the capital plan for such essential works.

Sustainability

As a part of the NHS, public health and the social care system, it is our duty to contribute towards the level of ambition set in 2014 of **reducing the carbon footprint** of the NHS, public health and social care system by the equivalent of a 28% from a 2013 baseline, by 2020. These represent ambitious goals to reduce carbon emissions in the healthcare sector, and in doing so protect the health and wellbeing of the UK population. It is our aim to meet these targets.

We are committed to continually improve on minimising the impact of its activities on the environment, and in doing so reinforcing its commitments to both the **Good Corporate Citizenship Model** and **cost improvement**.

In order to meet these targets we are working in a number of areas to invest in low-carbon technologies and practices. The key areas for action now and over the next five years are:

- energy, water and carbon management (including invest to save schemes)
- sustainable procurement, including of food
- low carbon travel, transport and access,
- waste reduction and recycling
- developing green spaces
- staff engagement and communication
- buildings and site design
- organisational and workforce development
- partnership and networks
- governance, IT and finance to underpin the above.

We regularly reviews and report on progress against the Good Corporate Citizenship (GCC) Assessment Model and key actions within an accompanying Sustainability Management Action Plan. Monitoring, reviewing and reporting of energy and carbon management are carried out quarterly via the Carbon Management Group.

We have been progressing with energy and carbon management in a number of areas over the last couple of years. In 2014 this was formally recognised through two national awards for our work:



- NHS Sustainability Day 2014 - Behaviour Change Award Winner
- NHS Sustainability Day 2014 - Waste Award Winner

We have also been recognised locally with regards to the work that has been carried out around promoting active travel to staff by receiving the following award:

- Bournemouth, Poole and Christchurch Business Travel Network - Travel Action Plan, Initiative of the Year 2015

Medical equipment strategy

We have invested heavily in medical equipment over the years, especially in radiology, cardiology, theatres and endoscopy. As a result we have cutting edge scanners, a theatre robot and many other examples of state of the art equipment.

The **asset register** is used, alongside the operational department's knowledge of likely replacement timings, to forward plan. This combined with horizon scanning of developments in technology sets a two year forward look. Over the next five years maintaining being at the forefront will become more difficult, as funding remains static, kit needs replacing and new equipment becomes more expensive.

As equipment becomes more sophisticated so the links with the IT systems become more crucial e.g. sharing results with electronic document management, and with test ordering (order comms).

To balance these demands the capital strategy has a three part response: **increasing of the medical equipment budget from £1m to £1.5m**; the charity fundraising strategy focusing more on equipment (which has the added benefit of saving on VAT, increasing the spending power by 20%); thirdly the Trust will also consider managed equipment services. These link operational and equipment needs with specialist suppliers, following a procurement process, which can be better value for money.

There will be several high capital cost items involving equipment in the next few years, which will be required regardless of the CSR. These include:

- developing the third CT scanner in our Emergency Department, transforming the speed of diagnostics, and creating much needed extra scanning capacity
- refurbishing the four cardiac labs at RBH
- upgrading the Derwent theatres

Other capital decisions, including the fifth cardiac lab plans and a wider theatres upgrade, will be reviewed in the light of CSR decisions.

Transport links

Access to and from the RBH site is a major issue, as peak time traffic combining with minor events such as roadworks, can create severe congestion. Minor works such as improved signalling, plus strenuous efforts to **manage traffic demand** and help staff with travel alternatives is maintaining a workable situation. However staff being unable to access work easily is a recruitment and retention concern. The strategic solution is an on/off junction from the Wessex Way. Some £6m of government funding is committed to this for 2018/19, but it requires at least match funding, via development of the unused land to the north of the hospital. We will work with the council and the land owners to develop a viable proposal. Improved road access, and staff parking are key outcomes we are looking to achieve from this partnership.

Five Year Capital Programme

Years one to two of this strategy will be about minimising spend for two reasons. Firstly major commitments without a CSR decision are unlikely to be appropriate, unless they are future proofed for either option (which is why CT3 is progressing now). Secondly the need to reduce draws upon capital reserves, as our financial plan requires us to maintain liquidity. For these reasons the 2016/17 capital plan will therefore be reviewed downwards.

The CSR decision, followed by Treasury approval of any major capital enabling works, will be the largest factors affecting the future capital programme from years two to five.

The plans for the planned care centre option will be minimal, as in effect this will allow de-commissioning of facilities on the RBH site. **A draft Five Year Capital Programme**, based on RBH as the major emergency site, is as shown below. The funding of which is assumed to be via the access to national enabling funds.

INDICATIVE CAPITAL PROGRAMME 2015/16 - 2019/20

	2015/16 (£k)	2016/17 (£k)	2017/18 (£k)	2018/19 (£k)	2019/20 (£k)	TOTAL (£k)
ENABLING SCHEMES (TO FREE SPACE)						
Women's Health (already incorporated in Jigsaw)		0				0
Ward 10 (already incorporated in Jigsaw)		0				0
Thoracic OPs (assumes incorporated into Main OPs post-Jigsaw)		0				0
Pathology (based on previous Archive building scheme)		2,500	2,500			5,000
TIU (assumes relocated on/off site)			1,150			1,150
Renal (assumes relocated off site; location tba)			495			495
Overnight Stay Ward (assumes relocated off site)			825			825
Orthodontics (assumes relocated off site; location tba)			825			825
Sexual Health (assumes relocated off site; location tba)			825			825
Medical Secretaries (to Stour building?)			1,000			1,000
Executive Suite (to Stour building?)			800			800
Rehabilitation (assumes Xch solution)				1,610		1,610
DPC (assumes Xch solution)				1,150		1,150
Ante Natal (assumes incorporated in Maternity new build)					0	0
SUB TOTAL	0	2,500	8,420	2,760	0	13,680
REFURBISHMENTS (TO CREATE ADDITIONAL WARD CAPACITY)						
Women's Health		330				330
Thoracic Outpatients		1,840				1,840
Ward 10		1,150				1,150
Pathology			600	4,000		4,600
Ward 8				500		500
Renal				690		690
Overnight Stay Ward				500		500
Orthodontics				1,150		1,150
Sexual Health				1,150		1,150
Executive Suite				1,840		1,840
Medical Secretaries				2,300		2,300
Rehabilitation				300	2,000	2,300
Ante Natal					495	495
SUB TOTAL	0	3,320	600	12,430	2,495	18,845
NEW BUILDS (TO CREATE AND SUPPORT ADDITIONAL WARD CAPACITY)						
Expend ED			1,800			1,800
Maternity Unit (incorporating increased Theatres capacity)			1,000	16,500	15,000	32,500
Cath Lab 5 (build & equipment)		1,600	1,150			2,750
SUB TOTAL	0	1,600	3,950	16,500	15,000	37,050
FURTHER STRATEGIC DEVELOPMENTS (OPTIONAL)						
Multi-Storey Car Park			5,000			5,000
Integrated SSD (location tba)			5,000	5,000		10,000
SUB TOTAL	0	0	10,000	5,000	0	15,000
CHRISTCHURCH HOSPITAL DEVELOPMENT						
Christchurch Development - NHS	7,565	2,570	0	0	0	10,135
SUB TOTAL	7,565	2,570	0	0	0	10,135
PERIODIC REFURBISHMENT, BACKLOG & COMPLIANCE						
JIGSAW New Build (to completion)	3,050					3,050
Aseptic Unit (NB cap charges covered)	510					510
Catering Equipment Replacement	150					150
Traffic Congestion Works by RBH (new junction)	100					100
Ward Refurbs	400	500	500	500	500	2,400
Estates Maintenance	400	400	400	400	400	2,000
Capital Management (Estates and Finance)	300	300	300	300	300	1,500
Miscellaneous Minor Schemes	100	250	250	250	250	1,100
Residences Refurbs	50	200	200	200	200	850
Cardiac Lab Equipment (Lab 5)		1,122				1,122
Cardiology (5th Lab)		300	1,230			1,530
Cath Labs 1-4 Equipment		1,500		500		2,000
Derwent & Theatres Upgrade (essential works)		1,250	1,250	1,250		3,750
SUB TOTAL	5,060	5,822	4,130	3,400	1,650	20,062
IT & MEDICAL EQUIPMENT						
IT Strategy	3,062	2,378	2,549	2,037	2,000	12,026
Medical Equipment Replacement	1,500	1,500	1,500	1,500	1,500	7,500
SUB TOTAL	4,562	3,878	4,049	3,537	3,500	19,526
GRAND TOTAL	17,187	19,690	31,149	43,627	22,645	134,298

NB: THIS DRAFT COST PLAN IS BASED ON CRUDE HIGH-LEVEL COST ESTIMATES & PROGRAMME ASSUMPTIONS

Financial strategy



Consistent with the national foundation trust picture, during 2014/15 we experienced significant operational and financial pressures for the first time since we were licensed as an foundation trust. These included considerable demand pressures - a 10% increase in emergency admissions, doubling the number of delayed discharges, and a national shortage of medical and nursing professionals resulting in a significant premium cost spend. As a result, we did not meet our planned deficit of £1.9m and ended the year incurring a deficit of £5.2m. Non-recurrent item adjustments resulted in this deteriorating further to an underlying deficit of £6.5m.

The financial strategy focuses on how we manage future performance building on our historic successes. Strong financial performance is fundamental to the Trust's service aspirations so our plans are grounded on a strong business model.

The financial strategy is set in context and covers the period from 2015/16 to 2017/18, being the period up to the point at which the commissioner-led Dorset Clinical Services Review (CSR) is anticipated to commence implementation of the agreed model of care.

Clinical Commissioning Group (CCG) allocation/resources

CCG allocation growth is predicted to average between 1.5% and 2% during the period of this strategy. Locally, our commissioners the Dorset CCG experienced growth of 2.5% during the last financial year, and remains 2% distance from target.

Tariff reform and efficiency

The current and predicted tariff continues the need for the NHS and in particular, the provider sector to continue with relentless and significant efficiency savings. The requirement is 3.5% in 2015/16 and indications are for a similar position thereafter. The newly elected government has confirmed that £8bn will be made available to the NHS by 2020, however this is conditional on delivery of £22bn of further recurrent (CIP) efficiencies, hence the trust must plan to deliver above the minimum requirement to reduce the current level of deficit.

The national expectation is that respective local health economies will determine the details of how productivity opportunities will be realised. The more significant cost improvement is assumed to be released from 2017/18 through the implementation of the CSR however in the medium term, we are obliged to stabilise the financial position internally through various areas of priority focus:

- **use of shared services in back office functions**
- improvements in the **use of the estate**
- **more efficient care** through better co-ordination with partners.
- prioritising the **most effective treatments** and reducing errors and waste
- enhanced **clinical productivity**
- **better use of resources**
- **workforce skill mix** review

- **rigorous premium cost avoidance**
- **matched demand and capacity**

This financial strategy is being developed within current and anticipated NHS foundation trust regime mandates. We will respond to and maximise the opportunities and flexibilities afforded by the current and any future regime to which it is subject.

Trust financial strategic aims

The primary financial strategic aim is to enable and support delivery of our objectives in accordance with our Trust values. Various tactical approaches will inform the successful implementation of our financial strategy acting as a set of coherent enabling strategies supporting the overall service strategy.

This three year financial strategy, in the context of continuing public sector austerity, will be to continue to **reduce the current deficit year on year** within the regime allowed, maximise the opportunities and flexibilities given. The key strategic financial targets are shown below:

- **reduce the level of deficit each and every year** of the plan
- maintain a **Continuity of Service Risk Rating (COSRR) of at least three**
- maintain a **minimum liquidity ratio of at least 14 days**

Accordingly we will work to realise this through:

- ensuring **viable contracts** with commissioners reflect our performance
- **delivering our cost improvement programme** through the wider quality improvement work and one that does not place patient safety at risk
- **improving cash-flow performance** and reporting in an organisation focused on sound financial management
- **using resources wisely**

We have a commitment to use public money responsibly.

We will:

- work within our financial plan that enables the delivery of high-quality commissioned care
- identify opportunities for developing and enhancing services with a local and sector wide view
- review our market position to ensure we are able to demonstrate value for money to our patients and commissioner
- by modelling a mind-set emphasising efficient performance, optimise the effective use of resources
- achieving contractual, statutory and regulatory requirements by doing what we say with our financial plan as part of our remit to deliver safe care.
- delivering significant savings, and challenging the organisation to do more with less but also motivating plans for system change
- finance will model behaviours for the Trust to emulate by producing vital quality and financial performance plans each year underpinning local objectives for care groups to develop their own priority plans within the financial context

Our **financial strategy** will additionally aspire to:

- deliver year on year financial targets
- commit to technology enabled processes
- ensure we are able to substantiate the delivery of care in a great environment
- conflate quality care with financial probity
- financially support local services where we are a preferred provider not necessarily on the hospital site ahead of CSR

Income and expenditure forecast for 2016/17 and 2017/18

In order to achieve the aims described above, we would not wish to exceed a deficit of £8.5m during 2016/17, thereby retaining a minimum cash position of £16.9m to maintain a risk rating of three. The following table sets out the projections for income and expenditure and indicative cost improvement requirement including income, expenditure reduction and cost of capital initiatives for the next two years.

	2015/16	2016/17	2017/18
	£m	£m	£m
Income	263.7	266.4	269.1
Expenditure	(261.9)	(260.1)	(260.7)
EBITDA	1.8	6.3	8.4
I and E deficit	(12.9)	(8.5)	(6.2)
Cash	27.0	16.9	12.0
CoSRR	3	3	3
CIP requirement	6.4	10.6	8.1

Improvement programme

We have an excellent record of delivering financial efficiencies, and have achieved savings in excess of £44m over the last five years, as set out below:

Financial year	2010/11	2011/12	2012/13	2013/14	2014/15
Savings delivered (£m)	£11.108	£8.893	£8.503	£8.798	£7.541

It is recognised that as each year passes it becomes increasingly difficult to find further schemes to achieve the national efficiency targets. Indeed, we have a Reference Cost Index of 91, evidencing that we are already delivering a mix of services at lower than expected (national average) cost.

We have therefore taken steps to appoint a specialist advisor who is helping to identify further CIP savings, recognising the

importance of this to underpin our core aims and purpose. Combined with the productivity gains, these are anticipated to exceed the 3.5% national efficiency gain for 2015/16 (PYE) with the resulting FYE impact felt in 2016/17 too. As such, the focus is also on developing a robust CIP programme for 2016/17, ensuring an effective transition to implementation of the CSR.

As part of this, in January 2015, the Board approved initial diagnostic work with an external consultancy (PWC) to undertake a financial baseline review, some of which work helped to part-evidence the availability of realistic cost improvement opportunities across identified selected clinical areas. This is underpinned by a financial baseline analysis to validate or otherwise challenge financial projections for 2015/16 and 2016/17.

In addition to this, the work programme is composed of:

- **Financial Baseline** update report (including working capital cash release options) and capital plan review
- the Four Eyes Insight Analytics report incorporating bespoke reviews of efficiency in specific areas with additional work to follow
- a **workforce review** to identify further pay opportunities
- a **governance process** which furthers idea generation and conversion of these to an identified CIP and implementation plan across all clinical and non-clinical operational domains

The efficiency strategy is being developed alongside service planning and the drive for quality improvement, and not in isolation in recognition that high quality and value for money are not competing alternatives; they are one and the same thing. To this end this work will form a core part of our ongoing approach to quality improvement.

Capital investment

The future Capital Programme will clearly reflect the changing affordability assumptions for the Trust as well as the inherent support via the CSR.

- Internally generated cash will be the primary source of capital funding.
- Circa £8m of cash from depreciation is available per annum.
- Additional funding will be realised through asset disposal although this is recognised as high risk in terms of market opportunity and is small in relation to the overall funding requirement.
- Each scheme within the capital programme will require a business case which demonstrates affordability and value for money and ensures that the Trust only invests in essential capital schemes.
- The potential for additional funding and alternative solutions through routes such as outsourced managed services and joint ventures will be considered.

Revenue affordability will be the key driver for determining the overall capital financing portfolio.

Risks and mitigation

The Annual Plan identified a range of key strategic risks and mitigations. The financial strategy is to ensure that the financial consequences of those risks and mitigation strategies are quantified, modelled and understood in terms of deliverability and impact in both service and financial terms.

There current risks identified include:

- Continued use of expensive medical and nursing agency and locums: Although the current year budget reflects the cost of the substantive establishment; together with a trajectory of expected agency spend as a result of national shortages of trained medical and nursing professionals. There is a risk that this trajectory could be exceeded if recruitment proves more challenging than currently anticipated. Additionally resource has been committed to improving recruitment and reviewing skill-mix over the medium term.
- Identification and delivery of the significant cost improvement requirements placed upon the provider sector.
- Non delivery against agreed CQUIN schemes: Our contracts will include payment for CQUIN delivery. If this is not achieved, we will not receive the budgeted income levels. The Trust is actively working to obviate this risk.
- Contract penalties for 18 week referral to treatment breaches: The contracts include the ability for commissioners to apply financial penalties for 18 week breaches. The intention is to meet the referral to treatment standards.
- Activity below the budgeted levels: Activity below the budgeted levels will reduce the level of income the Trust receives, however costs are unlikely to be reduced by the same value due to the marginal cost of delivery.
- Additional unplanned costs: In the current year, with the exception of a very small contingency, no budget provision has been made for additional, currently unforeseen costs. Granular management of expenditure drivers will minimise exposure to this risk.

Financial planning and reporting

We recognise the need to strengthen our financial planning, forecasting and reporting in line with the PWC reviews

- Our financial plan will appropriately reflect the consequences of service plans.
- Internal finance reports for the Board will include forecasts for the balance sheet and a forward looking cash flow to give the Board assurance on the Trust's working capital position.
- The Board finance report will be enhanced to incorporate a finance performance dashboard and provide trend analysis alongside in month and in year variances.

The key enhancement will be the further development of service line management which will provide the mechanism through which business decision making is developed to improve resource utilisation, decision making and thus clinical outcomes and the patient experience.

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THE ROYAL BOURNEMOUTH AND CHRISTOPHERS HOSPITALS NHS FOUNDATION TRUST
FINANCIAL FORWARD PLAN 2017-18
Report as at June 2015

	2016-17 Budget	Inflation Uplift	Activity Increases	Cost Pressures	Other Adj.	New CRIS	2017-18 Forecast	Key Assumptions
Operating income (inc in EBITDA)								
NHS Clinical income	233,376	(7,950)	1,000			2,950	241,976	Assume the loan contracts agreed (activity off with deflation)
Private Patient Income	4,418	0,000	0,000				4,418	Assume activity and income remains flat.
Public Health Income	2,400	(2,852)	0,000			0,000	3,450	Assume the loan contracts agreed (activity off with deflation).
Non-Clinical income	18,620	0,100	0,000			0,000	18,720	Assume 3% increase in non clinical income.
Total	265,420	(10,450)	1,000	0,000	0,000	2,950	266,102	
Operating expenses (inc in EBITDA)								
Employee expense	130,000	(1,000)	0,000			2,000	131,000	Inflation 2%; Quality Improvement (Q.I.) cost reduction in agency payments £1m.
Drugs expense	171,250	(1,213)	0,000			0,000	170,037	Inflation 2.5%.
Capital Support expense	17,000	0,000	0,000			0,000	17,000	Inflation 2.0%.
Other Non-Pay expense	17,250	(0,000)	0,000			0,000	17,250	Inflation 1.8%.
Total	265,500	(10,450)	0,000	0,000	0,000	2,000	263,500	Net 2.5% net of activity pressure (improve assume 2.4%).
Operating income (net from EBITDA)	0,920						0,602	Increase for future provision.
Donations and Grants for FY1 and intangible assets	0,965						0,965	Assume full capital programme, including impact of completion of liquor new build.
Operating expenses (excl from EBITDA)	(1,043)						(1,043)	
Depreciation & Amortisation	0,000						0,000	Assume reduced bank interest as a result of significantly reduced cash balance.
Non-operating income	0,000						0,000	
Non-operating expenses	(0,000)						(0,000)	
Interest expense (incl FY1 / FY1)	(0,000)						(0,000)	FY1 savings through reduced cash balances.
FDC expense	(0,000)						(0,000)	Refunds agreed FY1 loan interest charges.
Other financial costs	(0,000)						(0,000)	
Total	(0,000)						(0,000)	
Surplus / (Deficit) after tax	(8,579)	(0,000)	2,400	(1,000)	2,400	4,400	(6,200)	
Forecast Cash Flow								
Operating Cash	18,000	20,000	14,000	11,000			16,000	Assumes current closing cash less additional capital returns of £2.1m.
Revenue Divid	(2,000)	(0,000)	(2,000)	(1,000)			(5,000)	As above, assumes growing to consistent with 2015-16.
Capital Programme	(1,000)	(2,000)	(1,000)	(2,000)			(6,000)	Current 2016-17 capital programme - currently assumes equal monthly outlay.
LTIF Investment							0,000	As per latest LTIF loan repayment schedule.
HTF Capital Repayment							(0,000)	As above.
Depreciation Budget	2,500	2,500	2,500	2,500			10,000	TLC.
Movement in Working Capital							0,000	
Closing Cash	18,000	14,000	11,000	12,000			12,000	
Forecast Cash Flow								
Debt Service Cover	2	2	2	2			2	
Debt Ratio	1	1	1	1			1	
Actual Cash	18,000	14,000	11,000	12,000			12,000	
Forecast Cash Flow								
Debt Service Cover	2	2	2	2			2	
Debt Ratio	1	1	1	1			1	
Actual Cash	18,000	14,000	11,000	12,000			12,000	

(Left hand modelling, based on forecast closing cash balance per quarter)

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The Royal Bournemouth Hospital

Castle Lane East
Bournemouth
BH7 7DW

Christchurch Hospital

Fairmile Road
Christchurch
BH23 2JX

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on **01202 704271**.

BOARD OF DIRECTORS	
Meeting Date and Part:	31 July 2015 Part 1
Subject:	Constitution
Section:	Decision
Executive Director with overall responsibility	Tony Spotswood, Chief Executive
Author(s):	Sarah Anderson, Trust Secretary
Previous discussion and/or dissemination:	N/a
Action required: To approve the amendments to the Constitution.	
Summary: In line with best practice the Constitution should be reviewed annually. A detailed review of the Constitution has been completed and the proposed amendments have been agreed by the Constitution Working Group and Council of Governors.	
Related Strategic Goals/ Objectives:	
Relevant CQC Outcome:	
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

Narrative to support proposed Constitution amendments

Following the review of the Constitution, in the spring of 2014, the July 2014 version was shared with Monitor and published on the Trust's website. In May 2015 the Standing Financial Instructions were revised to incorporate aspects that were previously addressed within the Board Standing Orders and amendments to the Constitution were required and agreed. This was to avoid conflict in the guidance for issues such as tendering.

In line with best practice the Constitution should be reviewed annually. A detailed review has now been completed and the proposed amendments (additions and deletions) have been highlighted. Below is a narrative of the rationale for all proposed amendments. The proposed amendments have been agreed by the Constitution Working Group and the Council of Governors. The recommendation to the Board of Directors is to approve the amendments. The approved updated version of the Constitution will then be submitted to Monitor and uploaded to the Trust's website.

Page	Rationale
3	Index and paragraph numbering to be checked when the review is completed.
	Common amendments are to ensure that all paragraphs are numbered and to remove abbreviations such as SO for Standing Order.
5	Definition moved from Annex 8, Appendix 5
8	Unnecessary word
10	Moved for clarity and flow in reading
13	Provide clarity on the role
21	Moved from Annex 8, Appendix 5
23	No amendment proposed to the constituencies as these reflect the footfall of patients in the hospital. Expansion of the constituency to include all of Hampshire was considered
37	Consistency
63	Reduce cross referencing issues
80	Sense
81	Further option added
83	Added definition
84	Clarity and to update the action for the current practice
86	Clarity
88	Opportunity for action should the event occur
89	Update the action for the current practice
90	Update to match best practice
91	Current name of committee
94	Best practice and clarity
101	Update to current practice
103	Update to current practice
104	Clarity
105	Reduce cross referencing. Added at the request of the Counter Fraud Specialist to provide clarity

Page	Rationale
106	Added at the request of the Counter Fraud Specialist to provide clarity
107	Added at the request of the Counter Fraud Specialist to provide clarity
108	Add clarity
115	Update to current practice
Pp118-119	Moved to other more relevant parts of the document

*excellent care for every patient,
every day, everywhere*

The Royal Bournemouth and
Christchurch Hospitals 
NHS Foundation Trust

CONSTITUTION

THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

Approval Process	Version	Issue Date	Review Date	Document Author(s)
Council of Governors Board of Directors	Final	May 2015	July 2016	Trust Secretary

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1. Interpretation and Definitions

- 1.1 Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.
- 1.2 References in this Constitution to any statute, statutory provision or subordinate legislation is a reference to it as it is in force from time to time including any amendment or re-enactment or subordinate legislation made under it.
- 1.3 Any phrase introduced by the terms **including, include, in particular** or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.
- 1.4 Headings in this Constitution are used for convenience only and shall not affect the construction or interpretation of this Constitution.
- 1.5 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice versa.

2006 Act	means the National Health Service Act 2006.
2012 Act	means the Health and Social Care Act 2012.
Accounting Officer	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
Annual Members' Meeting	is defined in paragraph 11 of the Constitution.
Appointed Governors	means those Governors appointed by the Appointing Organisations.
Appointing Organisations	means those organisations named in this Constitution who are entitled to appoint Governors.
Auditor	means the person appointed to audit the accounts of the Trust who is called the auditor in the 2006 Act.
Board of Directors	means the Board of Directors of the Trust as constituted in accordance with this Constitution.
<u>Chairperson</u>	<u>means the chair of the Trust, or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution.</u>
Constitution	means this constitution and all annexes to it.
Council of Governors	means the Council of Governors as constituted in accordance with this Constitution, which has the same meaning as in the 2006 Act, as amended by the 2012 Act.
Director	means a member of the Board of Directors.

Elected Governor	means each Governor elected by the Public Constituency and the classes of the Staff Constituency.
Executive Director	means an executive director on the Board of Directors of the Trust.
Financial Year	means each successive period of twelve months beginning with 1 April.
Governor	means a member of the Council of Governors.
<u>Head Office</u>	<u>The Trust's head office is at the Royal Bournemouth Hospital, Castle Lane East, Bournemouth BH7 7DW.</u>
<u>Health Service in England</u>	<u>means the provision of Health Care in line with NHS core principles; that care should be universal, comprehensive and free at the point of need.</u>
<u>Lead Governor</u>	<u>means one (1) Governor appointed by the Council of Governors to lead the Council of Governors and to communicate directly with Monitor in certain circumstances.</u>
Local Authority Governor	means a Governor appointed by the local authorities listed in Annex 3 whose area includes the whole or part of the Trust.
Members' Meetings	means the Annual Members' Meeting and any Special Members' Meeting.
Monitor	is the body corporate known as Monitor, as provided by section 61 of the 2012 Act.
NHS Body	means an NHS foundation trust, the NHS Commissioning Board, an NHS trust, a clinical commissioning group, a special health authority or a Local Health Board.
Non-Executive Director	means an non-executive director on the Board of Directors of the Trust.
Panel	is defined in paragraph 19 of this Constitution.
Partner	means, in relation to another person, a member of the same household living together as a family unit.
Partnership Governor	means a Governor appointed by a Partnership Organisation.
Partnership Organisation	means those organisations specified in Annex 3 of this Constitution as Partnership Organisations, which are specified organisations for the purposes of sub-paragraph 9(7) of Schedule 7 of the 2006 Act, as amended by the 2012 Act.
Public Constituency	means that part of the Trust's membership consisting of members living in the area of the Trust specified in Annex 1.

Public Governor	means a Governor elected by the Public Constituency.
Secretary	means the secretary of the Trust , <u>the person appointed as the Secretary to the Trust or any other person appointed to perform the duties of secretary to the Trust , including a joint, assistant or deputy secretary, hereinafter to be referred to as the Secretary.</u>
<u>Senior Director</u> <u>Independent</u>	<u>means the non-executive Director appointed by the Board of Directors in accordance with paragraph 29.3 of this Constitution.</u>
Special Members' Meeting	shall have the meaning set out in Annex 8, Appendix 3, paragraph 1.2.
Staff Classes	means the classes of the Staff Constituency as specified in Annex 2.
Staff Constituency	means that that part of the Trust's membership consisting of the staff of the Trust and other person as described in paragraph 8 of this Constitution and which is divided into the Staff Classes.
Staff Governor	means a Governor elected by the members of one of the classes of Staff Constituency.
Trust	means The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

2. Name

The name of the Trust is The Royal Bournemouth and Christchurch Hospitals NHS Foundation 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 for the purpose of making additional income available in

order better to carry on its principal purpose.

4. Powers

- 4.1 The powers of the Trust are set out in the 2006 Act.
- 4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.
- 4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

5. Membership and Constituencies

- 5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:
 - 5.1.1 a Public Constituency; and
 - 5.1.2 a Staff Constituency.

6. Application for Membership

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

7. Public Constituency

- 7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.
- 7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.
- 7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

- 8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:
 - 8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
 - 8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

- 8.2 Individuals who exercise functions for the purposes of the Trust, 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. For the avoidance of doubt this does not include individuals who assist or provide services to the Trust on a voluntary basis.
- 8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.
- 8.4 The Staff Constituency shall be divided into five descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.
- 8.5 The Secretary shall make a final decision about the class of the Staff Constituency of which an individual is eligible for membership.
- 8.6 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic Membership by Default – Staff

9.1 An individual who is:

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

9.1.2 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 of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

10. Restriction on Membership

- 10.1 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.
- 10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.
- 10.3 An individual must be at least 12 years old to become a member of the Trust. Members must be 16 years old or over to vote in elections for Governors ~~or otherwise~~.

- 10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8, Appendix 2 – Further Provisions (Membership).

11. Annual Members' Meeting

- 11.1 The Trust shall hold an annual meeting of its members. The Annual Members' Meeting shall be open to members of the public.
- 11.2 Further provisions about the Annual Members' Meeting are set out in Annex 8, Appendix 3 – Further Provisions (Members' Meetings).

12. Council of Governors – Composition

- 12.1 The Trust is to have a Council of Governors, which shall comprise both elected and Appointed Governors.
- 12.2 The composition of the Council of Governors is specified in Annex 3.
- 12.3 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.

13. Council of Governors – Election

- 13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules using the first past the post system.
- 13.2 The Model Election Rules as published from time to time by the Department of Health form part of this Constitution. The Model Election Rules current at the date of this Constitution are attached at Annex 4.
- 13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 44 of the Constitution (Amendment of the Constitution).
- 13.4 An election, if contested, shall be by secret ballot.

14. Council of Governors - Tenure

- 14.1 An Elected Governor may hold office for a period of up to three years.
- 14.2 An Elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.
- 14.3 Subject to paragraph 14.7, an Elected Governor shall be eligible for re-

election at the end of his term.

14.4 An Appointed Governor may hold office for a period of up to three years.

14.5 An Appointed Governor shall cease to hold office if the Appointing Organisation withdraws its sponsorship of him.

14.6 Subject to paragraph 14.7, an Appointed Governor shall be eligible for re-appointment at the end of his term.

14.7 No Governor may serve for more than a total of nine consecutive years.

14.8 For the purposes of these provisions concerning terms of office for Governors, **year** means a period commencing immediately after the conclusion of the Annual Members' Meeting, and ending at the conclusion of the next Annual Members' Meeting.

15. Council of Governors – Disqualification and Removal

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

15.1.1 a person under 18 years of age;

~~15.1.1~~ 15.1.2 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

~~15.1.2~~ 15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

~~15.1.3~~ 15.1.4 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 him.

~~15.2 Governors must be at least 18 years of age at the date they are nominated for election or appointment.~~

~~15.3~~ 15.2 Further provisions as to the circumstances in which an individual may not become or continue, or may be removed, as a member of the Council of Governors are set out in Annex 5.

16. Council of Governors – Duties

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of

Directors; and

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

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

17. Council of Governors – Meetings

17.1 The ~~Chairman~~Chairperson of the Trust (i.e. the ~~Chairman~~Chairperson of the Board of Directors, appointed in accordance with the provisions of paragraph 26.1 below) or, in his absence the Vice-Chairman (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors.

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

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

18. Council of Governors – Standing Orders

18.1 The standing orders for the practice and procedure of the Council of Governors are attached at Annex 6.

19. Council of Governors – Referral to the Panel

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

19.1.1 to act in accordance with its constitution; or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - Conflicts of Interest

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

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

21. Council of Governors – Travel Expenses

- 21.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. These are to be disclosed in the annual report.

22. Council of Governors – further provisions

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

23. Board of Directors – Composition

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

- 23.2 The Board of Directors is to comprise:

23.2.1 a non-executive ~~Chairman~~Chairperson;

23.2.2 six other Non-Executive Directors; and

23.2.3 seven Executive Directors.

- 23.3 One of the Executive Directors shall be the Chief Executive.

- 23.4 The Chief Executive shall be the Accounting Officer.

- 23.5 One of the Executive Directors shall be the finance director.

- 23.6 One of the Executive Directors is to be a registered medical practitioner (a fully registered person within the meaning of the Medical Act 1983) or a registered dentist (within the meaning of the Dentists Act 1984).

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

23.8 The Board of Directors shall elect one of the Non-Executive Directors, in consultation with the Council of Governors, to be the Senior Independent Director of the Board. Any Non-Executive Director so elected may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman, and the Directors of the Trust may thereupon appoint another Non-Executive Director as Senior Independent Director in accordance with this paragraph.

23.9 The Directors shall at all times have one vote each save that where the number of votes for and against a motion is equal, the ~~Chairman~~Chairperson shall be entitled to exercise a second and casting vote.

24. Board of Directors – General Duty

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

25. Board of Directors – Qualification for Appointment as a Non-Executive Director

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

25.1.1 he is a member of a Public Constituency, and

25.1.2 he is not disqualified by virtue of paragraph 29 below.

26. Board of Directors – Appointment and Removal of ~~Chairman~~Chairperson and Other Non-Executive Directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the ~~chairman~~Chairperson of the Trust and the other Non-Executive Directors.

26.2 Removal of the ~~chairman~~Chairperson or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

27. Board of Directors – Appointment of Vice-~~Chairman~~Chairperson

27.1 The Council of Governors at a general meeting of the Council of Governors shall approve the appointment by the NED Nomination and Remuneration Committee Board of Directors shall appoint one of a the Non-Executive Directors as a Vice-~~Chairman~~Chairperson. The appointed Non- Executive Director may also be the Senior Independent Director-who will be appointed by the Board of Directors.

28. Board of Directors - Appointment and Removal of the Chief Executive and Other Executive Directors

28.1 A committee whose members shall be the ~~Chairman~~Chairperson and at

least two other Non-Executive Directors shall appoint or remove the Chief Executive.

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

28.3 A committee consisting of the ~~Chairman~~Chairperson, the Chief Executive and at least two other Non-Executive Directors shall appoint or remove the other Executive Directors.

29. Board of Directors – Disqualification

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

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

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

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

29.2 Further provisions as to the circumstances in which an individual may not become or continue as a Director on the Board of Directors are set out in Annex 8, Appendix 4 -Further Provisions (Board of Directors).

30. Board of Directors – Meetings

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

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

31. Board of Directors – Standing Orders

31.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 7.

32. Board of Directors - Conflicts of Interest

32.1 The duties that a Director of the Trust has by virtue of being a Director

include in particular:

- 32.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.
- 32.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.
- 32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if :
 - 32.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
 - 32.2.2 the matter has been authorised in accordance with the Constitution.
- 32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.
- 32.4 In sub-paragraph 32.1.2, **third party** means a person other than:
 - 32.4.1 the Trust, or
 - 32.4.2 a person acting on its behalf.
- 32.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.
- 32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.
- 32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.
- 32.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.
- 32.9 A Director need not declare an interest:
 - 32.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;
 - 32.9.2 if, or to the extent that, the Directors are already aware of it;
 - 32.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered –

32.9.3.1 by a meeting of the Board of Directors, or

32.9.3.2 by a committee of the Directors appointed for the purpose under the Constitution.

33. Board of Directors – Remuneration and Terms of Office

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

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

34. Registers

34.1 The Trust shall have:

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

34.1.2 a register of members of the Council of Governors;

34.1.3 a register of interests of Governors;

34.1.4 a register of Directors; and

34.1.5 a register of interests of the Directors.

35. Admission to and removal from the registers

35.1 The members of the Trust are those individuals whose names are entered in the register of members.

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

35.3. The Secretary is to send to Monitor a list of persons who are elected or appointed as Governors or Directors.

36. Registers – inspection and copies

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

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

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

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

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

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

37. Documents available for public inspection

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

37.1.1 a copy of the current Constitution;

37.1.2 a copy of the latest annual accounts and of any report of the Auditor on them;

37.1.3 a copy of the latest annual report;

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

37.1.5 a copy of the Trust's membership development strategy; and

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

37.2 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:

37.2.1 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.

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

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

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

- 37.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.
- 37.2.6 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 (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.
- 37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
- 37.2.8 a copy of any final report published under section 65I (administrator's final report).
- 37.2.9 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.
- 37.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.
- 37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.
- 37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Auditor

- 38.1 The Trust shall have an Auditor.
- 38.2 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors.

39. Audit committee

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

40. Accounts

- 40.1 The Trust must keep proper accounts and proper records in relation to the accounts.
- 40.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

- 40.3 The accounts are to be audited by the Trust's Auditor.
- 40.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.
- 40.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

41. Annual report, forward plans and non-NHS work

- 41.1 The Trust shall prepare an Annual Report and send it to Monitor.
- 41.2 The Trust shall give information as to its forward planning in respect of each Financial Year to Monitor.
- 41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.
- 41.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.
- 41.5 Each forward plan must include information about:
- 41.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and
 - 41.5.2 the income it expects to receive from doing so.
- 41.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 41.7.1 the Council of Governors:
- 41.6.1 must determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and
 - 41.6.2 notify the Directors of the Trust of its determination.
- 41.7 A trust which proposes to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.

42. Presentation of the annual accounts and reports to the Governors and members

- 42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:
- 42.1.1 the annual accounts;
 - 42.1.2 any report of the Auditor on them; and
 - 42.1.3 the annual report.
- 42.2 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.
- 42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

43. Instruments

- 43.1 The Trust shall have a seal.
- 43.2 The seal shall not be affixed except under the authority of the Board of Directors.

44. Amendment of the Constitution

- 44.1 The Trust may make amendments of its Constitution only if:
- 44.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments, and
 - 44.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments.
- 44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.
- 44.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):
- 44.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and
 - 44.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.
- 44.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect

and the Trust must take such steps as are necessary as a result.

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

45. Mergers etc. and significant transactions

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

45.2 The Constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

46. Dispute Resolution Procedures

46.1 In the event of any dispute about the entitlement to membership the dispute shall be referred to the Secretary who shall make a determination on the point in issue. If a member or applicant (as they case may be) is aggrieved of the decision of the Secretary he may appeal in writing to the Council of Governors within 14 days of the Secretary's decision. The decision of the Council of Governors shall be final.

46.2 In the event of any dispute about the eligibility, disqualification and removal of a Governor, the dispute shall be referred to the Council of Governors whose decision shall be final. The dispute must be notified to the Secretary within 28 days of the decision leading to the dispute.

46.3 In the event of dispute between the Council of Governors and the Board of Directors or between a Governor and the Council of Governors:

46.3.1 In the first instance the ~~Chairman~~Chairperson on advice of the Secretary, and such other advice as the ~~Chairman~~Chairperson may see fit to obtain, shall seek to resolve the dispute;

46.3.2 If the ~~Chairman~~Chairperson is unable to resolve the dispute he 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

46.3.3 If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the ~~Chairman~~Chairperson may refer the dispute back to the Board of Directors who shall make the final decision.

46.4 In the event of any dispute between a governor and the Council of Governors the dispute shall be referred within 28 days of it arising to the Secretary who shall make a determination on the point in issue and will reference the Chairperson and Council of Governors as necessary.

47. Indemnity

47.1 Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Council of Governors and the Board of Directors and the Secretary.

48. Notices

48.1 Any notice required by this Constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. **Address** in relation to electronic communications includes any number or address used for the purposes of such communications.

48.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice as given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

ANNEX 1 - THE PUBLIC CONSTITUENCY

Name of Area	Description	Minimum Number of Members
Bournemouth and Poole	The electoral area covered by Bournemouth and Poole Borough Councils	4
Christchurch and Dorset County	The electoral areas covered by Christchurch Borough Council and the rest of Dorset County Council	4
New Forest, Hampshire and Salisbury	<p>The following electoral divisions covered by New Forest Council:</p> <p>Downlands and Forest Fordingbridge Forest North West Ringwood North Ringwood South Ringwood East and Sopley Bransgore and Burley Bashley Fernhill Milton Barton Becton Milford Hordle Pennington Lymington town Buckland Boldre and Sway Brockenhurst and forest South East Lyndhurst Bramshaw, Copythorne North and Minstead Ashurst, Copythorne South and Netley Totton North Totton West Totton East Totton Central Totton South Marchwood Dibden and Hythe East Hythe and Langdown Butts Ash and Dibden Purlieu Furzedown and Hardley Holbury and North Blackfield Fawley, Blackfield and Langley</p>	4

	<p>The following electoral divisions covered by Wiltshire Council:</p> <p>Bemerton St. Mark and Stratford Bishopdown St. Paul Fisherton and Bemerton Village St. Edmund and Milford St. Martin and Milford Harnham West Harnham East Ebble Downton and Redlynch Alderbury and Whiteparish</p> <p>The following electoral divisions covered by Hampshire County Council:</p> <p>Blackwater Romsey Extra Chilworth, Nursling and Rownhams Cupernham Abbey Tadburn North Baddesley Valley Park Hiltingbury West Hiltingbury East Chandlers Ford West Chandlers Fords East Eastleigh North Eastleigh Central Eastleigh South Bishopstoke West Bishopstoke East Fair Oak and Horton Heath West End North West End South Botley Hedge End Grange Park Hedge End Wildern Hedge End St John's Bursledon and Old Netley Netley Abbey Hamble-le-Rice and Butlocks Heath</p> <p>The following electoral divisions covered by Southampton City Council:</p>	
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	Redbridge Coxford Bassett Millbrook Shirley Portswood Swaythling Freemantle Bargate Bevois Bitterne Park Harefield Peartree Sholing Woolston	
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ANNEX 2 - THE STAFF CONSTITUENCY

Name of Class	Minimum Number of Members
Medical and Dental	4
Nursing, Midwifery and Healthcare Assistants	4
Estates and Ancillary Services	4
Allied Health Professions, Scientific and Technical	4
Administrative, Clerical and Management	4

ANNEX 3 - COMPOSITION OF THE COUNCIL OF GOVERNORS

1. Public Elected Governors

There are 18 Governors in the Public Constituency.

Area	Number of Governors
Bournemouth and Poole	9
Christchurch and Dorset County	6
New Forest, Hampshire and Salisbury	3

2. Staff Elected Governors

There are five Governors in the Staff Constituency from the following Staff Classes:

Staff Class	Number of Governors
Medical and Dental	1
Nursing, Midwifery and Healthcare Assistants	1
Estates and Ancillary Services	1
Allied Health Professions, Scientific and Technical	1
Administrative, Clerical and Management	1

3. Appointed Governors

There are six Appointed Governors.

Appointing Organisation	Number of Governors
Local Authority Governors	
Bournemouth Borough Council	1
Borough of Poole	1
Dorset County Council	1
Partnership Organisations	
Bournemouth University	1
NHS Dorset Clinical Commissioning Group	1
The Royal Bournemouth and Christchurch Hospitals Volunteers Group	1

4. Majority of Public Governors

4.1. The aggregate number of Governors on the Council of Governors in the Public Constituency must be more than half of the total number of members of the Council of Governors.

4.2. Where for any reason the aggregate number of Governors on the Council of Governors in the Public Constituency falls to the same number or below the number of the other Governors then the Appointed Governors shall temporarily

stand down in the following order, until there is a majority of Governors on the Council of Governors in the Public Constituency. In such circumstances, the Governors that have stood down will be permitted to attend Council of Governors meetings but will not have a vote:

- firstly, the Governor from NHS Dorset Clinical Commissioning Group;
- secondly, the most recently appointed Local Authority Governor; and
- thirdly, the most recently appointed Partnership Governor (not including the Governor from NHS Dorset Clinical Commissioning Group).

4.3. The validity of any act of the Trust is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

5. Appointment Process for Appointed Governors

Each of the Appointing Organisations listed above are entitled to appoint a Governor in accordance with a process agreed with the Trust.

6. Policy on Composition of the Council of Governors

6.1. The Council of Governors, subject to the 2006 Act, shall seek to ensure that through the composition of the Council of Governors:

- 6.1.1. the interest of the community served by the Trust are appropriately represented;
- 6.1.2. the level of representation of the Public Constituency and the classes of the Staff Constituency and the Appointing Organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs,

and to this end, the Council of Governors

- 6.1.3. shall at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy; and
- 6.1.4. shall from time to time and not less than every three years review the policy for the composition of the Council of Governors; and
- 6.1.5. when appropriate shall propose amendments to the Constitution.

ANNEX 4 - MODEL ELECTION RULES

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

“2006 Act” means the National Health Service Act 2006;

“corporation” means the public benefit corporation subject to this constitution;

“council of governors” means the council of governors of the corporation;

“declaration of identity” has the meaning set out in rule 21.1;

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

“e-voting” means voting using either the internet, telephone or text message;

“e-voting information” has the meaning set out in rule 24.2;

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

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

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

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

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

“Monitor” means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

“numerical voting code” has the meaning set out in rule 64.2(b)

“polling website” has the meaning set out in rule 26.1;

“postal voting information” has the meaning set out in rule 24.1;

“telephone short code” means a short telephone number used for

the purposes of 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 ELECTION

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 and;

~~-(c) they are 18 years of age or over.~~

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.

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

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

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

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

- (a) the board of directors and the council of governors of the corporation have approved:
 - (i) the use of such software for the purpose of counting votes in the relevant election, and
 - (ii) a policy governing the use of such software, and
- (b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

- (a) count and record the number of:
 - (iii) ballot papers that have been returned; and
 - (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
- (b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates

information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

- 43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. Rejected ballot papers and rejected text voting records

44.1 Any ballot paper:

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which 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 44.2 and 44.3, be rejected and not counted.

- 44.2 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.

44.3 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.

44.4 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 44.2 and 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

44.5 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.

44.6 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 44.7 and 44.8, be rejected and not counted.

44.7 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.

44.8 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.

44.9 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 44.7 and 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

44.10 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.

45. Equality of votes

45.1 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

46. Declaration of result for contested elections

46.1 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~~Chairperson of the NHS Trust, or
 - (ii) in any other case, to the ~~chairman~~Chairperson of the corporation; and
- (c) give public notice of the name of each candidate whom he or she has declared elected.

46.2 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 44.5,
- (c) the number of rejected text voting records under each of the headings in rule 44.10,

available on request.

47. Declaration of result for uncontested elections

47.1 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~~Chairperson 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

48. Sealing up of documents relating to the poll

48.1 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.

48.2 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.

48.3 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.

49. Delivery of documents

49.1 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.

50. Forwarding of documents received after close of the poll

50.1 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~~Chairperson of the corporation.

51. Retention and public inspection of documents

- 51.1 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.
- 51.2 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.
- 51.3 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.

52. Application for inspection of certain documents relating to an election

- 52.1 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.
- 52.2 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.

52.3 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.

52.4 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

53. Countermand or abandonment of poll on death of candidate

53.1 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.

53.2 Where a new election is ordered under rule 59.1, 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.

53.3 Where a poll is abandoned under rule 59.1(a), rules 59.4 to 59.7 are to apply.

53.4 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.

53.5 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.

53.6 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.

53.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules 59.4 to 59.6, the returning officer is to deliver them to the ~~chairman~~Chairperson of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

54. Election expenses

- 54.1 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.

55. Expenses and payments by candidates

- 55.1 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.

56. Election expenses incurred by other persons

- 56.1 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.

- 56.2 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

57. Publicity about election by the corporation

- 57.1 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.

57.2 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.

57.3 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.

58. Information about candidates for inclusion with voting information

58.1 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.

58.2 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 a photograph of the candidate.

59. Meaning of “for the purposes of an election”

59.1 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.

- 59.2 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

60. Application to question an election

- 60.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

- 60.2 An application may only be made once the outcome of the election has been declared by the returning officer.

- 60.3 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.

- 60.4 The application must:

- (a) describe the alleged breach of the rules or electoral irregularity, and
- (b) be in such a form as the independent panel may require.

- 60.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

- 60.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

- 60.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

- 60.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of

the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

- 60.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

61. Secrecy

- 61.1 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.

- 61.2 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.

- 61.3 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.

62. Prohibition of disclosure of vote

- 62.1 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.

63. Disqualification

- 63.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

- (a) a member of the corporation,
- (b) an employee of the corporation,
- (c) a director of the corporation, or
- (d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

- (a) the delivery of the documents in rule 24, or
- (b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 22)

1. Eligibility to be on the Council of Governors

- 1.1. A person may not become or continue as a Governor, and if already holding such office will immediately cease to do so if:
 - 1.1.1. any of the grounds contained in paragraph 15 of the Constitution apply to him;
 - 1.1.2. they are under 18 years of age;
 - 1.1.3. they are a Director of the Trust, or a governor or director of another NHS Body or of an independent/private sector healthcare provider. These restrictions do not apply to Appointed Governors;
 - 1.1.4. they are the spouse, Partner, parent or child of a member of the Board of Directors;
 - 1.1.5. being a member of the Public Constituency, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;
 - 1.1.6. they are subject to a sex offender order;
 - 1.1.7. they are subject to an unexpired disqualification order made under the Company Directors Disqualification Act 1986;
 - 1.1.8. they have within the preceding two years been lawfully dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS Body;
 - 1.1.9. they are a person whose tenure of office as the ~~chairman~~Chairperson or as a member or director of an 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;
 - 1.1.10. they have had their name removed from any list maintained by health and care professional bodies in the UK, and have not subsequently had their name included on such a list;
 - 1.1.11. they have previously been expelled as a governor of a foundation trust in the previous nine years.

2. Disqualification as a Governor

- 2.1. A person holding office as a Governor shall immediately cease to do so if:
 - 2.1.1. they cease to fulfil the requirements of paragraph 1 above;
 - 2.1.2. they resign by notice in writing to the Secretary;
 - 2.1.3. they fail to attend two consecutive meetings of the Council of Governors, unless the Council of Governors is satisfied that:
 - 2.1.3.1. the absences were due to reasonable causes; and
 - 2.1.3.2. they will be able to start attending meetings of the Council of Governors again within such a periods as is considered reasonable by the Council of Governors;
 - 2.1.4. in the case of an Elected Governor, they cease to be a member of the constituency or class of constituency by which they were elected;
 - 2.1.5. in the case of an Appointed Governor, the Appointing Organisation terminates the appointment or the Appointing Organisation ceases to exist;
 - 2.1.6. they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;
 - 2.1.7. they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the code of conduct for Governors;
 - 2.1.8. they are removed from the Council of Governors pursuant to paragraph 3 below
- 2.2. The process for disqualification of a Governor is set out in paragraph 6.1 of the Council of Governor's Standing Orders (Annex 6).

3. Removal as a Governor

- 3.1. A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting at a meeting of the Council of Governors on the grounds that:
 - 3.1.1. they have committed a serious breach of the code of conduct for Governors;

- 3.1.2. they have acted in a manner detrimental to the interests of the Trust; and
- 3.1.3. the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor.
- 3.2. The process for removing a Governor from office is set out in paragraph 6.2 of the Council of Governor's Standing Orders (Annex 6).

4. Roles and responsibilities of the Council of Governors

- 4.1. The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with this Constitution are to:
 - 4.1.1. carry out in the general duties of the Council of Governors as set out in paragraph 16 of the Constitution;
 - 4.1.2. appoint or remove the ~~Chairman~~Chairperson and the other Non-Executive Directors;
 - 4.1.3. approve an appointment (by the Non-Executive Directors) of the Chief Executive;
 - 4.1.4. decide the remuneration and allowances and the other terms and conditions of office of the Non-Executive Directors;
 - 4.1.5. appoint or remove the Trust's Auditor;
 - 4.1.6. be presented with the annual accounts, any report of the Auditor on them and the annual report;
 - 4.1.7. approve the application for any merger, acquisition, separation, dissolution or the entering into of any significant transaction by the Trust;
 - 4.1.8. approve changes to the Constitution;
 - 4.1.9. vote on whether to approve the referral of a question to any Panel appointed by Monitor as to whether the Trust has failed or is failing to act in accordance with this Constitution or to act in accordance with provision made by or under Chapter 5 of the 2006 Act;
 - 4.1.10. require one or more of the Directors to attend a general meeting of the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties;
 - 4.1.11. decide whether to propose a vote on the Trust's or Directors' performance;

- 4.1.12. provide their views to the Board of Directors when the Board of Directors is preparing any document containing information about the Trust's forward planning;
- 4.1.13. determine whether it is satisfied that the carrying on of activities other than the provision of goods and services for the purposes of the health service in England proposed in the forward plan will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions;
- 4.1.14. approve the implementation of any increase of 5% or more in the proportion of the Trust's total income in any Financial Year attributable to activities other than the provision of goods and services for the purposes of the health service in England;
- 4.1.15. respond as appropriate when consulted by the Board of Directors in accordance with this Constitution;
- 4.1.16. undertake such functions as the Board of Directors may from time to time request;
- 4.1.17. prepare and from time to time review the Trust's membership strategy, and its policies for the composition of the Council of Governors and Non-Executive Directors, and when appropriate, to make recommendations;
- 4.1.18. to approve and from time to time (and at least every three years) review the Trust's membership strategy and its policy for the composition of the Council of Governors;
- 4.1.19. to consider disputes as to membership referred to them pursuant to paragraph 1.1 of Appendix 5 of Annex 8; and
- 4.1.20. exercise such other powers and to discharge such other duties as may be conferred on the Council of Governors under this Constitution and the 2006 Act.

5. Governors ~~V~~vacancies ~~amount~~ ~~Governors~~

- 5.1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply:
 - 5.1.1. Where the vacancy arises amongst the Appointed Governors, the Secretary shall request that the Appointing Organisation appoints a replacement to hold office for the remainder of the term of office.

5.1.2. If the term of office of an Elected Governor is terminated before it expires-, the Council of Governors shall be at liberty either:

5.1.2.1. -to call an election within three months to fill the seat for the remainder of that term of office; ~~or or~~

5.1.2.2. -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 for any unexpired period of the term of office ~~or; 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.~~

5.1.2.3. Carry the vacancy.

6. Remuneration of Governors

6.1. Governors are not to receive remuneration.

ANNEX 6

STANDING ORDERS - COUNCIL OF GOVERNORS

This document provides a regulatory and business framework for the conduct of the Council of Governors.

1. INTERPRETATION AND DEFINITIONS

- 1.1 Save as otherwise permitted by law and subject to the Constitution, at any Council of Governors' meeting the ~~Chairman~~Chairperson's interpretation of these Standing Orders (on which he should be advised by the Chief Executive or Secretary) shall be final.
- 1.2 Unless a contrary intention is evident or the context otherwise requires, the provisions relating to Interpretation and Definitions in paragraph 1 of the Constitution shall apply and the words or expressions contained in these Standing Orders shall bear the same meaning.
- 1.3 In these Standing Orders the following defined terms shall have the specific meanings given to them below:

~~Chairman~~Chairperson means the ~~Chairman~~Chairperson of the Trust.

~~Lead Governor~~ ~~Deputy Chairman~~Chairperson means one (1) Governor appointed by the Council of Governors to lead the Council of Governors and to communicate directly with Monitor in certain circumstances.~~means the Public Governor appointed by the Council of Governors to be deputy chairman~~Chairperson of the Council of Governors, subject to annual re-election by the Council of Governors.

Officer means employee of the Trust or any other person holding a paid appointment or office with the Trust.

~~Secretary~~ means the Trust Secretary or officer to whom he has delegated this duty.

SFIs means Standing Financial Instructions.

SOs means these Standing Orders of the Council of Governors.

2. MEETINGS OF THE COUNCIL OF GOVERNORS

2.1 Admission of the Public

The meetings of the Council of Governors shall be open to members of the public except when the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The ~~Chairman~~Chairperson may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

2.2 **ChairmanChairperson of the Meeting**

At any meeting of the Council of Governors, the **ChairmanChairperson**, if present, shall preside. If the **ChairmanChairperson** is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest the Vice-**ChairmanChairperson** shall preside. If the **ChairmanChairperson** and Vice-**ChairmanChairperson** are absent from the meeting or absent temporarily on the grounds of a declared conflict of interest, such Non-Executive Director as the Governors present shall choose shall preside. If the person presiding has a conflict of interest in relation to the business being discussed the **Lead Governor Deputy Chairman** of the Council of Governors will chair that part of the meeting.

2.3 **Calling Meetings**

2.3.1 The Council of Governors will meet at least four times in each Financial Year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least 14 days' written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published ~~in a local newspaper or newspapers circulating in the area served by the Trust and~~ on the Trust's website and in other locations and media as considered appropriate. Seminars, workshops or similar events involving governors are not to be treated as meetings of the Council of Governors.

2.3.2 Meetings of the Council of Governors are called by the Secretary or by the **ChairmanChairperson** or by ten governors (including at least two Public or Staff Governors and two Appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all governors as soon as possible after receipt of such a request. The Secretary shall call a meeting within at least fourteen but not more than 28 days to discuss the specified business. If the Secretary fails to call such a meeting, within seven clear days, then the **ChairmanChairperson** or ten governors, whichever is the case, shall call such a meeting.

2.3.3 Subject to SO 2.3.4 below, lack of service of the notice of the business of the meeting on any governor shall not affect the validity of a meeting.

2.3.4 Failure to serve such a notice on more than half of the governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in

the ordinary course of the post or, where the notice is sent by email, at the time at which the email is sent.

- 2.3.5 In the case of a meeting being called by ten governors in default of the Secretary or ~~Chairman~~Chairperson, the notice shall be signed by those members of the Council of Governors and no business shall be transacted at the meeting other than that specified in the notice.

2.4 **Agenda of Meetings and Motions on Notice**

- 2.4.1 Agendas and supporting papers will normally be issued to arrive with governors no later than seven days in advance of the meeting. Draft minutes of the previous meeting will be circulated with these papers for approval as a specific agenda item.
- 2.4.2 A governor desiring a matter to be included on an agenda including a formal proposition for discussion and voting on at a meeting shall make his request in writing to the Secretary at least 21 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 21 clear days before a meeting may be included on the agenda at the discretion of the ~~Chairman~~Chairperson. Receipt of such matters via electronic means is acceptable.
- 2.4.3 Motions for which notice has been given will be listed on the agenda unless the governor giving notice states, in writing, that they propose to move it to a later meeting or withdraw it.
- 2.4.4 Motions must be about matters for which the Council of Governors has a responsibility or which affect the area covered by the Trust.
- 2.4.5 There will not be an agenda item entitled 'Any Other Business'. See ~~Standing Order~~SO 2.4.2 for inclusion of agenda items. Instead, there will be an item for Questions on Notice, which is subject to ~~Standing Order~~Order 2.7 below.

2.5 **Motions without Notice**

- 2.5.1 The following motions may be moved without notice:
- (a) To change the order of business on the agenda
 - (b) To refer a matter to an appropriate body or individual
 - (c) To appoint a working group arising from an item on the agenda for the meeting

- (d) To receive reports or adopt recommendations made by the Board of Directors
- (e) To withdraw a motion
- (f) To amend a motion
- (g) To proceed to the next business
- (h) That the question now be put
- (i) To adjourn a debate
- (j) To adjourn a meeting
- (k) To suspend a particular Standing Order; see Standing Order 7.1 for further details.
- (l) To not hear further a governor, or to exclude them from the meeting. If a governor persistently disregards the ruling of the ChairmanChairperson by behaving improperly or offensively or deliberately obstructs business, the ChairmanChairperson may move that the governor not be heard further. If seconded, the motion will be voted on without discussion. If the governor continues to behave improperly after such a motion is carried the ChairmanChairperson may move that the governor leaves the meeting room or that the meeting is adjourned for a specified period. If seconded, the motion will be voted on without discussion.
- (m) To give consent of the Council where its consent is required by the Constitution.

2.6 Voting/Decision-Making

- 2.6.1 Save as provided otherwise in the Constitution, and/or the 2006 Act and/or the 2012 Act, the 2006 Act and these Standing Orders, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes of those present (in person) and voting.
- 2.6.2 Where a vote or approval of the Council of Governors is required pursuant to sections 37 (Amendments of constitution), 39A (Panel for advising governors), 43(3D) (Authorised services), 51A (Significant transactions), 56 (Mergers), 56A (Acquisitions), 56B (Separations) or 57A (Dissolutions) of the 2006 Act, a Governor entitled to attend and vote at the meeting of the Council of Governors may appoint the ChairmanChairperson, or anyone else presiding at the meeting or another governor as his proxy to attend and, on a paper ballot, to vote at the meeting on his behalf. Proxies validly appointed in accordance with these Standing Orders shall be deemed to be present at the meeting of the Council of Governors in determining the required majority on any vote in respect of which a proxy may be appointed.
- 2.6.3 The governor appointing a proxy may direct the proxy how to vote at the meeting or may allow the proxy to choose how to vote. A governor appointing a proxy may revoke the proxy by delivering a notice in writing to the Secretary before the start of

the meeting to which it relates or by attending the meeting in person.

- 2.6.4 The form for appointing a proxy shall be in writing, signed by the governor appointing the proxy and made in such form and include such declarations as the Council of Governors may from time to time determine. Any proxy appointed not using the agreed form shall be invalid. The signed form appointing a proxy must be received by the Secretary not less than 48 hours before the time and date of the meeting, or adjourned meeting, and shall not be treated as valid if received after this time.
- 2.6.5 At a meeting of the Council of Governors a vote shall be decided on a show of hands, the result being declared by the ~~Chairman~~Chairperson and recorded in the minutes. The entry in the minutes shall confirm the result without recording the number or proportion in favour or against the motion unless a request is made under ~~Standing Order~~ 2.6.7. Every Governor shall have one vote whether voting in person or by proxy. All valid proxies received for a vote at a meeting of the Council of Governors shall be declared at the meeting and recorded in the minutes regardless of whether a vote is taken by paper ballot.
- 2.6.6 A paper ballot may be used if a majority of the governors present so request. A proxy shall be deemed to have the authority to join in the request for a paper ballot on behalf of the governor(s) appointing the proxy. If a paper ballot is to be used, it shall be taken at such time and place and in such a manner as the ~~Chairman~~Chairperson of the meeting shall direct and the result of the ballot shall be deemed to be the resolution of the meeting at which the ballot was demanded. The demand for a ballot shall not prevent the continuance of a meeting for the transaction of any business other than the question on which a ballot has been demanded.
- 2.6.7 If at least one-third of the governors present so request, the voting on any question may be recorded to show how each governor present voted or abstained.
- 2.6.8 In the case of an equality of votes, whether on a show of hands or a ballot, the ~~Chairman~~Chairperson shall have a second or casting vote.
- 2.6.9 No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.
- 2.6.10 All decisions taken in good faith at a meeting of the Council of Governors shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the governors attending the meeting.

2.7 Questions from Governors

2.7.1 A governor may ask any question through the ~~Chairman~~Chairperson without notice upon a report from an Executive Director or other Officer of the Trust when that item is being received or under consideration by the Council of Governors.

2.7.2 Questions relating to matters other than those under report may be asked with due notice. For the avoidance of confusion, questions on notice must be given in writing (including email) to the Secretary at least 14 days in advance of the meeting. If the question is urgent and with the agreement of the person to whom the question is to be put, the content of the question may be given to the Secretary by 10.00 a.m. on the day of the meeting (if the meeting is scheduled for the afternoon) or by 2.00 p.m. on the preceding day (if the meeting is scheduled for the morning). Urgent is defined as a matter that will adversely affect the Trust in the next seven days.

2.8 ~~Chairman~~Chairperson's Ruling

Statements of members of the Council of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the ~~Chairman~~Chairperson of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

2.9 Attendance

The names of the ~~Chairman~~Chairperson and Governors present at the meeting shall be recorded in the minutes. Governors who are unable to attend the Council of Governors meeting should advise the Secretary in advance so that their apologies may be recorded.

2.10 Quorum

2.10.1—No business shall be transacted at a meeting unless at least twelve governors are present in person, which must include at least four Public Governors and one Staff Governor.

2.10.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting the meeting will stand adjourned for five clear days and upon reconvening those present shall constitute a quorum.

2.10.23 If the ~~Chairman~~Chairperson or any governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

2.11 Minutes

2.11.1 The minutes of the proceedings of a meeting shall be prepared and submitted to be read and for agreement at the next meeting of the Council of Governors where they will be considered to have been signed by the person presiding at it. The approved signed minutes will be conclusive evidence of the events of the meeting and retained in an electronic minute book held by the Trust Secretary.-

2.11.2 No discussion shall take place upon the minutes, except upon their accuracy, or where the ~~Chairman~~Chairperson considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

3. COMMITTEES

3.1 The Council of Governors may not delegate any of its powers to a committee or sub-committees, but it may appoint committees to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

3.2 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors.

3.2 Each committee and sub-committee shall have such terms of reference and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with any guidance issued by Monitor and any legislation or applicable guidance issued by the Secretary of State.

3.3 The Council of Governors shall establish the Non-Executive Director Nomination and Remuneration Committee, ~~the Nominations Committee~~ and such other committees as required to assist the Council of Governors in discharging its responsibilities.

- 3.4 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.
- 3.5 A governor or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the committee shall resolve that it is confidential.

4. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

4.1. Declaration of Interests

- 4.1.1 Any governor who has a material interest in a matter as defined below shall declare such interest to the Council of Governors via the Secretary.
- 4.1.2 Any governor who fails to declare any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining governors.
- 4.1.3 Subject to the exceptions below, a material interest
- is any directorship of a company;
 - any interest held by a governor or his spouse/partner in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;
 - any interest in an organisation providing health and social care services to the National Health Service; and
 - a position of authority in a charity or voluntary organisation in the field of health and social care.
- 4.1.4 The exceptions which shall not be treated as material interests are as follows:
- shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;
 - an employment contract held by Staff Governors;

- a contract with their Clinical Commissioning Group held by a Partnership Governor appointed by a Clinical Commissioning Group;
 - an employment contract with a Local Authority held by a Local Authority Governor; and
 - an employment contract with a Partnership Organisation held by a Partnership Governor.
- 4.1.5 It is the obligation of the governor to inform the Secretary in writing within seven days of becoming aware of the existence of an interest. If a governor is in any doubt whether an interest should be disclosed, they should discuss the position with the ~~Chairman~~Chairperson or Secretary
- 4.1.6 A governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a member of the Council of Governors. A governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of governors.

4.2 Conflict of Interest

During the course of a Council of Governors meeting, if a conflict of interest is disclosed the governor concerned shall withdraw from the meeting and take no further part in the matter under discussion.

4.3 Register of Interests

- 4.3.1 The Secretary will ensure that a register of interests is maintained to record formally the declarations of interests of governors.
- 4.3.2 The details on the register shall be reviewed at every meeting of the Council of Governors.
- 4.3.3 The register will be available to the public on request.
- 4.3.4 In establishing, maintaining, updating and publicising the register, the Trust shall comply with all guidance issued from time to time by Monitor.

5. STANDARDS OF BUSINESS CONDUCT

- 5.1 Governors must comply with the Constitution, the Trust's governor Code of Conduct, the NHS Foundation Trust Code of Governance Conduct for

Governors, the requirements of the law and any guidance issued by Monitor.

- 5.2 Governors will confirm their agreement to adhere to the Trust's Code of Conduct by signing a copy annually and returning it to the Secretary.
- 5.3 Canvassing of Directors or **gG** governors or of any members of any committee of the Trust directly or indirectly for any appointment by the Trust shall disqualify the candidate for such appointment.
- 5.4 A governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this **Standing Order** shall not preclude a governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.
- 5.5 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.
- 5.6 Governors will be permitted to gain access to membership data if:
 - 5.6.1 they have explained the intended use to the Secretary;
 - 5.6.2 the Secretary has agreed the use; and
 - 5.6.3 they agree to keep the information secure and have regard for the Data Protection Principles.

6. SPECIAL PROVISIONS RELATING TO THE DISQUALIFICATION AND REMOVAL OF A GOVERNOR'S TENURE

6.1 Disqualification

- 6.1.1 Grounds - The grounds for disqualification are as set out in paragraph 15 of the Constitution.
- 6.1.2 Process - Where a person has been elected or appointed to be a governor and he becomes disqualified from office under paragraph 15 of the Constitution, he shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which render him disqualified. The Secretary shall remove him from the register of the governors immediately.
- 6.1.3 If it comes to the notice of the Secretary that the governor is disqualified under paragraph 15 of the Constitution, whether at the time of the governor's appointment or later, the Secretary shall immediately declare that the individual in question is disqualified and give him notice in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration. In the event that the governor shall dispute that he is disqualified

the governor may refer the matter to the dispute resolution procedures set out in Annex 8, Appendix 5, Paragraph 1 of this Constitution within 28 days of the date upon which the notice was given to the governor.

6.2 Removal

- 6.2.1 Grounds – The grounds for removal are as set out in paragraph 15 of the Constitution.
- 6.2.2 Process - The ~~Chairman~~Chairperson shall be authorised to take such action as may be immediately required, including but not limited to exclusion of the governor concerned so that any allegation made against a governor on any of the grounds set out in paragraph 15 of the Constitution can be investigated.
- 6.2.3 Where any grounds within paragraph 15 of the Constitution are alleged, it shall be open to the Council of Governors to decide, by three-quarters of those present and voting, to lay a formal charge of non-compliance or misconduct.
- 6.2.4 The governor in question will be notified in writing of the allegations. The notification will detail the specific behaviour which is considered to be detrimental to the Trust and invite him to respond. His response will be considered within a defined, appropriate and reasonable timescale.
- 6.2.5 The governor may be invited to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence.
- 6.2.6 The governors, by three-quarters majority of those present and voting can decide whether to uphold the charge of non-compliance or misconduct detrimental to the Trust. If the charge is upheld then the governor will cease to be a governor with immediate effect and the Secretary shall cause his name to be removed immediately from the register of governors.

6.2.7 The governor in question will be permitted to appeal any decision of the Council of Governors to terminate his tenure of office made in accordance with Annex 5, Paragraph 3, in writing, within 28 days of the date upon which notice of the decision is received.

6.2.8 ~~6.2.7~~—Any appeal of the decision of the Council of Governors to terminate a governor's tenure of office may be referred by the governor concerned to the dispute resolution procedures set out in ~~Paragraph 46 of the Constitution~~Annex 8, Appendix 5, Paragraph 1 of the Constitution within ~~28~~14 days of the date upon

which notice in writing of the Council of Governors' decision made in accordance with Annex 5, Paragraph 3 of the Constitution is communicated to the governor concerned.

- 6.2.89 A governor who has been removed in accordance with these provisions shall not be eligible to stand for re-election to the Council of Governors for a period of nine years from the date of his removal from office or the date upon which any appeal against his removal from office is disposed of, whichever is later.

7 STANDING ORDERS

7.1 Suspension of Standing Orders

- 7.1.1 Except where this would contravene any statutory provision or any direction made by Monitor, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors are present and that a majority of those present vote in favour of suspension.

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

- 7.1.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the ChairmanChairperson and the members of the Council of Governors.

- 7.1.4 No formal business may be transacted while the Standing Orders are suspended.

7.2 Amendment of Standing Orders

These Standing Orders may be amended only in accordance with paragraph 44 of the Constitution.

7.3 Review of Standing Orders

These Standing Orders shall be reviewed annually by the Council of Governors. The requirement for review extends to all documents having effect as if incorporated in these Standing Orders.

—8. Nominated Lead Governor

ANNEX 7

STANDING ORDERS - BOARD OF DIRECTORS

This document provides a regulatory and business framework for the conduct of the Board of Directors.

1 INTERPRETATION AND DEFINITIONS

- 1.1. Save as otherwise permitted by law, and subject to the Constitution, at any Board of Directors' meeting the ~~Chairman~~Chairperson's interpretation of these Standing Orders (on which he should be advised by the Chief Executive or Secretary) shall be final.
- 1.2. Wherever the title Chief Executive, Director or other Nominated Officer is used in these Standing Orders, it should be deemed to include such other officers who have been duly authorised to represent them in their absence.
- 1.3. Unless a contrary intention is evident or the context otherwise requires the provisions relating to Interpretation and Definitions in paragraph 1 of the Constitution shall apply and the words or expressions contained in these Standing Orders shall bear the same meaning.
- 1.4. In these Standing Orders the following defined terms shall have the specific meanings given to them below:

Chief Executive or **CEO** shall mean the Chief Officer of the Trust.

Committee shall mean a Committee appointed by the Trust.

Committee Members shall be persons formally appointed by the Trust to sit on or to chair specific Committees.

Director of Finance or **DOF** shall mean the Chief Finance Officer of the Trust.

Funds Held On Trust shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under section 51 of the 2006 Act. Such funds may or may not be charitable.

Motion means a formal proposition to be discussed and voted on during the course of a meeting.

Nominated Officer means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

Officer means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

SFIs means Standing Financial Instructions.

SOs means these Standing Orders of the Board of Directors.

2 THE TRUST

- 2.1 All business shall be conducted in the name of the Trust.
- 2.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to Funds Held On Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.
- 2.3 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable Funds Held On Trust is to the Charity Commission and to Monitor. Accountability for non-charitable Funds Held On Trust is only to Monitor.
- 2.4 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Reservation of Powers and Scheme of Delegation of the Board of Directors.
- 2.5 Powers of the Vice-~~Chairman~~Chairperson - Where the ~~Chairman~~Chairperson of an NHS Foundation Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as ~~Chairman~~Chairperson owing to illness, absence from England and Wales or any other cause, references to the ~~Chairman~~Chairperson in these SOs shall, so long as there is no ~~Chairman~~Chairperson able to perform his duties, be taken to include references to the Vice-~~Chairman~~Chairperson.
- 2.6 Joint Directors - Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count for the purpose of SO 3.8.1 as one person.

3 MEETINGS OF THE BOARD OF DIRECTORS

3.1 Admission of the Public

- 3.1.1 The meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds. The ~~Chairman~~Chairperson may exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

3.2 ~~Chairman~~Chairperson of the Meeting

- 3.2.1 At any meeting of the Trust, the ~~Chairman~~Chairperson, if present, shall preside. If the ~~Chairman~~Chairperson is absent from the meeting the Vice-~~Chairman~~Chairperson shall preside. If the ~~Chairman~~Chairperson and Vice-~~Chairman~~Chairperson are absent such Non-Executive Director as the Directors present shall choose shall preside.

3.2.2 If the ~~Chairman~~Chairperson is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-~~Chairman~~Chairperson, if present, shall preside. If the ~~Chairman~~Chairperson and Vice-~~Chairman~~Chairperson are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

3.3 Calling Meetings

3.3.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.3.2 Meetings of the Board of Directors are called by the Secretary, or by the ~~Chairman~~Chairperson, or by four Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Secretary shall call a meeting within at least 14 but not more than 28 days to discuss the specified business. If the Secretary fails to call such a meeting within seven clear days the ~~Chairman~~Chairperson or four Directors, whichever is the case, shall call such a meeting.

3.3.3 Subject to Standing Order 3.3.4 below, lack of service of the notice on any Director shall not affect the validity of a meeting.

3.3.4 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served 48 hours after it was posted or sent or, where the notice is sent by email, at the time when the email is sent.

3.3.5 In the case of a meeting called by Directors in default of the ~~Chairman~~Chairperson, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.3 Agenda of Meetings and Motions on Notice

3.4.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.) Before holding a meeting, a copy of the agenda shall be provided to the Council of Governors.

3.4.2 A Director desiring a matter to be included on an agenda shall make his request in writing to the ~~Chairman~~Chairperson at least ten clear days before the meeting, subject to Standing Order 3.3.2. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the ~~Chairman~~Chairperson.

- 3.4.3 A Director desiring to move or amend a Motion shall send a written notice thereof at least ten clear days before the meeting to the ~~Chairman~~Chairperson, who shall insert in the agenda for the meeting all Motions so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any Motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to ~~Standing Order~~ 3.3.5.
- 3.4.4 A Motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the ~~Chairman~~Chairperson.
- 3.4.5 Notice of Motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of four other Directors. When any such Motion has been disposed of by the Board of Directors, it shall not be competent for any Director other than the ~~Chairman~~Chairperson to propose a Motion to the same effect within six months; however the ~~Chairman~~Chairperson may do so if he considers it appropriate.
- 3.4.6 The mover of a Motion shall have a right of reply at the close of any discussion on the Motion or any amendment thereto.
- 3.4.7 When a Motion is under discussion, or immediately prior to discussion, it shall be open to a Director to move:
- An amendment to the Motion.
 - The adjournment of the discussion or the meeting.
 - That the meeting proceed to the next business.*
 - The appointment of an ad hoc committee to deal with a specific item of business.
 - That the Motion be now put.*

In the case of sub-paragraphs denoted by * above to ensure objectivity Motions may only be put by a Director who has not previously taken part in the debate.

- 3.4.8 No amendment to the Motion shall be admitted if, in the opinion of the ~~Chairman~~Chairperson of the meeting, the amendment negates the substance of the Motion.

3.5 Voting/Decision-Making

- 3.5.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. However, no resolution shall be passed if it is opposed by all of the Non-Executive Directors or by all of the Executive Directors

present.

3.5.2 All questions put to the vote shall, at the discretion of the ~~Chairman~~Chairperson of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.5.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.5.4 If a Director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

3.5.5 In no circumstances may an absent Director vote by proxy. This does not prohibit an absent Director recording their vote with the Secretary in the election of the Vice-~~Chairman~~Chairperson and Senior Independent Director. Absence is defined as being absent at the time of the vote.

3.5.6 An Officer, who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.5.7 Where a post of Executive Director is shared by more than one person:

- both persons shall be entitled to attend meetings of the Trust;
- either, but not both, of those persons shall be eligible to vote in the case of agreement between them;
- in the case of disagreement between them no vote should be cast;
- the presence of either or both of those persons shall count as one person for the purposes of Standing Order 3.8.1.

3.6 ~~Chairman~~Chairperson's Ruling

3.6.1 Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the ~~Chairman~~Chairperson of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

3.7 Attendance

3.7.1 The names of the Directors present at the meeting shall be recorded in the minutes.

3.8 Quorum

- 3.8.1 No business shall be transacted at a meeting of the Board of Directors unless at least six Directors are present including at least two Executive Directors, one of whom must be the Chief Executive or Deputy Chief Executive, and two Non-Executive Directors, one of whom must be the ~~Chairman~~Chairperson or the Vice-~~Chairman~~Chairperson.
- 3.8.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.
- 3.8.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration Committee).

3.9 Minutes

- 3.9.1 The minutes of the proceedings of a meeting shall be prepared and submitted to be read and for agreement at the next ensuing meeting where they will be considered to have been signed by the person presiding at it. The ~~approved~~signed minutes will be conclusive evidence of the events of the meeting and retained in an electronic minute book held by the Trust Secretary.-
- 3.9.2 No discussion shall take place upon the minutes except upon their accuracy or where the ~~Chairman~~Chairperson considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
- 3.9.3 Minutes shall be circulated in accordance with Directors' wishes. A copy of the minutes of the meetings of the Board of Directors shall be sent to the Council of Governors as soon as practicable following the meeting. Where providing a record of a public meeting the minutes shall be made available to the public.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

- 4.1 Subject to paragraph 4.3 of the Constitution, Standing Order 2.4 or any relevant statutory provision, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of Standing Order 5.1 or 5.2 below or by a Director or an Officer of the Trust

in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

- 4.2 Emergency Powers - The powers which the Board of Directors has retained to itself under Standing Order 2.4 may in emergency be exercised by the Chief Executive and the ChairmanChairperson after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the ChairmanChairperson shall be reported to the next formal meeting of the Board of Directors for ratification.
- 4.3 Delegation to Committees - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.
- 4.4 Delegation to Officers - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Board of Directors.
- 4.5 The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors as indicated above.
- 4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the DOF or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory or Monitor requirements.

5 COMMITTEES

- 5.1 Subject to paragraph 4.3 of the Constitution, Standing Order 2.4 and such other guidance as may be given by Monitor, the Trust may and, if directed by Monitor, shall appoint Committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.
- 5.2 A Committee appointed under Standing Order 5.1 may, subject to such directions as may be given by Monitor or the Trust, appoint sub-committees consisting wholly or partly of members of the Committee (whether or not they include Directors of the Trust or wholly of persons who are not members of that Committee).

- 5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or sub-committee established by the Trust.
- 5.4 Each such Committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide.
- 5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.
- 5.6 The Board of Directors shall approve the appointments to each of the Committees which it has formally constituted. Where the Board of Directors determines that persons, who are neither Directors nor Officers, shall be appointed to a Committee, the terms of such appointment (including payment of travelling and other allowances) shall be determined by the Board of Directors.
- 5.7 Where the Board of Directors needs to appoint persons to a Committee and/or to undertake required statutory functions, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with any national regulations laid down.
- 5.8 The Committees and Sub-Committees established by the Trust are:

Audit Committee

~~Charitable Funds Committee~~

~~Finance Committee~~

~~Healthcare Assurance Committee~~

~~Infection Prevention and Control Committee~~

~~Patient Experience and Communication~~

Nomination and Remuneration Committee

~~Trust Management Board~~

~~Workforce Strategy & Development Committee~~

and such other Committees as the Board of Directors determines are required to discharge the Board of Directors' ~~responsibilities.~~
responsibilities in relation to quality, finance and performance.

- 5.9 A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

- 5.10 A Director of the Trust or a member of a Committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or Committee shall resolve that it is confidential.

6 **DECLARATION OF INTERESTS AND REGISTER OF INTERESTS**

6.1 **Declaration of Interests**

6.1.1 The Constitution, the 2006 Act and the Code of Accountability for NHS Boards require Directors to declare interests which are relevant and material to the Board of Directors. All existing Directors should declare such interests. Any Directors appointed subsequently should do so on appointment. Any Director who fails to disclose any interest required to be disclosed under this section must permanently vacate their office if required to do so by a majority of the remaining Directors and (in the case of a Non-Executive Director) by the requisite majority of the Council of Governors.

6.1.2 Interests which should be regarded as **relevant and material** are:

- a. Any directorship of a company;
- b. Any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding is less than 2% of the total shares in issue) held by a Director in ~~any~~ firm or company or business which, in connection with the matter, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust;
- c. Any interest in an organisation providing health and social care services to the National Health Service;
- d. A position of authority in a charity or voluntary organisation in the field of health and social care.

6.1.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the ~~Chairman~~Chairperson.

6.1.4 At the time a Directors' interests are declared, they should be recorded in the minutes. Any changes in interests should be declared at the next Board of Directors' meeting following the change occurring.

6.1.5 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

6.1.6 There is no requirement for the interests of Directors' spouses or Partners to be declared, but for pecuniary interests see Standing Order 7.5.

6.1.7 A separate policy exists for the declaration of interests for all other staff.~~The applicable policy and procedure on the declaration of interests for all staff other than the Board of Directors is set out in SO 8.~~

6.2 **Conflict of Interest**

6.2.1 During the course of a Board of Directors' meeting, if a conflict of interest

is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision and shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

6.3 Register of Interests

6.3.1—The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, ~~as defined in SO 6.2.~~

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

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

7 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the Constitution and the following provisions of this Standing Order, if any member of staff or –Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 Monitor may, subject to such conditions as it may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to Monitor in the interests of the National Health Service that the disability should be removed.

7.3 The Trust shall exclude a Director from a meeting of the Trust while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

7.4 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 of Schedule 7 to the 2006 Act or pursuant to the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.5 For the purpose of this Standing Order the ChairmanChairperson or a Director shall be treated, subject to Standing Order 7.2 and Standing Order 7.6, as having indirectly a pecuniary interest in a contract, proposed

contract or other matter, if:

- a. he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

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

and in the case of married persons or civil partners living together the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.6 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- a. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;
- b. of an interest in any company, body or person with which he is connected as mentioned in Standing Order 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of, or in voting on, any question with respect to that contract or matter.

7.7 Where a Director:

- a. has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and
- b. the total nominal value of those securities does not exceed £10,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less; and
- c. if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

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

7.8 Standing Order 7 applies to a Committee or sub-committee of the Trust as it applies to the Trust and applies to any member of any such Committee or sub-committee (whether or not he is also a Director of the Trust) as it

applies to a Director of the Trust.

8 STANDARDS OF BUSINESS CONDUCT

8.1 Policy - All staff must comply with the national guidance contained in HSG(93)5 'Standards of Business Conduct for NHS staff' as amended by the Bribery Act 2010 and the 'Code of Conduct and Accountability for all NHS Boards'. The following provisions should be read in conjunction with this document.

8.2 Interest of Officers in Contracts - If it comes to the knowledge of a Director or an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive of the fact that he is interested therein. In the case of married persons, civil partners or persons living together as Ppartners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 All Officers involved in contracting, tendering and procurement are required to make the appropriate declarations of actual or nil interests, hospitality or sponsorship both at the start and conclusion of each process.

8.4 An Officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, civil partner or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

8.5 The Trust may require interests, employment or relationships so declared by staff to be entered in a Register of Interests of staff.

8.6 Canvassing of, and Recommendations by, Directors in Relation to Appointments - Canvassing of Directors of the Trust or members of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Orders shall be included in application forms or otherwise brought to the attention of candidates.

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

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

8.9 Relatives of Directors or Officers - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to

disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.10 The Directors and every Officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.11 On appointment, Directors ~~(and prior to acceptance of an appointment in the case of Executive Directors)~~ should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

8.12 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, the Standing Order headed 'Disability of Directors in Proceedings on Account of Pecuniary Interest' (Standing Order 7) shall apply.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 Custody of Seal -The Common Seal of the Trust shall be kept by the Secretary in a secure place.

9.2 Sealing of Documents - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a Committee thereof or where the Board of Directors has delegated its powers.

9.3 Before any ~~building, engineering, property or capital~~ document is sealed it must be approved and signed by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate) and authorised and countersigned by the ~~Chairman~~Chairperson (or an Officer nominated by him who shall not be within the originating directorate).

9.4 Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

[Note the legal requirement to seal documents executed as a deed has been removed. Trusts may however, choose to continue to use the seal].

9.5 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.

10 SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or DOF, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or Committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11 STANDING ORDERS

11.1 Standing Orders to be given to Directors and Officers

11.1.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall receive advice on where to find Standing Orders and Standing Financial Instructions.

11.2 Suspension of Standing Orders

11.2.1 Except where this would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

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

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

11.2.4 No formal business may be transacted while Standing Orders are suspended.

11.2.5 The Audit Committee shall review every decision to suspend Standing Orders

11.3 Amendment of Standing Orders

11.3.1 These Standing Orders may be amended only in accordance with paragraph 44 of the Constitution.

11.4 Review of Standing Orders

11.4.1 The Standing Orders shall be reviewed annually by the Trust.

ANNEX 8 – FURTHER PROVISIONS

Appendix 1: Trust Core Principles

1. Trust Commitment

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

2. Representative Membership

2.1 The Trust shall take steps to secure that taken as a whole its actual membership is representative of those eligible for membership.

To this end:

2.2 the Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years; and

2.3 the Council of Governors will report to the members at each Annual Members' Meeting in accordance with the provisions in Annex 8, Appendix 3, Paragraph 1.6.2.

3. Co-operation with NHS Bodies

3.1 In exercising its functions the Trust shall co-operate with other NHS Bodies. For the purposes of this section, each of National Institute for Health and Care Excellence and the Health and Social Care Information Centre is an NHS Body.

4. Respect for rights of people

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

5. Openness

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

6. Prohibiting distribution

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

ANNEX 8 – FURTHER PROVISIONS

Appendix 2: Membership

1. Disqualification from membership

- 1.1 A person may not become or continue as a member of the Trust if:
- 1.1.1 within the last five years they have shown aggressive or violent behaviour towards Trust staff which has resulted in a Violent and Aggressive Patient Assessment being completed and/or a warning letter being sent in accordance with the Trust's Policy for Managing Violence and Aggression;
 - 1.1.2 they have been confirmed as an unreasonable or persistent complainant in accordance with the relevant Trust policy for handling complaints; or
 - 1.1.3 they have been removed as a member from another NHS foundation trust.

2. Termination of membership

- 2.1 A member shall cease to be a member of the Trust if:
- 2.1.1 they resign by notice to the Secretary;
 - 2.1.2 they die;
 - 2.1.3 they are expelled from membership under the Constitution;
 - 2.1.4 they are disqualified from membership under the Constitution;
 - 2.1.5 they cease to be entitled under this Constitution to be a member of the Public Constituency or of any of the classes of the Staff Constituency; or
 - 2.1.6 if it appears to the Secretary that they no longer wish to be a member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the Trust.

3. Expulsion from membership

- 3.1 A member may be expelled by a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a general meeting of the Council of Governors. The following procedure is to be adopted:
- 3.1.1 Any member may complain to the Secretary that another member of the Trust has acted in a way detrimental to the interests of the Trust.

3.1.2 If a complaint is made, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that each member of the Trust's point of view is heard and may:

3.1.2.1 ~~dismiss~~ the complaint and take no further action; or

3.1.2.2 for a period not exceeding twelve months suspend the rights of the member of the Trust complained of to attend Members' Meetings and vote under the Constitution; or

3.1.2.3 arrange for a resolution to expel the member of the Trust complained of to be considered at the next general meeting of the Council of Governors.

3.1.3 If a resolution to expel a member of the Trust is to be considered at a general meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

3.1.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

3.1.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

3.3 A person expelled from membership will cease to be a member of the Trust upon the declaration of the ~~Chairman~~Chairperson of the meeting that the resolution to expel them is carried.

3.4 No person who has been expelled from membership is to be readmitted except by a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a general meeting of the Council of Governors.

4. Member declaration

4.1 A member of a Public Constituency may not vote at an election for a Public Constituency unless within 21 days before they vote they have made a declaration in the form specified by the Secretary that they are qualified to vote as a Member of the relevant Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

ANNEX 8 – FURTHER PROVISIONS

Appendix 3: Members' Meetings

1. Members' Meetings

- 1.1 The Trust shall hold the Annual Members' Meeting within nine months of the end of each Financial Year.
- 1.2 All Members' Meetings other than Annual Members' Meetings are called Special Members' Meetings.
- 1.3 Both Annual and Special Members' Meetings are open to all members of the Trust, governors and Directors, representatives of the Auditor, and members of the public. The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend a Members' Meeting.
- 1.4 All Members' Meetings are to be convened by the Secretary by order of the Council of Governors.
- 1.5 The Council of Governors may decide where a Members' Meeting is to be held and may also for the benefit of members:
 - 1.5.1 arrange for the Annual Members' Meeting to be held in different venues each year; and/or
 - 1.5.2 make provisions for an Annual or Special Members' Meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.
- 1.6 At the Annual Members' Meeting:
 - 1.6.1 the documents below shall be presented to the members with at least one member of the Board of Directors in attendance:
 - 1.6.1.1 the annual accounts;
 - 1.6.1.2 any report of the Auditor on them;
 - 1.6.1.3 the annual report; and
 - 1.6.1.4 forward planning information for the next Financial Year;
 - 1.6.2 the Council of Governors shall present to the members:
 - 1.6.2.1 a report on steps taken to secure that (taken as a whole) the actual membership of its Public Constituency and of the

classes of the Staff Constituency is representative of those eligible for such membership;

1.6.2.2 the progress of, and any changes to, the membership strategy;

1.6.2.3 any proposed changes to the policies for the composition of the Council of Governors and of the Non-Executive Directors;

1.6.3 the results of any election or appointment of Governors and the appointment of any Non-Executive Directors in the year will be announced.

1.7 Notice of a Members' Meeting is to be given:

1.7.1 by notice to all members;

1.7.2 by notice prominently displayed at the head office and at all of the Trust's places of business; and

1.7.3 by notice on the Trust's website,

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

1.7.4 be given to the Council of Governors and the Board of Directors, and to the Auditor;

1.7.5 state whether the meeting is an Annual or Special Members' Meeting;

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

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

1.8 Before a Members' Meeting can do business there must be a quorum present. Except where this Constitution says otherwise a quorum is three members present from any of the Trust's constituencies.

1.9 The Trust may make arrangements for members to vote by post, or by using electronic communications.

1.10 It is the responsibility of the Council of Governors, the ~~Chairman~~Chairperson of the meeting and the Secretary to ensure that at any Members' Meeting:

1.10.1 the issues to be decided are clearly explained; and

1.10.2 sufficient information is provided to members to enable rational discussion to take place.

1.11 The ~~Chairman~~Chairperson of the Trust, or in their absence the Lead Governor ~~Deputy Chairman~~ of the Council of Governors, or in their absence one of the other governors from the Public Constituency shall act as ~~chairman~~Chairperson at all Members' Meetings of the Trust. If neither the

~~Chairman~~Chairperson nor the ~~Deputy Chairman~~ Lead Governor of the Council of Governors is present, the members of the Council of Governors present shall elect a governor from the Public Constituency to be ~~Chairman~~Chairperson and if there is only one such governor present and willing to act they shall be ~~Chairman~~Chairperson.

- 1.12 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.
- 1.13 A resolution put to the vote at a Members' Meeting shall be decided upon by a poll.
- 1.14 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the ~~Chairman~~Chairperson of the meeting is to have a second or casting vote.
- 1.15 The result of any vote will be declared by the ~~Chairman~~Chairperson and recorded in the minutes. The minutes will be conclusive evidence of the result of the vote.
- 1.16 Minutes of the proceeding of a Members' Meetings shall be prepared and submitted to be read and for agreement at the next ~~ensuing~~ Members' Meeting where they will be considered to have been signed by the person presiding at it. The approved signed minutes will be conclusive evidence of the events of the meeting and retained in an electronic minute book held by the Secretary-

ANNEX 8 – FURTHER PROVISIONS

Appendix 4: Board of Directors – Further Provisions

1. Board of Director's Disqualification

1.1 A person may not become or continue as a Director of the Trust if:

- 1.1.1 they are a member of the Council of Governors, or a governor or director of another NHS Body;
- 1.1.2 they are a member of a Patient's Forum of an NHS Body;
- 1.1.3 they are the spouse, Partner, parent or child of a member of the Board of Directors;
- 1.1.4 they are a member of Bournemouth Borough Council's Oversight and Scrutiny Committee covering health matters;
- 1.1.5 they are subject to an unexpired disqualification order made under the Company Directors Disqualification Act 1986;
- 1.1.6 in the case of a Non-Executive Director, they are no longer a member of the Public Constituency;
- 1.1.7 they are a person whose tenure of office as a ~~chairman~~Chairperson or as a member or director of an NHS Body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- 1.1.8 they have had their name removed, from any list maintained by health and social care professional bodies in the UK and have not subsequently had their name included on such a list;
- 1.1.9 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS Body;
- 1.1.10 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; or
- 1.1.11 they have refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

2. Process for appointing Non-Executive Directors and the ~~Chairman~~Chairperson

- 2.1 Non-Executive Directors are to be appointed by the Council of Governors using the following procedure:

- 2.1.1 The Council of Governors will maintain a policy for the composition of the Non-Executive Directors which takes account of the skills and experience required for Non-Executive Directors identified by the Board of Directors, and which they shall review from time to time and not less than every three years.
- 2.1.2 The Board of Directors will identify the skills and experience required for Non-Executive Directors and may work with an external organisation recognised as expert at such appointments.
- 2.1.3 Appropriate candidates (not more than five for each vacancy) will be identified by a Nominations Committee through a process of open competition, which take account of the policy maintained by the Council of Governors and the skills and experience required.
- 2.1.4 The Nominations Committee will comprise a majority of Governors.
- 2.1.5 Any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors has approved.

3. **Process for removal of Non-Executive Directors and the ~~Chairman~~Chairperson**

- 3.1 The removal of the ~~Chairman~~Chairperson or another Non-Executive Director shall be in accordance with the following procedure:
 - 3.1.3 Any proposal for removal must be proposed by a Governor and seconded by not less than ten Governors including at least two Elected Governors and two Appointed Governors.
 - 3.1.4 Written reasons for the proposal shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.
 - 3.1.5 In making any decision to remove a Non-Executive Director, the Council of Governors shall take into account the annual appraisal carried out by the ~~Chairman~~Chairperson.
 - 3.1.6 If any proposal to remove a Non-Executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

4. **Expenses**

- 4.1 The Trust may reimburse Directors' travelling and other costs and expenses at such rates as the remuneration committee of Non-Executive Directors decides. These are to be disclosed in the annual report.
- 4.2 The remuneration and allowances for Directors are to be disclosed in bands in the annual report.

~~ANNEX 8—FURTHER PROVISIONS~~

~~Appendix 5: Further Provisions – General~~

~~46.—Dispute Resolution Procedures~~

~~46.1 In the event of any dispute about the entitlement to membership the dispute shall be referred to the Secretary who shall make a determination on the point in issue. If a member or applicant (as they case may be) is aggrieved of the decision of the Secretary he may appeal in writing to the Council of Governors within 14 days of the Secretary's decision. The decision of the Council of Governors shall be final.~~

~~46.2 In the event of any dispute about the eligibility, disqualification and removal of a Governor, the dispute shall be referred to the Council of Governors whose decision shall be final.~~

~~46.3 In the event of dispute between the Council of Governors and the Board of Directors or between a Governor and the Council of Governors:~~

~~46.3.1 — In the first instance the Chairman on advice of the Secretary, and such other advice as the Chairman may see fit to obtain, shall seek to resolve the dispute;~~

~~46.3.2 — If the Chairman is unable to resolve the dispute he 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~~

~~46.3.3 — If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chairman may refer the dispute back to the Board of Directors who shall make the final decision.~~

~~47.—Indemnity~~

~~2.1 — Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Council of Governors and the Board of Directors and the Secretary.~~

~~48. Secretary~~

~~48.1 The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the chief executive or the finance director. The Secretary's functions shall include:~~

~~48.1.1 acting as a Secretary to the Council of Governors and the Board of Directors, and any committees;~~

~~48.1.2 summoning and attending all Members' Meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;~~

~~48.1.3 keeping the register of members and other registers and books required by this Constitution to be kept;~~

~~48.1.4 having charge of the Trust's seal;~~

~~48.1.5 acting as returning officer in any elections;~~

~~48.1.6 publishing to members in an appropriate form information which they should have about the Trust's affairs;~~

~~48.1.7 preparing and sending to Monitor and any other statutory body all returns which are required to be made;~~

~~48.1.8 advising the Board of Directors and the Council of Governors on the provisions and interpretation of the Constitution.~~

~~48.2 The Secretary is to be appointed and removed by the Board of Directors, subject to the approval of the Council of Governors.~~

~~49. Head Office~~

~~4.1 The Trust's head office is at the Royal Bournemouth Hospital, Castle Lane East, Bournemouth BH7 7DW.~~

~~Notices~~

~~Any notice required by this Constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. **Address** in relation to electronic communications includes any number or address used for the purposes of such communications.~~

~~Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice as given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.~~

BOARD OF DIRECTORS	
Meeting Date and Part:	31 July 2015 - Part 1
Subject:	Communications Report (including media KPIs and Core Brief)
Section:	Information
Executive Director with overall responsibility	Karen Allman, Director of Human Resources
Author(s):	James Donald, Head of Communications, and Jane Bruccoleri-Aitchison, Communications Manager
Previous discussion and/or dissemination:	
Action required: The Board of Directors is asked to: To note the report	
Summary: The Communications Report provides a summary of key communication activities over the past month as well as upcoming activities and media KPIs	
Related Strategic Goals/ Objectives:	Access to care Provider of choice
Relevant CQC Outcome:	Section 1, Outcome 1, Section 4, Outcome 13 and 14
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? ii. Have any risks been created? 	
Reason paper is in Part 2	N/A

Communications activities July 2015

1. Introduction

The following paper includes:

- recent and future communication activities
- media coverage summary key performance indicators
- July Core Brief

2. Recent activities

- Preview of October's CQC inspection in Core Brief
- Production of Trust Strategy 2015/20 document
- Christchurch newsletter
- Pride Awards – shortlisting
- A338 roadworks and potential traffic disruption – update in Core Brief
- Website updates
- Update on increase in public car parking charges
- Secured Camps International as sponsor of Pride Awards
- Update to all staff on delay to public consultation to the Clinical Services Review being organised by Dorset CCG
- BBC South Today coverage for delay in CSR public consultation
- Very successful social media campaign on knitting hats for babies for World Breastfeeding Week – has also been picked up by local media

3. Upcoming activities

- Widespread communications in preparation for CQC inspection
- Trust Strategy – production of version for staff and help communicate this across the Trust
- Planning the 2015 Pride Awards
- Raising further sponsorship for 2015 Pride Awards
- A338 roadworks – producing map and details for staff and covering letter for all patient appointments after 6 September
- Do you have a concern? Communications flow chart being produced with HR
- Workforce transformation communications
- Communicate RBCH's financial situation to staff – Q&A being produced with Stuart Hunter
- Quality improvement communications
- Annual Report – summary document for members
- Promote range of Health & Wellbeing services
- Update media relations policy
- Writing a social media strategy
- Communications support for opening of Jigsaw building
- Supporting Flu Fighters campaign

4. Recommendation

The Board is asked to note the report.
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Media relations - Key Performance Measures

The Trust received substantial positive media coverage during June, with articles including coverage of our 'Five Daily Actions Week' and positive opinion pieces surrounding the Clinical Services Review.

Twitter has continued to grow steadily and good use was made of online interaction around the RCN Congress. Positive feedback has also been received regarding the Twitter training sessions for the recruitment team and tweets regarding recruitment have increased with the team's confidence.

Facebook also saw robust audience reach during June, with followers increasing to 1015 individuals and an organic post reach of 37,437. Overall reach was boosted by Cardiology's 'tenth anniversary' music film, with a reach of 15,608.

For more information, or to access any of the media coverage the Trust has received, contact communications@rbch.nhs.uk or call 01202 726172.

2015	Number of proactive news releases distributed	% that received media coverage in <u>that month</u>	Total PRINT coverage (includes adverts)	Total OTHER coverage (online, radio, TV)	Positive media coverage	Neutral media coverage	Negative media coverage	Media enquiries
June	10 (Including Five Daily Actions, Pride Awards 'Unsung Hero', charity news and Cardiology Department ten year anniversary	100%	32	17	46	3	0	10 (including the Clinical Services Review and nursing migration laws)

May	11 (including International Nurses' Day, the CSR, patient survey and charity news)	100%	24	24	46	2	0	13 (including the Clinical Services Review, babies born on the same day as Princess Charlotte and stroke statistics)
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*excellent care for every patient,
every day, everywhere*

The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust



Core Brief



From: Tony Spotswood, Chief Executive

July 2015

CQC inspection

The Care Quality Commission (CQC) has announced it will be inspecting our hospitals from **21 to 23 October** this year to give us an official rating.

The last inspection in 2014 found we had improved in the areas of concern highlighted in the initial inspection in 2013. The inspectors will obviously be looking to confirm we have continued to improve in these areas and others across the Trust. The inspection will involve a team of inspectors (40+) spending three days visiting all areas and services we provide at both hospitals.

What will the CQC inspectors be looking for?

When they inspect a hospital they are looking to answer five questions:

- are services safe?
- are services effective?
- are services caring?
- are services responsible to people's needs?
- are services well led?

The CQC will use current information about us to decide their initial key lines of enquiry and will gather information from a variety of data sources including the national patient survey, staff survey and audits, the GMC Survey 2015, the Friends and

Family Test, serious incidents and never events. They will also review our performance against national targets and objectives such as RTT, cancer waiting times and Emergency Department performance.

What will happen during the inspection?

Inspectors will talk to staff, patients, carers, visitors and other key stakeholders such as the Clinical Commissioning Groups, Healthwatch, Patients Association and other patient forums. They will also host public listening events and staff focus groups during the inspection period. The CQC will look at any concerns people have at using our services, or our staff have, and will encourage people to contact them directly with these. They will look to see how we deal with these concerns, complaints and whistleblowing.

What will happen after the inspection?

From all the data and the inspections they will award a rating to each service and use these results to provide one of the following ratings to the Trust:

- outstanding

- good
- requires improvement
- inadequate

The results will have to be displayed at the entrance to our hospitals, on our websites and in the individual services that have been inspected alongside their own results.

How should I prepare?

Over the coming months, we shall give you further details of the inspection and how you might be involved. We shall also give details of what to do when the inspectors come to your ward or department and also what to do if journalists contact you as inspections can generate a lot of interest from the media.

The CQC inspection is an opportunity for us to showcase what we have done at the Trust to continually improve the quality of the services we provide. We want to be able to demonstrate the work that we have undertaken since the previous inspections in 2013 and 2014 and showcase our areas of best practice.



Further details of how the CQC carry out an inspection:

www.cqc.org.uk/content/how-we-inspect-and-regulate-guide-providers

Transformation workshop

Tony Spotswood opened the first transformation cross-cutting workshop on Wednesday 1 July by outlining the financial pressures facing the Trust and explaining how we all have a role to play in addressing these.

With a planned deficit of £12.9m for this year, he explained that we need to join together our focus on money and our focus on quality improvement.

Over 50 staff from across the Trust attended the workshop and split into groups to come up with ideas for how we can improve quality and performance and help save money to ensure our future viability.

Further workshops will be held over the coming months in addition to the 15 transformation steering groups.

For details of how to get involved, or if you have any ideas for our transformation and improvement team, please email

Thomas.munday@rbch.nhs.uk

Extensive roadworks on the A338

Dorset Country Council is planning extensive roadworks for the A338 that will affect traffic around both our sites. From Sunday 6 September one side of the dual carriageway will be closed from Ashley Heath Roundabout to Blackwater Junction and traffic will use the other side in a contra flow with a speed limit of 40mph.

This work will last for nine months. We are putting plans in place to help our staff, patients and visitors to be prepared during this time for the disruption this may cause. These include promoting travel alternatives to driving and exploring flexible working patterns where possible.

Further details will be included in next month's *Core Brief* and across all our communication channels.

Your comments and ideas are welcome at communications@rbch.nhs.uk



Parking charges at RBCH

We are implementing new public car park charges at both RBH and Christchurch Hospital from **Monday 13 July 2015**.

Parking fees are going up by between 20p and 50p depending on the length of time parked. This is only the second increase since 2003, with the last being in 2011.

Income from our car parks will contribute toward road and pavement repairs and improvements, the installation of a new CCTV system and fund the increased cost of lighting the car parks.

Free parking is available for certain tax exempt vehicles, regular patients and visitors to our hospitals and patients receiving certain cancer treatments. There are no increases for parking for longer than five hours.

All surplus income from our car park revenue goes to frontline services and patient care.



Pride Awards 2015

last few days to nominate!

The deadline to get your nominations in for this year's Pride Awards is **Friday 10 July at 12noon**.

Make sure you don't miss out and nominate today via the official 2015 Pride Awards nomination pack (call ext. **4394** for a copy), or nominate online at **www.rbch.nhs.uk/pride_awards**

So far we have had more than 100 nominations, but there are still some areas that are yet to be represented.

Remember, making a nomination is an ideal opportunity for you to celebrate the work of your colleagues or department and get the recognition you deserve.

Please ensure your nominations are **at least 200 words long** and don't forget the Communications Team can help you. Simply call ext. **4271** or email **communications@rbch.nhs.uk**

This year's ceremony will take place on **Thursday 12 November** at Poole Lighthouse.

The categories are:

Award for Patient Experience

Award for Teamwork

Learning and Development Award

Award for Improving Quality

Inspirational Leadership Award

Community and Charity Award

Award for Improving Patient Safety

Behind the Scenes Award

Unsung Hero Award

Chairman's Award for Living our Values



Booking patient transport - use your Discharge Lounge

Please can all wards be aware that during **9am-6pm** on working weekdays, the booking of patient transport for discharges and transfers must be arranged through the Discharge Lounge.

Ward staff should arrange transport by completing the online Discharge Lounge Checklist in full. Our Discharge Lounge staff are best placed to ensure that any transport booking made includes all the necessary information to ensure our patients are safely

transferred in a timely manner with an appropriate vehicle and crew.

Where possible, to avoid discharge or transfer delays, all requests should be made at least 24 hours in advance for patients either registered with a Hampshire GP requiring a paramedic crew or for journeys out of county.

Private ambulance costs incurred as a result of incorrectly completed bookings by ward staff may subsequently be charged back to the ward.

Between the hours of **6pm-9am**, transport bookings for discharges or transfers should be made via the Clinical Site Team.



Electronic Nurse Assessment: the latest

Electronic Nurse Assessment (eNA) will officially go live on **Monday 13 July**, allowing our nurses to electronically record core nursing risk assessments, such as Waterlow, MUST, VTE, mobility and frailty, falls and bedrails and the dementia CQuin.

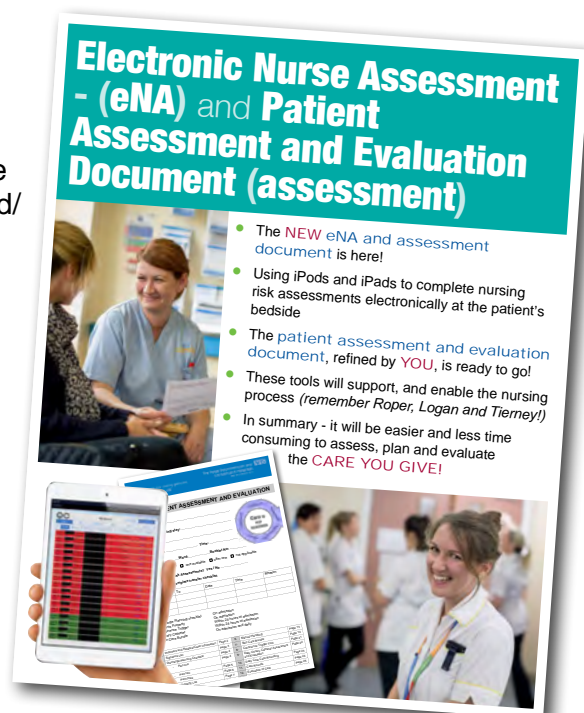
The mobile app, which uses iPods and iPads, can be used at the patient's bedside and was created by our Applications Development Team in collaboration with the clinical leads for the nursing risk assessments.

It will be launched in tandem with the new seven day patient assessment and evaluation document and five day short stay care plan.

How do I use the system?

You can log in using your VitalPAC pin. If you don't have a pin please contact your ward/department super user who can create you an account. Alternatively please contact the IT Service Desk from 13 July.

On the go live day, eNA and the new assessment/care plan document should be used for all new patients. For patients admitted before this date, you should continue to use the paper documentation until either the document is completed and a new document is required (at which point please start using the new documentation and eNA) or the patient is discharged from the old documentation.



Become a staff governor

Do you want to learn more about how the Trust is run and have a greater influence on this?

Would you like to represent the views of your work colleagues on how the Trust is run?

We have a Council of Governors who represent the interests of members, partner organisations and the local population, and this includes staff at our hospitals.

The Council of Governors has specific powers and responsibilities including:

- the appointment of the Chairman and non-executive directors on the Board of Directors
- approving the appointment of the Chief Executive by the Chairman and non-executive directors
- appointing the external auditors
- sharing their views on the Trust's forward plans and strategy and on its quality priorities and objectives

There is currently one staff governor vacancy (two-year term of office) available to those working

in administration, clerical and management roles and only members of this staff group will be eligible to vote in this election.

The Trust will support you in your role with time away from your workplace and funding available to backfill your role when you are attending Council of Governors meetings and training.

Tony Spotswood, Chief Executive, said:

"Staff representation on the Council of Governors is critical to its success and the Trust has provided this funding to enable members of staff who want to be a governor to have time to contribute fully to the work of the Council of Governors."

If you want to check if you are a member, would like an application form or would just like to find out more, please contact Dily Ruffer on ext. 4246 or email her at dily.ruffer@rbch.nhs.uk.

Application forms should be completed and returned by **12noon on Thursday 16 July**.



Nursing, midwifery and care staff: 'Compassion in Practice' questionnaire

We have been invited to participate in NHS England's evaluation of the 'Compassion in Practice' strategy.

All nursing, midwifery and care staff are asked to please visit the webpage below and complete their five minute questionnaire before **Thursday 9 July**.



www.engage.england.nhs.uk/survey/abb5eccc

New lead consultant for Stroke Unit

Dr Becky Jupp has been appointed as our new lead consultant for stroke.

She takes over from Dr Damian Jenkinson, and has been working as a consultant in medicine for the elderly at RBCH for over five years.

Becky said: *"I want to build on the success of the Stroke Unit and lead it into a new era of interventional stroke medicine while recognising that exemplary medical and nursing care for all stroke patients is essential to give them the best chance of recovery."*



Wessex AHSN issue guidance after latest Asthma UK report

A recent report has been published by the respiratory charity Asthma UK which claims that tens of thousands of people suffering with asthma across the country are not getting the right medicines to safely control their condition.

In response to this, Wessex Academic Health Science Networks (AHSN), which works towards improving the health of the region by linking quality improvement in the NHS with research and innovations, has issued some helpful information for health professionals.

It has also announced a number of new projects to support this.

You can find out more and read the official report by logging on to

<http://wires.wessexahsn.org.uk/news-and-events/news-asthma-prescribing/>

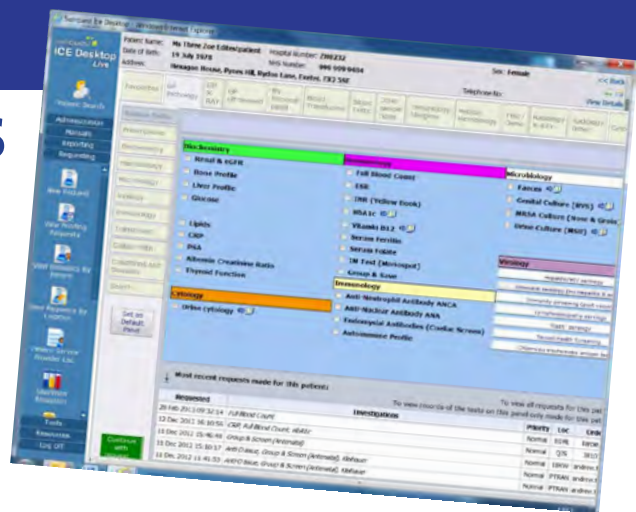


Let's talk about IT

Order Communications System demo - Friday 10 July

The Order Communications system (ICE) is a new application that is going to be implemented in our hospitals to enable electronic requesting of acute investigations to radiology, pathology, endoscopy, and cardiology. This will:

- enable the delivery of high-quality, safe and efficient diagnostic services
- develop and implement clinical protocols and decision support aids that will replace existing manual and paper based processes
- improve safety and quality of care to patients and reduce clinical incidents



The software company, Sunquest, will be hosting 30-minute demonstration sessions for all would-be users of the system on **Friday 10 July** in the Lecture Theatre at RBH at 9.30am, 10.15am, 11am and 11.45am.

If you would like to attend, please email nicola.chaplin@poole.nhs.uk indicating a preferred time.

OCR text processing qualification

Staff can now undertake a nationally accredited course in OCR text processing, designed to develop and recognise your ability to produce a variety of business documents.

The induction session and course will take place in IT Tutorial Room 2 at RBH:

Induction session
Thursday 20 August 2015
11am-12noon

Course start date
Thursday 1 October 2015

Course time: 11am-1pm

Course start date
Thursday 25 February 2016

To enrol please call ext. 4285.



Microsoft eLearning from beginner through to advanced

The IT Skills Pathway is an innovative learning tool that provides training and assessment on Microsoft Office 2010 from beginner through to advanced.

Using the pathway, NHS staff can review their current IT skills against recognised standards, determine their skill gaps and identify their training requirements.

NHS Elite (entry level)

NHS Elite is aimed at complete beginners with limited experience in using computer systems. It covers a range of learning outcomes including how to use a mouse and keyboard, using Windows, working with files and applications, email and the internet.

Ready for Microsoft Office skills training (Level 1)

This is a set of learning materials designed to for people who already have basic IT skills to prepare for progression on to the Microsoft Office Specialist course.

Microsoft Office Specialist (Level 2 and 3)

This offers the opportunity to learn Microsoft Word, Excel, PowerPoint and Outlook.

The Knowledge Bank

This gives instant access to the full range of resources available via the IT Skills Pathway. Rather than doing a search via the internet, or working through full courses, you can access quality controlled, standardised answers to your Office queries in bite sized chunks delivering training by way of e-Learning and videos.

To find out more log on to www.itskills.nhs.uk/KnowledgeBank/Default.aspx?CentreID=156

Please use this form to cascade key messages from Core Brief to your staff – please return to the Communications Department, ppB43, RBH

Core Brief

Date of Core Brief cascade briefing: 8 July 2015

Name:
Department/Ward:

Date delivered:

Who to:
How many:

Please use the *Core Brief* that has been circulated to all staff via global email to support you in cascading the following messages:

CQC inspection: The Care Quality Commission (CQC) will be inspecting our hospitals from 21 to 23 October this year. The inspectors will be talking to staff, patients, carers and visitors during their time here and will be looking at whether our services are safe, effective, caring, well led and are meeting people's needs. From all the data collected they will award us an overall rating of either outstanding, good, requires improvement or inadequate.

Action: Information on what staff can do to prepare for the inspectors can be found in this edition of Core Brief. Alternatively further details of how the CQC carry out an inspection are available at <http://www.cqc.org.uk/content/how-we-inspect-and-regulate-guide-providers>. We will provide regular updates in the coming months.

Transformation workshop: The first transformation cross cutting workshop was opened at the beginning of the month. Here we outlined the financial pressures facing the Trust and explaining how we all have a role to play in addressing these. Further workshops will be held over the coming months in addition to the 15 transformation steering groups.

Action: For details of how to get involved, or if you have any ideas for our transformation and improvement team, please email Thomas.munday@rbch.nhs.uk

Extensive roadworks planned for A338: You may already be aware that Dorset County Council is planning extensive roadworks for the A338 that will affect traffic around both our hospital sites. From Sunday 6 September one side of the dual carriageway will be closed from Ashley Heath Roundabout to Blackwater Junction and traffic will use the other side in a contra flow with a speed limit of 40mph. The work is likely to last for nine months.

Action: We will keep you up to date with the planned works and any other potential delays when they arise through our communication channels. We will also include more information in next month's edition of Core Brief. Don't forget you can also visit the 'tackling traffic congestion' pages of on our website for the latest news.

Parking charges at RBCH: New public car parking charges will be implemented at both RBH and Christchurch Hospital from Monday 13 July 2015. Parking fees will go up by between 20p and 50p depending on the length of time you are parked. This is only the second increase since 2003, with the last being in 2011. Income from our car parks will contribute toward road and pavement repairs and improvements, the installation of a new CCTV system and fund the increased cost of lighting the car parks.

Action: Please can all managers ensure their staff are aware of the new charges and provide them with any future updates which will be included in Core Brief.

Pride Awards 2015: Time is almost up to submit your nominations for this year's Pride Awards. The deadline is Friday (10 July) at 12noon. We have yet to see any nominations from some areas so please make a nomination and ensure your department is represented. Remember each nomination must be at least 200 words long.

Action: To make a nomination you can use one of our 2015 Pride Awards Nomination Packs available on the intranet or visit www.rbch.nhs.uk/pride_awards. If you require assistance filling in your nominations contact the Communications Team on ext. 4271 or via email at communications@rbch.nhs.uk. The deadline for nominations is 12 noon on **Friday 10 July**.

Staff questions: (please list any questions your staff have following the briefing)

Chief Operating Officer

Richard Renaut

Surgical surgery, anaesthetics, orthopaedics and maternity

**Director
of Operations:**
Mark Titcomb

**Head of
Nursing and
Quality:**
Kate Horsefield

Clinical Directors

- Surgery - David Bennett
- Anaesthetics - Martin Schuster-Bruce
- Orthopaedics - Richard Hartley

Directorate Managers

- Surgery - Jane Burns
- Anaesthetics - Corrina Jordan
- Orthopaedics - Jo Clothier

Directorate Matrons

- Surgery - Sue Davies
- ITU - Andy Gyngell
- Head of Midwifery - Carmen Cross
- Anaesthetics - Sue Langlois
- Orthopaedics - Lisa Lee

Medical medicine, elderly care and cardiology

**Director of
Operations:**
Frances Wiseman

**Head of Nursing
and Quality:**
Martin Smith

Clinical Directors

- Medicine - Tristan Richardson
- Elderly care - Andrew Williams
- Cardiology - Mark Sopher

Directorate Managers

- Medicine (including ED, and AMU) - Alex Lister
- Elderly care and therapies - Vanessa Mason
- Cardiology - Jo Blackwell

**Associate Director for
Integrated Care**
Vanessa Mason

Directorate Matrons

- Medicine - Troy Welch
- Emergency Department - Claire Liggins
- Ambulatory care - Kelly Spaven
- Cardiology - Paula Rayson
- Elderly care - Trudi Ellis and Nicola Bowers
- Head of Therapy - Darren Sparkes (outpatients) and Gemma Brittan (inpatients)

Specialties specialist services, ophthalmology, cancer care, radiology and pathology

**Director
of Operations:**
Abigail Daughters

**Head of Nursing
and Quality:**
Sue Reed

Clinical Directors

- Specialist Services - Ellie Thickett
- Ophthalmology - Non Matthews
- Cancer Care and Pathology - Rachel Hall
- Radiology - Arnie Drury

Directorate Managers

- Specialist Services - Tracey Hall
- Ophthalmology - Louise Neville
- Pathology - Paul Massey
- Cancer Care - Paul Massey
- Radiology - Sarah Oliver

Directorate Matrons

- Specialist Services and
- Ophthalmology - Alison Pressage
- Cancer care - Marie Miller

**Deputy Chief
Operating Officer**
Donna Parker
operations and strategy

Associate Director (Operations)
BJ Waltho

- Clinical Site and Patient Flow
- Facilities
- Emergency Planning
- Bereavement / Patient Affairs Office

**Head of Commercial
Development**
Steve Thomas

**Associate Director Service
Development**
Sandy Edington

**Head of Public Health and
Strategic Planning**
Michelle Burden

Programme Lead - Performance
Dawn Ailes

**Associate Director for
Cancer and Outpatients**
Alison Ashmore

**Associate Director of
Capital and Estates**
Edwin Davies

BOARD OF DIRECTORS	
Meeting Date and Part:	31 July 2015 Part 1
Subject:	Corporate Events Calendar
Section:	Information
Executive Director with overall responsibility	Tony Spotswood, Chief Executive
Author(s):	Anneliese Harrison
Previous discussion and/or dissemination:	N/a
Action required: To note for information	
Summary: Corporate Events arranged until December 2015	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	N/a
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

CORPORATE EVENTS CALENDAR JULY 2015

Date and Time	Event Description	Venue	Contact Details
Friday 31 July	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Friday 7 August	Breast feeding picnic	Hospital Lake	01202 704271
Saturday 12 September	Volunteer's Tea Party	Invitation Only- Volunteer's Office	01202 704253
Tuesday 15 September	Using our Library	Between restaurants	01202 704394
Monday 21 September	Understanding Diabetes	The Village Hotel 11:00	01202 704271
Wednesday 23 September	Annual Members' Meeting	The Village Hotel	01202 704246
Friday 25 September	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Sunday 27 September	Pedal Power	10am New Forest	01202 704060
Saturday 3 & Sunday 4 October	Bournemouth Marathon	Bournemouth Hospital Charity	01202 704060
Wednesday 7 October	Understanding the Prostate & Prostate Cancer	Greyfriars Community Centre Ringwood 6:00	01202 704246
Wednesday 7-11 October	Free Will writing service	Royal Bournemouth Hospital	01202 704060
Friday 9 October	Free Will writing service	Christchurch Hospital	01202 704060
Friday 23 October	Light up the Prom- for Oncology & Haematology	8pm Bournemouth Pier	01202 704060
Friday 30 October	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Thursday 5 November	Council of Governors' Meeting	Conference Room, Education Centre, Royal Bournemouth Hospital	01202 704246

Thursday 13 November	Pride Awards	Lighthouse, Poole	01202 704394
Friday 27 November	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777
Friday 4 December	Understanding Knee Pain	The Village Hotel 11:00	01202 704271
Friday 18 December	Board of Directors' Meeting	Committee Room, Trust Management Office, Royal Bournemouth Hospital	01202 704777

Key

	Surveys and audits
	Meetings
	Volunteer events
	Health and other talks
	Stakeholder groups, events and forums
	Stands at local/community events
	Bournemouth Hospital Charity events
	Staff Events
	Other activities/events

BOARD OF DIRECTORS	
Meeting Date and Part:	31 July 2015 Part 1
Subject:	Directors Forward Programme
Section:	Information
Executive Director with overall responsibility	Tony Spotswood, Chief Executive
Author(s):	Sarah Anderson, Trust Secretary
Previous discussion and/or dissemination:	N/a
Action required: To note for information	
Summary: Update of the Board of Directors Forward Programme	
Related Strategic Goals/ Objectives:	All
Relevant CQC Outcome:	
Risk Profile: <ul style="list-style-type: none"> i. Have any risks been reduced? No ii. Have any risks been created? No 	
Reason paper is in Part 2	N/A

[illegible][illegible][illegible][illegible]

Infection Control Annual Report and Board Statement of Commitment to Prevention of Healthcare Associated Infection	PS	Infection Control								Part 1			N/A
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[illegible]

BOARD OF DIRECTORS	
Meeting Date and Part:	31 st July 2015 Part 1
Subject:	Communications Plan for A338 roadworks
Section:	Information
Executive Director with overall responsibility	Richard Renaut, Chief Operating Officer
Author(s):	James Donald, Head of Communications
Previous discussion and/or dissemination:	PMG
Action required: The Board of Directors is asked to consider the information provided and support any actions highlighted.	
Summary: From September 2015 to May 2016 the A338 from Ashley Heath to Blackwater Junction will be rebuilt. This will mean the road will temporarily change from dual carriage way to single carriage way, with a 40mph speed limit and contra flow. This communications plan is to ensure staff and patients are aware of the works and preparations are made in advance.	
Related Strategic Goals/ Objectives:	1. to offer patient centred services by providing high quality, responsive, accessible, safe, effective and timely care
Relevant CQC Outcome:	Outcome 4 – Responsive Outcome 5 – Well-led
Risk Profile: i. Have any risks been reduced? N ii. Have any risks been created? Y reference number 001423	
Reason paper is in Part 2	N/A

Subject:	Communications Plan for A338 roadworks
Executive Director with overall responsibility	Richard Renaut, Chief Operating Officer
Author(s):	James Donald, Head of Communications
Summary: <p>From September 2015 to May 2016 the A338 from Ashley Heath to Blackwater Junction will be rebuilt. This will mean the road will temporarily change from dual carriage way to single carriage way, with a 40mph speed limit and contra flow. This communications plan is to ensure:</p> <ul style="list-style-type: none"> • our staff are aware of the works, know what we have in place to help them and that they have prepared themselves in advance, looking at alternative modes of transport or flexible working patterns, where possible. • our patients and visitors know what we have in place and this informs them of alternative modes of transport and, estimated extra journey times to help them prepare and arrive on time. 	
Background: <p>The Dorset Local Enterprise Partnership (DLEP) has secured funding from Government for a four year programme to improve access to South East Dorset including Aviation Park, which is a key site capable of delivering significant economic growth.</p> <p>To release the full potential of Aviation Park and the surrounding land, five major highway schemes have been identified for substantial improvement to increase their capacity, reduce congestion and improve journey times between Bournemouth Airport, Bournemouth town centre and the wider road network.</p> <p>The first scheme will be a reconstruction of the A338 Bournemouth Spur Road. It carries around 59,000 vehicles per day of which 3.7% (2,200 vehicles) are HGVs, which makes it Dorset's most heavily trafficked road.</p> <p>It was built in the late 1960s and the construction of the road is failing due to its age and the volume of traffic it carries.</p> <p>From 6 September 2015 the A338 from Ashley Heath to the Blackwater junction will become a contra flow, with a 40mph speed limit.</p> <p>The work will last until 31 May 2016.</p> <p>It will add on times to any local journeys and could cause further disruption should there be any local incidents as an already congested system struggles to cope.</p>	
How this could affect RBCH <ul style="list-style-type: none"> ▪ Emergency vehicles to be unable to enter or leave RBCH (Including clinical supplies, such a blood products which are time sensitive) 	

- Patients, visitors and staff unable to get to RBCH
- Patients, visitors and staff unable to leave RBCH
- Shifts affected as staff late for work
- Patients late for appointments and procedures
- Staff recruitment/retention affected by time takes to get here/leave here
- Staff morale affected

Key stakeholders for communications

<p><i>Internal:</i></p> <ul style="list-style-type: none"> ▪ Clinical staff ▪ Support staff ▪ Contractors 	<p><i>External:</i></p> <ul style="list-style-type: none"> ▪ Patients ▪ Outpatients ▪ Visitors ▪ Suppliers ▪ GPs
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Key communication messages

Internal - In advance:

- What RBCH will do to support you during this time – and what we are doing to prepare
- Be prepared, “have a plan”, this work is happening and will cause disruption
- Where to go for further information when work starts –
 - RBCH intranet microsite
 - Dorset County Council Travel project blog - <http://news.dorsetforyou.com/bournemouth-spur-road/>
 - BBC twitter feeds - @traveldorset; @dorsetforyou #A338
- Background information on why the work is happening – see www.dorsetforyou.com/bournemouth-spur-road
- Explore alternatives (see below for list of alternatives for travel and work patterns)

Internal - During:

- Updates via twitter if things are particularly bad
- List alternatives (see below for list of alternatives for travel and work patterns)
- Reassurance on patient safety
- Extra options in place

External - In advance:

- Be prepared – use alternative routes of transport
- Show what plans we have in place to ensure levels of care
- Letter to all outpatient appointments (see attached)

External - During:

- Updates via twitter if things are particularly bad
- List alternative ways of getting to us (see below for list of alternatives for travel)
- Reassurance on patient safety

Alternatives for staff

Travel:

- Alternative routes
- Promote car share
- Bus and subsidised bus passes
- Promote biking, with suggested routes etc
- Park and ride (bike)
- Promote salary sacrifice to buy bikes

Work arrangements:

- Flexible start/end times for work, agreed in advance with line managers
- Working from home, if possible (30% of staff non-patient facing) – this has to be confirmed with line managers

Proposed schemes:

Car free week – we will issue free one week bus passes to staff who participate

Cycle events – try a bike, bike loan scheme and more storage for cycles

Car share – investment in new software and a campaign to support this

Support for Yellow bus campaigns to increase bus use

More pool cars, so staff travelling during the day can book and don't need to bring in cars.

Communication channels

Internal:

- All staff emails
- Weekly Bulletin
- Publications – Core Brief; Buzzword; FT Focus; Christchurch newsletter;
- Screensavers
- Car Parks:
 - Posters/banners at entrance to car parks
 - Windscreen drop offs
 - Car park attendants to handout leaflets as staff drive in
- Microsite for staff - with link on intranet
- Trust social media channels

External:

- Press and PR
- Trust social media channels

Microsite for visitors – with link on internet

Timings

June 2015 – Agree key messages/Q&As with Exec, including workforce policies

June 2015 – Produce briefing paper for staff

Summer 2015 – Promote “try the bus week”

July 2015 – All staff email

Communicate scale of works and reasons behind it

Communicate what we shall be putting in place

Promote Q&As

Core brief

Buzzword

August 2015 – Car park comms – posters; windscreens; leaflets

Launch of websites – internal and external

Promote alternatives

Core brief

Screensaver

September 2015 - All staff email

Promote all channels of communication

Reactive comms depending on severity of problem

Core brief

Christchurch newsletter

Screensaver

FT Focus

*providing the excellent care we
would expect for our own families*

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Appointments at our hospitals after 6 September 2015 – traffic delays

Dorset County Council is carrying out extensive roadworks on the A338 Spur Road from 6 September. This will significantly affect traffic around the Royal Bournemouth Hospital and the wider conurbation as other roads are expected to be busy as well, including into the Christchurch Hospital site. These works will last for nine months.

The A338 Spur Road is the dual carriage way that comes into Bournemouth from the north and the roadworks will be between Ashley Heath Roundabout and the Blackwater Junction – a stretch of over five miles. One side of the dual carriageway will be closed to be rebuilt and traffic will use the other side in a contra flow with a speed limit of 40mph.

Dorset County Council has anticipated that these works will cause major traffic delays around the area in all directions, and this could mean that access into and out of our car parks will also be very slow.

For your appointment, we would ask you to plan ahead for these roadworks:

- please ensure you allow plenty of extra travelling time for your appointment
- listen to local radio for traffic updates to hear where congestion spots are on the day and plan accordingly
- if you have a twitter account, follow Dorset County Council's @TravelDorset for traffic updates
- if you can, please seek alternative modes of transport, such as coming to our hospitals by bus. You can see Yellow Buses Limited timetables, routes and traffic updates for local buses at www.bybus.co.uk and bus timetables for further afield around Dorset and Wiltshire with the more bus company at <http://morebus.co.uk>

Unfortunately if you are late for your appointment because of the traffic delays, it may not always be possible to fit you in that day due to the need to see other patients. Please do be prepared for having your appointment postponed to another day if you miss your booked time.

By planning ahead now for your next appointment, and giving yourself plenty of time to travel in, we hope you will be able to receive your healthcare on time.