## A G E N D A

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Item presenter</th>
<th>Appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome</td>
<td>Chair</td>
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<tr>
<td>2</td>
<td>Apologies for Absence</td>
<td>Chair</td>
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<td>3</td>
<td>Declaration of Interests</td>
<td>Chair</td>
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<td>4</td>
<td>Approval of the Minutes of the Meeting held on 28 April 2015</td>
<td>Chair</td>
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<tr>
<td>5</td>
<td>MATTERS ARISING</td>
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<tr>
<td></td>
<td>5.1 Actions Log from Minutes of the Meeting held on 28 April 2015</td>
<td>Chair</td>
<td>C</td>
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<tr>
<td>6</td>
<td>STRATEGY</td>
<td></td>
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<tr>
<td></td>
<td>6.1 Update of Trust Strategy 2015-2020</td>
<td>Tony Spotswood</td>
<td>Oral</td>
</tr>
<tr>
<td>7</td>
<td>PERFORMANCE 09:00 – 10:20</td>
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<tr>
<td></td>
<td>7.1 Quality Performance Report</td>
<td>Paula Shobbrook</td>
<td>D</td>
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<tr>
<td></td>
<td>7.2 Performance Report</td>
<td>Richard Renaut</td>
<td>E</td>
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<td></td>
<td>7.3 Workforce Report</td>
<td>Karen Allman</td>
<td>F</td>
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<td></td>
<td>7.4 Financial Performance</td>
<td>Stuart Hunter</td>
<td>G</td>
</tr>
<tr>
<td>8</td>
<td>DECISION 10:20 – 11:30</td>
<td></td>
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<tr>
<td></td>
<td>8.1 Changes to the Trust’s Constitution</td>
<td>Sarah Anderson</td>
<td>H</td>
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<td></td>
<td>8.2 Changes to the Governor Code of Conduct</td>
<td>Sarah Anderson</td>
<td>I</td>
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<tr>
<td></td>
<td>8.3 Revised Statutory and Governor Committee Terms of Reference</td>
<td>Sarah Anderson</td>
<td>J</td>
</tr>
<tr>
<td></td>
<td>8.4 Reports of the NED Remuneration and Nomination Committees including the appointment of Trust’s Vice Chairperson</td>
<td>Sarah Anderson</td>
<td>K</td>
</tr>
<tr>
<td>Item description</td>
<td>Item presenter</td>
<td>Appendix</td>
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<tr>
<td>8.5 Council of Governor meeting dates for 2016 – March 2017</td>
<td>Sarah Anderson</td>
<td>L</td>
<td></td>
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<tr>
<td>9 FOR INFORMATION and DISCUSSION 11:30-11:50</td>
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<tr>
<td>10 FOR INFORMATION 11:50-12:00</td>
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<tr>
<td>10.1 Forward Planner</td>
<td>Sarah Anderson</td>
<td>N</td>
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<tr>
<td>10.2 Governor Sub-Committee Meeting Reports</td>
<td>Reporting Governors</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>10.3 Trust Sub-Committee Reports</td>
<td>Reporting Governors</td>
<td>P</td>
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<tr>
<td>10.4 Reports from Appointed Governors</td>
<td>Appointed Governors</td>
<td></td>
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<tr>
<td>10.5 Reports from Staff Governors</td>
<td>Staff Governors</td>
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<tr>
<td>10.6 Governor reports of activities attended outside the Trust</td>
<td>All Governors</td>
<td></td>
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<tr>
<td>11 DATE OF THE NEXT COUNCIL OF GOVERNORS MEETING</td>
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<tr>
<td>Thursday 5 November 2015</td>
<td></td>
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<tr>
<td>08:30 Conference Room, Education Centre</td>
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<tr>
<td>Royal Bournemouth Hospital</td>
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To resolve that under the provision of Section 1, Sub-Section 3, of the Public Bodies Admission to Meetings Act 1940, representatives of the press, members of the public and others not invited to attend 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 following Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust have declared interests as listed below:

<table>
<thead>
<tr>
<th>NAME/CONSTITUENCY</th>
<th>DECLARED INTEREST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ELECTED GOVERNORS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Public: Bournemouth and Poole</strong></td>
<td></td>
</tr>
<tr>
<td>David Bellamy</td>
<td>• The Chairman of the Patient Panel of a local GP Group</td>
</tr>
<tr>
<td>Carole Deas</td>
<td>• Partner – Roger Parsons, Public Governor</td>
</tr>
<tr>
<td>Paul Higgs</td>
<td>None</td>
</tr>
<tr>
<td>Colin Pipe</td>
<td>• Member of the team at the Office of the Police and Crime Commissioner (PCC) as Special Advisor (volunteer position)</td>
</tr>
<tr>
<td></td>
<td>• Director of the Sunningtonn Management Company Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Alum Court Ltd</td>
</tr>
<tr>
<td>Roger Parsons</td>
<td>• Partner – Carole Deas, Public Governor</td>
</tr>
<tr>
<td>Keith Mitchell</td>
<td>None</td>
</tr>
<tr>
<td>Guy Rouquette</td>
<td>• Chair of the Board of Trustees of the Steven James Practice</td>
</tr>
<tr>
<td></td>
<td>• Member of the Liberal Democrat Party</td>
</tr>
<tr>
<td>David Triplow</td>
<td>None</td>
</tr>
<tr>
<td>Vacancy</td>
<td></td>
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<tr>
<td><strong>Public: Christchurch and Dorset County</strong></td>
<td></td>
</tr>
<tr>
<td>Chris Archibold</td>
<td>• Wife is a member of staff employed in the Orthopaedic Department, based at the Royal Bournemouth Hospital</td>
</tr>
<tr>
<td>Paul McMillan</td>
<td>None</td>
</tr>
<tr>
<td>Derek Chaffey</td>
<td>• Member of the Stanpit and Mudeford Residents’ Association</td>
</tr>
<tr>
<td>Eric Fisher</td>
<td>• Member of East Dorset Locality Health Network Group (in a personal capacity) which is arranged through the Dorset CCG</td>
</tr>
<tr>
<td></td>
<td>• Member of the Patient and Public Engagement Group (PPEG) with Dorset CCG as part of the Clinical Services Review</td>
</tr>
<tr>
<td>Doreen Holford</td>
<td>None</td>
</tr>
<tr>
<td>Brian Young</td>
<td>• Consultant (salaried) for Immunotec</td>
</tr>
<tr>
<td><strong>Public: New Forest, Hampshire and Salisbury</strong></td>
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<tr>
<td>Mike Allen</td>
<td>None</td>
</tr>
<tr>
<td>Bob Gee</td>
<td>None</td>
</tr>
<tr>
<td>Graham Swetman</td>
<td>• Member of the Conservative Party</td>
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<tr>
<td></td>
<td>• Director, Family Property Investment Companies</td>
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</tbody>
</table>
## Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Berridge</td>
<td>Medical and Dental</td>
<td>None</td>
</tr>
<tr>
<td>Dean Feegrade</td>
<td>Administration, Clerical and Management</td>
<td>None</td>
</tr>
<tr>
<td>Ian Knox</td>
<td>Allied Healthcare Professionals, Scientific and Technicians</td>
<td>None</td>
</tr>
<tr>
<td>Petrina Taylor</td>
<td>Nursing, Midwifery and Healthcare Assistants</td>
<td>None</td>
</tr>
<tr>
<td>Richard Owen</td>
<td>Hotel Services and Estates</td>
<td>None</td>
</tr>
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</table>

## NOMINATED GOVERNORS

### Local Authority Governors

<table>
<thead>
<tr>
<th>Borough Council</th>
<th>Vacancy</th>
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<tbody>
<tr>
<td>Bournemouth Borough</td>
<td></td>
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<tr>
<td>Hampshire Council</td>
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<tr>
<td>Dorset County Council</td>
<td>Vacancy</td>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests</th>
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</thead>
<tbody>
<tr>
<td>Colin Jamieson</td>
<td>Elected member of Christchurch Borough Council</td>
</tr>
<tr>
<td></td>
<td>Elected member of Dorset County Council</td>
</tr>
<tr>
<td></td>
<td>Chairman of the Christchurch Planning Committee</td>
</tr>
<tr>
<td></td>
<td>Cabinet Member for E</td>
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<tr>
<td></td>
<td>Reserve Member of the Dorset Health and Wellbeing Board</td>
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<tr>
<td></td>
<td>Member of the Cabinet of Dorset County Council (Economic Growth and Enterprise Portfolio)</td>
</tr>
<tr>
<td></td>
<td>Wife is a Constituency Agent for the Conservative Party</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests</th>
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</thead>
<tbody>
<tr>
<td>Poole Borough Council</td>
<td>Vacancy</td>
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</table>

### Partnership Governors

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests</th>
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</thead>
<tbody>
<tr>
<td>Philip Copson</td>
<td>None</td>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Interests</th>
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<tbody>
<tr>
<td>Dr Gail Thomas</td>
<td>None</td>
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### Primary Care Trust Governors

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests</th>
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<tbody>
<tr>
<td>Dr Tom Knight</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>CCG Dorset</td>
<td>Board Member of Dorset Clinical Commissioning Group (CCG)</td>
</tr>
</tbody>
</table>
## Council of Governors Meeting Minutes – Part 1

<table>
<thead>
<tr>
<th>Name:</th>
<th>Council of Governors</th>
<th>Chair:</th>
<th>Jane Stichbury</th>
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</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Tuesday 28 April 2015</td>
<td>Time:</td>
<td>08:30</td>
</tr>
<tr>
<td>Venue:</td>
<td>Conference Room, Education Centre</td>
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### Present:
- Jane Stichbury (JS), Chairman
- Mike Allen (MA), Public Governor (New Forest, Hampshire and Salisbury)
- Chris Archibold (CA), Public Governor (Christchurch and Dorset County)
- David Bellamy (DB), Public Governor (Bournemouth and Poole)
- Sarah Berridge (SB), Staff Governor (Medical and Dental)
- Derek Chaffey (DC), Public Governor (Christchurch and Dorset County)
- Philip Copson (PC), Appointed Governor (Hospital Volunteers)
- Eric Fisher (EF), Public Governor (Christchurch and Dorset County)
- Bob Gee (BG), Public Governor (New Forest, Hampshire and Salisbury)
- Phil Goodall (PG), Appointed Governor (Borough of Poole)
- Paul Higgs (PH), Public Governor (Bournemouth and Poole)
- Doreen Holford (DH), Public Governor (Christchurch and Dorset County)
- Ian Knox (IK), Staff Governor (Allied Health Professionals, Scientific and Technical)
- Paul McMillan (PM), Public Governor (Christchurch and Dorset County)
- Keith Mitchell (KM), Public Governor (Bournemouth and Poole)
- Richard Owen (RO), Staff Governor (Hotel Services and Estates)
- Colin Pipe (CP), Public Governor (Bournemouth and Poole)
- Guy Rouquette (GR), Public Governor (Bournemouth and Poole) *(from item 7)*
- Graham Swetman (GS), Public Governor (New Forest, Hampshire and Salisbury)
- Petrina Taylor (PT), Staff Governor (Nursing, Midwifery & Healthcare Assistants)
- Gail Thomas (GT), Appointed Governor (Bournemouth University)
- David Triplow (DT), Public Governor (Bournemouth and Poole)

### Apologies:
- Carole Deas (CD), Public Governor (Bournemouth and Poole)
- Dean Feegrade (DF), Staff Governor (Administrative, Clerical and Management)
- Colin Jamieson (CJ), Appointed Governor (Dorset County Council)
- Roger Parsons (RP), Public Governor (Bournemouth and Poole)
- Monika Whitmarsh, Public Governor (Bournemouth and Poole)
- Brian Young (BY), Public Governor (Christchurch and Dorset County)
- Basil Fozard (BF), Medical Director
- Tony Spotswood (TS), Chief Executive

### Non Attendance:
- John Adams (JA), Appointed Governor (Bournemouth Borough Council)
- Tom Knight (TK), Appointed Governor (NHS Dorset Clinical Commissioning Group)

### In Attendance:
- Sarah Anderson (SA), Trust Secretary
- Anneliese Harrison (AH), Assistant Trust Secretary (minute taker)
MINUTES

The meeting commenced: 08:30

15/25 Welcome

JS welcomed everyone attending the meeting of the Council of Governors and welcomed the new staff governors and governor for volunteers.

15/26 Apologies for absence

As listed above.

15/27 Declarations of interest

None.

15/28 Approval of the minutes of the Meeting held 22 January 2015

The minutes were confirmed as an accurate record.

MATTERS ARISING

15/29 Actions Log from Minutes of the Meeting held on 22 January 2015

- 15/05 KM queried whether the food audit results would be provided to the Council of Governors. PS confirmed that the ward guide would be circulated.
- 15/13 Clarification as to the tendering process in light of the CSR is to be considered as an agenda item for the next governor CSR update.
- 15/13 governor profiles are still to be updated and will include the new staff governors along with RBCH email addresses being added for public governors.

DECISION

15/30 Trust Secretary’s Report (item 2 only)

SA outlined that following the resignation of Glenys Brown the Council of Governors were required to approve the election of the next eligible candidate from the elections held in 2014. It was proposed that the new publically elected governor for Bournemouth and Poole, Guy Roquette, was approved. The Council of Governors approved the election and invited GR to join the Council of Governors meeting.

SA requested that in future the approval to fill vacancies using the next eligible candidate from the previous election was to be delegated to the
Trust Secretary to ensure that governor vacancies can be filled promptly.

<table>
<thead>
<tr>
<th>STRATEGY</th>
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<tr>
<td>15/31 Clinical Services Review (CSR) Update</td>
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<tr>
<td>PS updated the Council of Governors on the recent developments of the</td>
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<tr>
<td>clinical services review (CSR) noting the information was shared in</td>
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<tr>
<td>confidence with governors:</td>
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<tr>
<td>• The process has sought to engage clinicians in shaping services for the</td>
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<tr>
<td>future. Clinicians, within the clinical reference group, have developed</td>
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<tr>
<td>recommendations for the CSR and support the clinical commissioning group</td>
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<tr>
<td>(CCG);</td>
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<tr>
<td>• CCG are developing a business case to help support the decision</td>
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<td>making process and consultation commencing on 19 May;</td>
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<tr>
<td>• Models for in-hospital and out of hospital care are being developed</td>
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<tr>
<td>together with proposals for how hospitals will be run throughout</td>
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<tr>
<td>Dorset;</td>
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<tr>
<td>• McKinseys suggest consulting on a suite of options and public</td>
</tr>
<tr>
<td>consultation will not begin until after the election;</td>
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<tr>
<td>• The models include: one site will provide a broad range of district</td>
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<tr>
<td>general hospital services; another site will provide hyper acute</td>
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<td>services with 24/7 consultant care and a site providing elective care</td>
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<td>services and in-patient day services;</td>
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<tr>
<td>• There are a number of challenges for Dorset including workforce;</td>
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<tr>
<td>24/7 consultant delivered services, A&amp;E is not currently available</td>
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<td>within Dorset and the focus is on working to improve services;</td>
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<tr>
<td>• Work has been conducted internally on the services being provided by</td>
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<td>Poole or RBCH and how services would be realigned across the sites;</td>
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<tr>
<td>• The criteria that the CCG are using to evaluate each site has been</td>
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<tr>
<td>developed through the clinical teams to ensure quality services across</td>
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<tr>
<td>Dorset, focusing on clinical effectiveness and patient care;</td>
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<tr>
<td>• Factors include access, value for money services that are sustainable,</td>
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<tr>
<td>workforce, deliverability and research/education;</td>
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<td>• The Board have ensured that activity from West Hampshire is included</td>
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<td>in the modelling;</td>
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<td>EF commented that the CCG’s PPEG group contributed to the input process</td>
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<tr>
<td>and a future meeting was due in June. EF was encouraged by the</td>
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<tr>
<td>engagement with both clinicians and the public and felt assured that the</td>
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<tr>
<td>overall provision for care within Dorset was priority.</td>
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<tr>
<td>BG queried whether there were firm plans for a 24/7 consultant led ED. PS</td>
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<tr>
<td>responded that the service was being considered within the modelling in</td>
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<tr>
<td>line with the NICE recommendations.</td>
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<tr>
<td>CP queried the review and how future proof it would be for Dorset. PS</td>
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<tr>
<td>advised that the modelling is undertaken over five years and has been</td>
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<tr>
<td>developed with clinician recommendations. The out of hospital services</td>
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<tr>
<td>will be configured differently to provide shortened length of stay and</td>
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<td>there must</td>
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be better provisions of community services. The Trust will need to work with local authorities and the CCG on this issue and are ensuring that all hospitals, including Christchurch Hospital are being considered.

DT queried the implication on staff at each site and whether there was protection for those who may lose their jobs. PS commented that once the options are provided further detail will be considered. The HR group meetings as part of the process are considering the future workforce required for Dorset.

The Chairman noted the importance of governor involvement at the consultation stage. Regular briefings are to be provided and the item will be included for discussion at the next Council of Governors meeting regarding the proposals with involvement from communications.

<table>
<thead>
<tr>
<th>15/32 Workforce Report</th>
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<tbody>
<tr>
<td>KA outlined the report highlighting the following themes:</td>
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<tr>
<td>• The report reflects the workforce data to the end of the financial year;</td>
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<tr>
<td>• There is an increased focus on recruitment and the review of methods used to demonstrate how great the organisation is to work for;</td>
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<td>• Joining rate is higher than the leaving rate;</td>
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<td>• Mandatory training - compliance with essential core skills training and appraisal remains challenging;</td>
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<tr>
<td>• The virtual learning training environment has been successful and staff are able to access modules online. 5000 staff have completed modules were completed in one month. More work is required but progress has been shown;</td>
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<tr>
<td>• Overseas nursing recruitment has been successful. 16 Filipino nurses will be joining in September and 14 overseas EU nurses from 18 May. Additional support will be provided through an adaptation course;</td>
</tr>
<tr>
<td>• Following an RCN event the Trust has confirmed 6 offers for newly qualified nurses;</td>
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<td>• The Trust’s Nursing open day will be held on 16 May with 60 interviews booked;</td>
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<td>• The new appraisal process has received strong feedback and will be fundamental to the culture and values within the organisation;</td>
</tr>
<tr>
<td>• FFT for staff - the results highlighted a need for further staff engagement. The survey included a composite of questions and overall 58% of staff would recommend the Trust as a place to work. More work is required to improve communication with staff and their managers.</td>
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</table>

SB noted some concerns amongst staff about retention in light of the CSR. KA responded that this was not reflective of the feedback provided recently but that the Trust was working to ensure staff are kept up to date and once the options are available further reassurance will be provided.

The Council of Governors requested further detail from the analysis of the FFT for staff data to enable staff governors to support improvements. KA
confirmed that once the data had been analysed a summary would be made available. The Council of Governors also queried when the Trust would be compliant with the 90% mandatory training target. KA highlighted that a cultural change was necessary and that managers need to take responsibility for their directorates and the Chairman confirmed that this is discussed monthly by the Board.

IK highlighted the current staff vacancies in theatres and issues with retention. PS responded that the vacancies are reviewed by DOOs and this has been given priority and support. PS will provide the actions being implemented in theatres.

KA advised governors that the latest EXIT information would be provided to the Board in May/June and following this the governors would have sight of the data. The information is discussed with individual areas. The outcomes/themes will be brought back to the Council of Governors.

RO raised concerns that the current recruitment and retention premia within Estates was having a negative impact upon staff. KA will provide a response on the issue.

### 15/33 Results from Staff Survey

VD outlined the staff survey data noting the following key themes:

- **Response rate** was lower than previous years but was higher than the national average;
- **Top strengths**—staff reporting errors, near misses and concerns about clinical practice. The feedback from patient services users was above average. Fewer staff are feeling pressured at work and fewer staff are working whilst unwell;
- **Weaknesses**—there are still a number of staff reporting experiences of harassment and bullying but this has improved slightly since last year. This issue is being addressed through staff wellbeing and further communication;
- A small percentage of staff have reported experiencing violence from colleagues. This has been investigated thoroughly and little or no evidence was found to support the results in the staff survey;
- There has been an increase in physical violence from patients, a decline in attendance at health and safety training, staff not receiving annual appraisals;
- **Corporate action plan**—focus on zero tolerance of staff physical violence with health and wellbeing initiatives for staff and further security managers helping to address patient physical violence. The whistleblowing policy is being reviewed and work is underway on freedom to speak up review;
- Bullying and harassment sessions are being held with conflict resolution sessions supported by e-learning to tackle harassment and bullying in the organisation.

The information is to be circulated to the Council of Governors. Governors raised concern about staff reporting experiences of physical violence. VD
assured the Council that the Trust had a zero tolerance policy and the interpretation of the definition of physical violence was also a factor. Incidences had not been identified following investigation. The Chairman supported that the improvement was not satisfactory and that a rigorous approach was required. The issue will be remitted to the Board and it was emphasised that the Trust must demonstrate an improvement next year. The Council of Governors noted the varying perception of the definitions and how respondents interpret the question.

**15/34 Quality Performance Report**

PS presented the quality performance report noting the following information:

- **SIs** - the Trust has encouraged an open reporting culture and reporting is in line with other acute Trusts in Dorset;
- **Harm free care** - there is still a high number of patients admitted with existing pressure ulcer damage. The Trust achieved above 97% and is an improved position to last year;
- **Quality objectives within the end of year report:**
  - Trust achieved its objective for patient safety incidents,
  - Patient fall target was not achieved but slightly improved, moderate and severe harm 50% reduction but more work to do,
  - Medication administration 12% reduction,
  - Medication prescription 32% reduction,
  - 30% reduction in SIs for the year and the Trust is introducing an electronic system,
  - Reduction of category 3 and 4 pressure ulcers was not achieved but improvements have been made,
  - Staff accidents 9% reduction but objective not achieved.

PS advised that the actions to improve in areas highlighted include improvements to care plan completion. These are being reviewed and streamlined to make the process more efficient. ‘ENA’ is being introduced to support this process and will be launched in July.

The Council of Governors commented on the number of patients admitted with pressure ulcer damage and queried whether this was due to a lack of community care. PS advised 100 patients a month are admitted with pressure ulcers and they are monitored and information provided back to the CCG.

PS confirmed that once reviewed the recent Dr Foster information would be provided to the Governors following submission to the Board. The Chair noted the positive improvements and assured the Council of Governors that the Trust was not complacent and further work was required.

**15/35 Performance Report**

RR highlighted that the report contained a summary of the key performance and non-compliances in Q4 for 2014/15. He emphasised the key themes:

- In the last financial year there has been a significant number of breaches of the standards;
- The programme for 2015/16 focuses on 18 weeks RTT where a number of new processes have been put in place to address waiting times. The individual tracking process for outpatients has identified areas for improvement within pathways;
- The result for the first three months will not achieve compliance for outpatient diagnostics;
- ED performance in March was strong. This has decreased slightly in April but patients are being treated more efficiently. Actions and work streams in place involve daytime process changes and earlier discharge;
- The Trust is an outlier for cancer 2 week waits, 31 and 62 day waits;
- Significant backlog in endoscopy due to a mis-match of capacity and demand. It is expected that the Trust will be compliant this quarter;
- RTT incomplete pathways are at risk in Q4 as the current reporting methodology cannot be confirmed until the end of April although it is expected the Trust will be compliant;
- 62 day waits— the Trust is expected to be reporting non-compliance for the quarter due to backlog issues within urology. Work is underway to reduce the robot backlog, template biopsies will improve diagnostic waits and the individual patient tracking will provide the attention to detail to resolve waiting times;
- VTE and 52 week waits returned to compliance;
- Action plans for the recovery of cancer; RTT and ED 4 hour/flow are in place and is being monitored by the Board.

The Council of Governors queried the Trust’s position in relation to stroke data. RR advised that recruitment for the stroke outreach team has just started. The stroke data from Jan-March has been validated and will be provided to the governors. The data for April is unvalidated. The Trust is currently achieving the one hour scanning target. Capacity pressures impacted upon performance during Jan-March however improvements are being seen.

Further, the Council of Governors queried how the Trust can measure the success of operations completed at the Trust. RR advised that mortality score which is significantly lower than the expected level and is consistent. PS added that the in-patient survey will be published on 1 May and provides a good indication of the Trust’s performance. The CQC intelligent monitoring report is due to be published and will support the Trust’s progress. PS emphasised that outcome data is reviewed by consultants as part of the appraisal process.

A summary of the headlines of the outcome data is to be provided to Governors to indicate the Trust’s performance compared to other organisations. The Chairman proposed that the subject could be addressed in a seminar.

EF queried the impact of the Monitor breaches upon the CSR. RR advised that three red breaches would trigger a review and a number of organisations are in the same position as pressures are consistent across
the country. RR added that the Board are paying adequate attention to the issues and the actions to address them. Governors will be kept up to date on Monitor’s review of the Trust’s performance.

<table>
<thead>
<tr>
<th>15/36 Financial Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>SH provided an update on the Trust’s financial position noting the key issues:</td>
</tr>
<tr>
<td>• End of year position- final position prior to audit the Trust is reporting a £5.2 million deficit;</td>
</tr>
<tr>
<td>• Within the FT sector 3/4 are reporting a deficit amounting to £350 million in total and the average forecast out-turn is 5 times worse than the expected outcome at the beginning of the year;</td>
</tr>
<tr>
<td>• National funding for the back log of RTT has been provided;</td>
</tr>
<tr>
<td>• Auditors will provide their view of the Trust’s accounts to governors;</td>
</tr>
<tr>
<td>• Trust needs to focus on the transformation savings not impacting upon quality care and the quality impact assurance committee has been developed to monitor this.</td>
</tr>
</tbody>
</table>

SH advised if it was not for the use of agency staff the Trust would have been able to achieve a break even position. It is expected that the agency spend will reduce although it remains a national problem. PS commented that overseas staff have been recruited to fill gaps in specific skill sets. The Trust are working with qualified nurses from Bournemouth University and implementing a recruitment drive throughout the UK and ensuring RBCH is an attractive employment opportunity.

DB queried the expected deficit for next year and the Trust’s reserves. SH commented that the Trust has predicted a £12.9 million budgeted deficit and the Trust will have some reserves but if expenditure continues cash reserves will not be available at the end of 2016/17 and this will be due to agency costs.

The Chairman emphasised the work underway throughout the Trust to improve the financial position whilst maintaining quality for patients. She thanked SH for his work under the challenging circumstances.

<table>
<thead>
<tr>
<th>DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/37 Trust Secretary’s Report (other than item 2)</td>
</tr>
<tr>
<td>The report was taken as read. The Council of Governors were asked to consider the following decision items:</td>
</tr>
<tr>
<td>• Item 2 the Council of Governors approved the appointment of GR (at 15/30);</td>
</tr>
<tr>
<td>• Item 3 the Council of Governors were asked to ratify the election of BG as deputy Chairman. EF proposed approval and DB seconded the decision. The Council of Governors ratified the appointment;</td>
</tr>
<tr>
<td>• Item 4 the Council of Governors noted the new staff governor appointments;</td>
</tr>
<tr>
<td>• Item 5 the Council of Governors noted the appointment of the new governor for volunteers;</td>
</tr>
</tbody>
</table>
- Item 6 the Council of Governors noted the update on the structure of the Council of Governor committees;
- Item 7 the Council of Governors noted the update on the structure of Board committees;

EF queried the definition of governor observers on Board committees. JS confirmed that governors would remain active on Board committees but cannot be a part of the decision making. The NHS providers network survey of FTs highlighted that 36% of Trusts had governors on committees who were active, 54% were observers only and 11 had no governors on committees. The Trust was within the top tranche for governor involvement. EF requested ‘active’ to be included within the description of the structure of committees.

- Item 8- the Council of Governors were asked to note the update on governor involvement in clinical areas;

Governors highlighted concern that previous benefits from governor involvement, such as outpatient membership and patient feedback, could be lost. SA added that in practice it is only the way in which governors will access wards that will change. Governors enforced that the Savile report should not be used to restrict governor interaction with patients. The Chairman emphasised that the Trust must adhere to the national review and assurance must be provided to Monitor. Policies relating to volunteer activity have been in place and are developed to cover all non-staff visits to clinical areas, including governors.

The role of governors is to engage both patients and the public and there needs to be more of a focus on public engagement. This policy along with the other new policies will be submitted to PECC and provided to the Board and will be circulated once agreed.

- Item 9 the Council of Governors endorsed agreement for 2015/16 priorities and the selection of stroke data as the KPI indicator to be audited;

EF requested a separate report of the scope for the audited indicator from last year. SA confirmed the external auditors are due to attend the July Council of Governors meeting. SA will clarify whether the indicator was reported last year.

- Item 10 the Council of Governors noted the need for an extraordinary meeting to appoint the new NED.

JS updated governors that the Non-executive director role for Vice Chair and SID will be divided and current NEDs have been invited to express their interests in these posts. The Council of Governors will appoint the Vice Chair and the Board will appoint the SID under the constitution. An update will be provided to the meeting on 11 May and the new NED will be appointed.
<table>
<thead>
<tr>
<th>15/38</th>
<th>Role of the Governors with actions from Governors Workshops held on 30 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SA tabled the paper. She outlined that there had been some changes which have led to uncertainties and the workshop on 30 March was arranged to resolve these.</td>
</tr>
<tr>
<td></td>
<td>It was discussed that the role of governors needs to be clear and transparent as evident in the governor guide and within legislation. SA to construct a governor role and responsibility document by expanding the presentation appended to the paper.</td>
</tr>
<tr>
<td></td>
<td>It was emphasised that the active observer role during Board committee meetings is a slight change in practice. The Board has a responsibility to ensure governors are provided with the right training and education. SA encouraged that the Board and governors needed to develop relationship and to provide any feedback for areas where it is felt training is required.</td>
</tr>
<tr>
<td></td>
<td>DT commented that some governor bodies have a strategy committee and that governors felt uncomfortable about making decisions about the Trust’s strategy and proposed there should be a strategy committee. SA confirmed that this will be considered within the review of the Council of Governors committees. EF commented that each governor-led committee should have a clear remit incorporating the aims of the Trust to ensure alignment and to also ensure that it is fed back to the public at the AMM as to what governors have achieved.</td>
</tr>
<tr>
<td></td>
<td>DH commented on the governor responsibility of recruiting new members and that Poole hospital HR have greater involvement in events. DH emphasised that RBCH HR should be more involved in events which will aid recruitment and also membership engagement. PS supported that this had already been proposed by the NED chair of the Workforce Committee.</td>
</tr>
<tr>
<td></td>
<td>CP emphasised that the Council of Governors should develop the working relationship with NEDs to facilitate the role more. The Chairman commented that the SID plays an important part in this and having one NED as the SID would better support the relationships going forward. It was proposed that further dialogue with NEDs should be enhanced at a future BoD/CoG away day.</td>
</tr>
<tr>
<td></td>
<td>Governors queried the future of the Scrutiny Committee. JS explained that any survey work was to be determined and approved by GIPPE and commissioned in this regard. SA added that the Scrutiny Committee overlapped with GIPPE as part of the review of the committee structures as a whole.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15/39</th>
<th>Forward Planner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The item was noted for information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15/40</th>
<th>Governor Sub-Committee Meeting Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Membership Development Committee (MDC)</td>
</tr>
<tr>
<td></td>
<td>DT requested governor attendance at the Bransgore fete and on 18 July at</td>
</tr>
<tr>
<td>15/41</td>
<td>Trust Sub-Committee Reports</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>The reports were <strong>noted</strong> for information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15/42</th>
<th>Reports from Appointed Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The reports were <strong>noted</strong> for information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15/43</th>
<th>Report from Staff Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The reports were <strong>noted</strong> for information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15/44</th>
<th>Governor reports of activities outside the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The reports were <strong>noted</strong> for information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15/45</th>
<th>Date of the next Council of Governors Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Concluded at 12:00 am. <strong>Next meeting to be held on Wednesday 15 July 2015 at 08:30am</strong> Conference Room, Education Centre, Royal Bournemouth Hospital.</td>
</tr>
</tbody>
</table>

To resolve that under the provision of Section 1, Sub-Section 2, of the Public Bodies Admission to Meetings Act 1940, representatives of the press, members of the public and others not invited to attend 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

Actions carried forward from a meeting of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust **Council of Governors Part 1** held on **28 April 2015** and previous.

<table>
<thead>
<tr>
<th>Actions from Minutes of the Meeting held on 22 January 2015</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FOR INFORMATION</strong></td>
<td></td>
</tr>
<tr>
<td><strong>15/12</strong> Events for Membership</td>
<td></td>
</tr>
<tr>
<td>DR advised CoG that the MDC were developing a presentation to use at recruitment events and encouraged Governor involvement. JS proposed that a standard script should be devised for use at groups and events to attract members and the MDC were to lead on this.</td>
<td><strong>MDC</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Agenda item at the next MDC meeting planned August 2015</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MATTERS ARISING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>15/29</strong> Actions Log from Minutes of the Meeting held on 28 April 2015</td>
<td></td>
</tr>
<tr>
<td><strong>i)</strong> 15/05 14/71 KM queried whether the food audit results could be circulated.</td>
<td><strong>PS/DR</strong></td>
</tr>
<tr>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td><strong>ii)</strong> 15/07 Clarification as to the tendering process in light of the CSR is to be considered as an agenda item for the next governor CSR update.</td>
<td><strong>SA/DR</strong></td>
</tr>
<tr>
<td><strong>CCG have been</strong></td>
<td></td>
</tr>
<tr>
<td><strong>iii)</strong> 15/13 governor profiles are to be updated and will include the new staff governors along with RBCH email addresses for public governors. Governors to provide personal profiles.</td>
<td><strong>BG/EF</strong></td>
</tr>
<tr>
<td><strong>All Governors</strong></td>
<td><strong>On-going</strong></td>
</tr>
</tbody>
</table>
## STRATEGY

### Clinical Services Review (CSR) Update

Invite the CCG to present the detail around the proposed options at the next meeting in July. Communications are also to be involved.  
**Agenda Item July/SA/Comms**  
CCG attending on 22 July to speak to CoG

## Workforce Report

1. **i)** Provide a summary of the analysis of FFT for staff data 204/15.  
   - **KA**  
   - Analysis of data in progress. To be provided once collated and submitted to the Board of Directors.

2. **ii)** Provide a list of the actions being implemented in theatres to IK.  
   - **PS**  
   - Update to be provided at the next CoG meeting

3. **iii)** The outcomes/themes of the EXIT data will be provided to the Council of Governors once it has been presented to the Board of Directors  
   - **KA**  
   - In progress. To be provided following submission to the Board of Directors.

4. **iv)** Provide a response to RO Estates policy query.  
   - **KA**  
   - Completed

## Quality Performance Report

Provide the Dr Foster information to Governors following submission to the Board.  
**PS**  
Completed. Circulated to Governors

## Performance Report

1. **i)** Provide the validated stroke data from Jan-March to governors.  
   - **RR**  
   - See 15/35ii) below, and future COG performance reports.

2. **ii)** Provide a summary/seminar to outline the key outcomes data compared to other organisations.  
   - **RR/SA**  
   - Tuesday September 15 seminar set up 10-11am to review SSNAP in detail with Dr Jupp (Stroke Lead)
## DECISION

<table>
<thead>
<tr>
<th>15/37</th>
<th>Trust Secretary’s Report (other than item 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>i)</td>
<td>Circulate the access to clinical areas policy once agreed by PECC and Board.</td>
</tr>
<tr>
<td>ii)</td>
<td>Clarify whether the governor KPI indicator was reported last year.</td>
</tr>
<tr>
<td>iii)</td>
<td>Provide an update on the Vice Chair and SID expressions of interest and the appointment of the NED at the meeting on 11 May</td>
</tr>
</tbody>
</table>

## FOR INFORMATION

<table>
<thead>
<tr>
<th>15/38</th>
<th>Role of the Governors with actions from Governors Workshops held on 30 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>i)</td>
<td>Compile a governor role and responsibility document to clearly define the governor role, incorporating the reference to the Monitor guide and legislation.</td>
</tr>
<tr>
<td>ii)</td>
<td>Arrange a BoD/CoG away day to enhance the dialogue with NEDs.</td>
</tr>
</tbody>
</table>
**Action 15/32ii)
Theatre Organisational Development**

**Introduction**
A stable and motivated Theatre workforce is crucial to the delivery of timely and appropriate care to our patients. In recent years it has been increasingly difficult to recruit into roles with many of the experienced staff having retired or will do so in the next few years. As part of our Organisational Plan for Theatres we have three interlinked streams of work being implemented during 2015-16: Recruitment; Retention; & Education and Training. The delivery of these programmes will be enabled through two working groups; Recruitment and Retention and the Peri-Operative Education Forum. The aims being, to have a workforce that is fit for purpose for a new way of working in the future, supporting the delivery of patient care, activity and income for the Trust whilst removing the need to utilise agency staffing and the associated costs.

**The Issues**
The groups initially focussed on understanding the issues and took two main actions:

1. A detailed analysis was undertaken in the New Year to compare the capacity and demand for staffing within the theatres environment. The capacity analysis included an assessment of vacant posts and staff competency to assess the gap in staffing within the area. This revealed that the shortfall in appropriately skilled staff was far greater than the known vacancies and the training and development of staff required review and improvement.

2. A further analysis was undertaken by the HR/Organisational Development Team and a report produced that combined three sources, the Staff Impressions Survey; the National Staff Survey 2014 and the Surgical Listening event that involved 90 staff in a 4 hour timeout. The main themes this highlighted are; communication between senior management and staff; staff reported low morale and a lack of recognition; and the Training and education content and relevance.

From this a detailed programme of work and action plan has been developed and this incorporates;

<table>
<thead>
<tr>
<th>Area</th>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of forecasts for recruitment, turnover, bank and agency costs</td>
<td>Completed. Actual is running close to forecast at month 2.</td>
</tr>
<tr>
<td>Leadership of training &amp; education agenda</td>
<td>Band 7 Educational Lead appointed with Band 6 p/t Support</td>
</tr>
<tr>
<td>Database of skills and where staff are on a programme of development</td>
<td>Completed. Updated on a monthly basis.</td>
</tr>
<tr>
<td>Revised competency &amp; training documentation with timelines</td>
<td>New competency framework with clear expectations &amp; deadlines.</td>
</tr>
<tr>
<td>Specific role developments</td>
<td>In development</td>
</tr>
<tr>
<td>Human Factors</td>
<td>Trainers training completed and first large group (70+) completed session. Additional sessions scheduled.</td>
</tr>
<tr>
<td>Local induction programme</td>
<td>Revision completed</td>
</tr>
<tr>
<td>Communications</td>
<td>Strategy developed</td>
</tr>
<tr>
<td>How staff can share ideas</td>
<td>Detailed actions developed and in implementation</td>
</tr>
<tr>
<td>How staff can be involved &amp; engaged</td>
<td>Detailed actions developed and in implementation</td>
</tr>
<tr>
<td>How staff can be recognised</td>
<td>Detailed actions developed and in implementation.</td>
</tr>
<tr>
<td>Mentor training and allocation</td>
<td>Mentors numbers &amp; training reviewed.</td>
</tr>
<tr>
<td>ODP Trainee Allocations</td>
<td>10 Newly qualified ODPs starting in September</td>
</tr>
<tr>
<td>Recruitment</td>
<td>On-going</td>
</tr>
<tr>
<td>Recruitment of overseas nurses</td>
<td>14 nurses commence October</td>
</tr>
<tr>
<td>Staff rotations between areas / departments</td>
<td>Not commenced</td>
</tr>
</tbody>
</table>

**Current Performance**
Recruitment is progressing in line with forecasts and the training and development work is progressing well. The quarter 1 staff survey results are also showing improvement with 86% of staff reporting an overall good experience in comparison to 75% the previous year; 84% would recommend the Trust as a place for treatment compared to 68% previously; and 63% would recommend Theatres as a place to work, up from 49% previously. The work around communication, engagement and involvement of the staff remains a big challenge and will be an area of focus over the coming months as well as continuing to focus on recruitment and retention.
<table>
<thead>
<tr>
<th>COUNCIL OF GOVERNORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting Date and Part:</strong></td>
</tr>
<tr>
<td><strong>Subject:</strong></td>
</tr>
<tr>
<td><strong>Section:</strong></td>
</tr>
<tr>
<td><strong>Executive Director with overall responsibility:</strong></td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
</tr>
<tr>
<td><strong>Previous discussed at:</strong></td>
</tr>
</tbody>
</table>

**Action required:**
The Council of Governors is asked to receive the summary report of quality performance for April and May.

**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. Quality indicators are reviewed monthly at the Healthcare Assurance Committee and Board of Directors. The latest data was presented to the Board of Directors on the 25<sup>th</sup> June 2015.

The Trust level dashboard provides information on patient safety and patient experience indicators including:

- 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**

i. Have any risks been reduced? No
ii. Have any risks been created? No

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 April and May 2015.

2. Serious Incidents

2 Serious Incidents (SI’s) were confirmed and reported on STEIS in April 2015 and four Serious Incidents (SI’s) were confirmed and reported in May 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”. The information for April and May 2015 is below.

<table>
<thead>
<tr>
<th>NHS SAFETY THERMOMETER</th>
<th>14/15 Trust Average</th>
<th>14/15 National Average</th>
<th>15/16 Target</th>
<th>Apr</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Thermometer % Harm Free Care</td>
<td>90.68%</td>
<td>93.80%</td>
<td>95%</td>
<td>92.56%</td>
<td>92.51%</td>
</tr>
<tr>
<td>Safety Thermometer % Harm Free Care (New Harms only)</td>
<td>97.18%</td>
<td>97.59%</td>
<td>98%</td>
<td>96.78%</td>
<td>97.86%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>April 2015</th>
<th>May 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Pressure Ulcers</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>New falls (Harm)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>New VTE</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Catheter UTI</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk assessment compliance</th>
<th>Jan 2015</th>
<th>Feb 15</th>
<th>Mar 15</th>
<th>April 15</th>
<th>May 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>86%</td>
<td>88%</td>
<td>88%</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>Waterlow</td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
<td>96%</td>
</tr>
<tr>
<td>MUST</td>
<td>74%</td>
<td>76%</td>
<td>81%</td>
<td>83%</td>
<td>87%</td>
</tr>
<tr>
<td>Mobility</td>
<td>87%</td>
<td>88%</td>
<td>89%</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td>Bedrails</td>
<td>88%</td>
<td>90%</td>
<td>89%</td>
<td>92%</td>
<td>93%</td>
</tr>
</tbody>
</table>
4. Patient Experience Report

4.1. Friends and Family Test: National Comparison using the NHS England data base

- **In-Patients Family and Friends Test**
  The Trust is maintaining fairly consistent performance in the inpatient FFT in terms of ranking and percentage, coming 4th in February, then 3rd in March and April out of 167 Trusts together with 98% of patients recommending the Trust in March and April. 97% inpatient stays recommended the Trust in May.

- **Emergency Department (ED) - Family and Friends Test ranking**
  The Trust saw a slight improvement ranking order of FFT, 7th in February, 8th in March and 6th in April with a fairly consistent performance in likely to recommend resulting in a 94% score in April and 92% in May.

- **The Maternity FFT**
  Maternity FFT was 79 in February and 71 in March with consistent compliance (19/20%), and reported as a percentage in April at 98% and 99% in May.

- **Outpatients FFT**
  Outpatients are reporting externally for which there is no compliance target, in April this attained 97% and 96% in May.

4.2. Extremely Unlikely results from FFT

In April, the unlikely and extremely unlikely responses were elevated although there was a significantly increased FFT uptake.

<table>
<thead>
<tr>
<th>Unlikely &amp; Extremely Unlikely Responses</th>
<th>Dec-14</th>
<th>Jan-15</th>
<th>Feb-15</th>
<th>Mar-15</th>
<th>Apr-15**</th>
<th>May-15**</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT submission areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of FFT responses for submission areas only: Unlikely or Extremely Unlikely to recommend (exc. don’t know).</td>
<td>15</td>
<td>29</td>
<td>34</td>
<td>33</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>No of FFT responses</td>
<td>1262</td>
<td>1469</td>
<td>1325</td>
<td>1362</td>
<td>2347</td>
<td>3216</td>
</tr>
<tr>
<td>% Unlikely or Extremely Unlikely to recommend from FFT responses</td>
<td>1.2%</td>
<td>2.0%</td>
<td>2.6%</td>
<td>2.4%</td>
<td>1.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>% Unlikely or Extremely Unlikely from total activity</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>
4.3. Care Audit
The Care Audit provides an overview of fundamental of care continues to be monitored monthly. The overall trend is of sustained improvement with the green areas being maintaining fairly consistently. The areas where we have performance which is a focus in terms of improvement to green centres around noise at night, call bell answering, evaluation of pain intervention, or other measures of intervention. A focus on these has been driven with clinical teams, in terms of behaviour sets and driving the Dignity pledge. Areas have also reviewed and implemented local solutions demonstrating engagement. This is discussed at the patient experience and communications committee and the healthcare assurance committee.

4.4. Patient Opinion and NHS Choices:

Thirty five comments over the three months have been received on the website which have all been actioned and answered appropriately. Positive comments were quality of care, professionalism, communication and pain management, negative comments were pain management, staff attitude and communication. These are all answered by the Patient experience team who liaise with relevant teams.

5. Recommendation

The Council of Governors is asked to note the report which is provided for information and assurance.
### COUNCIL OF GOVERNORS

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>15 July 2015 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subject:</strong></td>
<td>Performance Summary Report – Quarter 1 2015/16</td>
</tr>
<tr>
<td><strong>Section:</strong></td>
<td>Performance</td>
</tr>
<tr>
<td><strong>Author of Paper:</strong></td>
<td>Richard Renaut</td>
</tr>
<tr>
<td><strong>Details of previous discussion and/or dissemination:</strong></td>
<td>TMB / BoD</td>
</tr>
<tr>
<td><strong>Key Purpose:</strong></td>
<td>Patient Engagement</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action Required by Council of Governors:</strong></td>
<td>To note the Trust’s performance against key Monitor and national/local indicators and actions highlighted in relation to non-compliant or ‘at risk’ indicators.</td>
</tr>
<tr>
<td><strong>Summary:</strong></td>
<td>This report provides a summary of the key performance highlights and non compliances in Q1 2015/16. It outlines the key challenges and context of the non compliances as well as our outline trajectories for recovery.</td>
</tr>
<tr>
<td></td>
<td>Key non compliances for Quarter 1 were:</td>
</tr>
<tr>
<td></td>
<td>- A&amp;E 4 hours</td>
</tr>
<tr>
<td></td>
<td>- Cancer 62 day</td>
</tr>
<tr>
<td></td>
<td>- RTT non-admits (though noting changes to the national targets)</td>
</tr>
<tr>
<td></td>
<td>- 6 week wait diagnostics</td>
</tr>
</tbody>
</table>
Three key streams of work are underway, implementing detailed action plans for the recovery of our key performance indicators:

- Cancer
- ED - 4 hour and Flow
- RTT and diagnostics

<table>
<thead>
<tr>
<th>Strategic Goals &amp; Objectives:</th>
<th>Performance</th>
</tr>
</thead>
</table>

| Links to CQC Registration: (Outcome reference) | Caring  
Well lead |
Performance Summary Report
Quarter 1 – 2015/16

Purpose of the Report

This report provides a summary of the key performance highlights and non compliances in Q1 2015/16. It outlines the key challenges and context of the non compliances as well as our outline trajectories for recovery. Detailed information on performance targets is available in the monthly Board of Directors Performance Indicator Matrix and Exception Report.

As an overview of the key Monitor risks for our final Q1 position, these are ED 4 hour compliance and 62 day cancer waits. Whilst we remain below the 95% threshold on the 18 week RTT Non Admitted target, new national guidance has indicated a change to the targets to focus on the RTT Incomplete Pathways target. This means that our Non Admitted performance will not be deemed non compliant.

Quarter 1 Position – Monitor Governance Indicators

- All cancer targets are expected to have returned to compliance in the final, validated Quarter 1 report, excepting the 62 day wait from suspected cancer referral to treatment.
- Non-compliant areas: A&E 4 hours; Cancer 62 day (see detail below on RTT Non-Admits).
- ‘At risk’ for Q2 is RTT incomplete pathways, predominantly due to continued pressures in the Poole visiting specialties, GI and Endoscopy services. However, our current expectation is that this will be compliant at aggregate level.
- Whilst 4 cases of C. Difficile were indicated in Q1, investigations are completed or underway and no cases have yet been confirmed as due to lapses in care which is the measure of the national Monitor target.

Looking over the coming three quarters, the best estimate of performance risk against is as set out below:

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

Note: RTT admitted and non admitted will no longer flag as compliance risks due to the new national guidance (see below).
Quarter 1 Position – Indicators within the Forward View into Action – Planning for 15/16 and Key Contractual Priorities

- Non-compliant areas: 6 week wait diagnostics, due to pressures in GI services and Endoscopy.
- A separate paper reporting the latest Stroke Sentinel Audit data was presented to the Board of Directors. At a headline level, the report for RBCHFT shows our score has improved from 57 to 66, moving us for the first time into C rating, with the highest score in Wessex (against the previous quarter).

Overarching Context and Challenges in Q1

Despite an improving position against the ED 4 hour target in Q1 we remained below the 95% threshold with a Quarter position of 93.27%. An increasing trend in ED attendances has been seen in recent months reflecting seasonal trends, though overall April and May attendances were slightly lower than last year. However, we have seen some particular peaks with some days being over 250/260 attendances in June. June has also seen a return to some higher levels of non elective admissions.

![Chart Image]

The sustained level of cancer fast track referrals together with demand and capacity challenges in Urology, continue to be our key challenge in relation to the 62 day cancer target. The below graph compares RBH with the national Urology 62 day performance. This is a challenging service for the whole of England. RBCH is especially affected as Urology makes up a disproportionate element of workload.
In relation to 18 weeks RTT, national guidance has now been released indicating a change in the national reporting to focus on the Incomplete Pathways target where 92% of patients on an RTT pathway must be within 18 weeks. This moves away from the RTT Admitted and non Admitted targets. This change is to support trusts in their focus on clearing longer waiting patients. Therefore, our current below 95% performance against the Non Admitted target will not be deemed non compliant from April 2015. Following the significant work undertaken on moving to our new patient tracking system as well as on reducing backlogs of long waiters (especially in Orthopaedics - see below), we are currently in a good position in relation to the Incomplete Pathways target. In May we achieved 93.9% against the 92% performance target. Key risks remain the capacity provided by the Poole visiting specialities (Oral Surgery, ENT and Neurology), GI/Endoscopy service pressures and Dermatology demand and capacity.

Recovery Plan

Three key streams of work continue, implementing detailed action plans for the recovery of our key performance indicators: Cancer, ED, 4 hour and flow, and RTT and diagnostics.

- Cancer 62 day – continuing joint working with Dorchester to reduce their and our prostatectomy waiting list and reducing the backlog of patients awaiting template biopsies, now that the local service has commenced, will be crucial to success. A focus on cancer pathway improvement and recovery across Trusts in the South is also being supported by NHS South and the Wessex cancer network, with facilitated workshops underway.

- ED 4 hour - extension of our rapid assessment model in ED and a focus on our ‘5 Daily Actions’ project within the Flow Quality Improvement Programme have been key priorities and will support continued improvement as we go into Q2.

- RTT and Diagnostics – we will continue to focus on reducing backlogs, particularly in Orthopaedics (see graph below), and on joint work with Poole Hospital to secure additional ‘ad hoc’ capacity for ENT, Oral Surgery and Neurology pending finalisation and agreement of longer term solutions. Continued risk relating to demand and capacity in Dermatology require continued proactive management. An admin process review project is well progressed in Endoscopy which is also supporting the development of demand and capacity tools. This, together with the detailed recovery plan for additional ad hoc
capacity over the summer and more substantive capacity from September continues to be progressed.

Graph: patients waiting >18 weeks in Orthopaedics

The Trust response to the challenges is to continue to plan on higher levels of activity becoming the norm, to improve our service resilience for unplanned mismatches in capacity and demand, and to tighten operational management. There is also considerable service redesign to better align our limited staffing and budgets to ensure safe, timely care within the national standards.

We are also redoubling our efforts for working with partner organisations, such as Poole Hospital. When their emergency and elective services are under strain we are regularly affected.

RICHARD RENAUT
CHIEF OPERATING OFFICER
## COUNCIL OF GOVERNORS

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>15&lt;sup&gt;th&lt;/sup&gt; July 2015 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Workforce Report</td>
</tr>
<tr>
<td>Section:</td>
<td>Performance</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Karen Allman</td>
</tr>
</tbody>
</table>
| Details of previous discussion and/or dissemination: | Workforce Committee 22/6/15  
Board of Directors 30/6/15 |
| Key Purpose:          | Patient Engagement                |
| Action Required by Council of Governors: | For Noting. |
| Summary:              | This report is a variation on that tabled at Board and shows Trust-wide figures for a range of workforce metrics. The report includes an update on recruitment initiatives and staff retention. |
| Strategic Goals & Objectives: | To listen to, support, motivate and develop our staff |
| Links to CQC Registration: (Outcome reference) | Outcomes 12, 13 & 14 - Staffing |
The workforce data at the end of May is shown below, both by care group and category of staff. Performance has been RAG rated against current targets.

<table>
<thead>
<tr>
<th>Care Group</th>
<th>Appraisal Compliance Values Based</th>
<th>Appraisal Compliance Medical &amp; Dental Training</th>
<th>Mandatory Training Compliance</th>
<th>Sickness Absence</th>
<th>FTE Days</th>
<th>Joining Rate</th>
<th>Turnover Rate</th>
<th>Vacancy Rate (from ESR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical</td>
<td>0.9% 75.0% 77.8%</td>
<td>4.62% 14958 12.7% 10.9%</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>0.7% 63.0% 77.3%</td>
<td>3.95% 18247 18.4% 12.9%</td>
<td>9.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialties</td>
<td>3.4% 78.8% 75.1%</td>
<td>3.96% 11864 11.3% 11.3%</td>
<td>8.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>2.4% 50.0% 74.8%</td>
<td>3.66% 10794 11.4% 16.4%</td>
<td>4.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trustwide</td>
<td>1.7% 71.0% 76.5%</td>
<td>4.05% 55862 14.0% 12.8%</td>
<td>6.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**

Appraisal compliance was reset to zero with the introduction of the new values based appraisal. Around 700 staff have attended the training to date and good feedback continues to be received. The cascade process has therefore begun from those Managers who have completed the training and we should see appraisal completion rates start to rise.

However, the number of appraisals reported is under the trajectory at 5.8% as at the end of June against a trajectory of 15%. It is thought that figures are under-reported due to delays in uploading completion into ESR; this is being escalated to directorate managers and heads of departments..

2. **Essential Core Skills Compliance**

Overall compliance has increased to 76.5% (75.7% for April).

Compliance reports by cost centre for each subject are circulated each month and followed-up with those departments showing lower compliance.

It is vital that we ensure the basic training needs of our staff are met, particularly with the planned CQC inspection as this was one of the areas picked up in the last report. Communications to this effect have already gone out reinforcing the importance of compliance.

3. **Sickness Absence**

The Trust-wide sickness rate has increased to 4.05% for May (3.99% for April) and whilst this is only a very small (0.06%) increase, this now represents a red rating.
By staff group, 3 areas remain red-rated, all showing small increases on the previous month:

- Additional Clinical Services: 6.40% (6.31% in April)
- Estates & Ancillary: 5.78% (5.70% in April)
- Nursing & Midwifery: 4.31% (4.17% in April)

A new pilot for sickness absence launched in June and although there have been some initial teething problems, which are now sorted, we have had some positive feedback. The areas for the trial include Theatres, Facilities and Estates – three areas with higher sickness rates than the norm. This trial will inform any future potential roll out across other areas.

4. Recruitment Initiatives

Work continues on the recruitment actions and initiatives for the Trust including successful attendance at the RCN National Conference in Bournemouth at the BIC from the 21-25 June, and exhibiting in Birmingham on the 2/3 July at the RCN job fair.

The Council of Governors may have seen national media regarding the limitations placed on non EU work permits and we are concerned at the impact that this might have on our ability to secure in particular registered nurses for hard to fill specialties. These issues, and demonstrating the potential impact on the Trust and therefore patients, are being escalated locally and nationally.

5. Education & Training

The Council of Governors may be aware that Widening Participation is an agenda that supports workforce planning and development of staff across the NHS. Widening Participation aims to:

- widen access and opportunity of learning, development and employment opportunities within Bands 1-4;
- promote the wide range of careers and progression routes available within healthcare through information and guidance;
- involve healthcare staff in learning by developing learning cultures.

We are currently advertising the opportunity for staff to apply to complete a Foundation Degree (Fd) through the Open University with support being provided through the Trust. The Fd in Healthcare Practice starts at the beginning of September and will support the development of Assistant Practitioners at band 4 in the Trust.
6. **Staff Retention**

A second review of the detailed reasons why staff members were leaving the organisation has taken place. This was carried out by a retired senior nurse and focused on both healthcare assistants and registered nurses (22 in total). This report is being shared with Heads of Nursing and senior managers as appropriate. Key themes include:

- The lack of flexibility experienced by some staff regarding agreed patterns of work - 8 staff gave this as the main reason for leaving although 4 of these staff have joined the staff resource pool instead which is positive.

- 3 members of staff retired and have returned either part time or to work on the staff resource pool.

- 2 people left for personal reasons – one of which hopes to return in time.

- 4 staff left primarily because of the pressure experienced and a further 2 because they were unhappy with the support they were given in their roles.

Specific actions and plans to address these issues will be required and reviewed through the care group and corporate structure.
## COUNCIL OF GOVERNORS

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>15 July 2015 – Part I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Financial Performance</td>
</tr>
<tr>
<td>Section:</td>
<td>Performance</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Pete Papworth, Deputy Director of Finance</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td>Finance Committee, Trust Management Board, and Board of Directors</td>
</tr>
<tr>
<td>Key Purpose:</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Required by Council of Governors:</td>
<td>The Council of Governors is asked to note the financial performance of the Trust.</td>
</tr>
<tr>
<td>Summary:</td>
<td>The Trust ended the 2014/15 financial year with a net deficit of £5.323 million and a continuity of services risk rating of 3. This was in line with the mid-year re-forecast, but represented a significant adverse variance against the initial budgeted deficit of £1.9 million. Following a very challenging and thorough budget setting process, a planned deficit of £12.927 million has been agreed for the current financial year.</td>
</tr>
</tbody>
</table>
As at 31 May 2015; the Trust is reporting an adverse variance of £202,000. Further and immediate action must be taken to ensure that costs are contained within the agreed budget lines. Where this is not possible, additional savings opportunities must be identified to ensure that these unavoidable cost pressures are managed within the agreed financial plan. Continued overspends of this scale will cause serious financial challenges for the Trust both in the current and future years.

<table>
<thead>
<tr>
<th>Strategic Goals &amp; Objectives:</th>
<th>Goal 7 – Financial Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Links to CQC Registration: (Outcome reference)</td>
<td>Outcome 26 – Financial Position</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

This report summarises the financial performance of the Trust for the quarter ending 31 May 2015.

2. OVERVIEW

The Trust ended the 2014/15 financial year with a net deficit of £5.323 million and a continuity of services risk rating of 3. This was in line with the mid-year re-forecast, but represented a significant adverse variance against the initial budgeted deficit of £1.9 million.

Following a very challenging and thorough budget setting process, a planned deficit of £12.927 million has been agreed for the current financial year. This represents a significant deterioration in the Trust’s financial position, and must be delivered or improved upon to avoid significant future financial consequences.

3. 2014/15 FINANCIAL OUTTURN

For the first time since achieving ‘Foundation’ status; the Trust moved into a deficit financial position during 2014/15, with a planned deficit of £1.9 million.

However, the Trust experienced considerable activity and demand pressures which placed significant operational pressure on the Trust. These pressures included activity increases above the initial plan in the following areas:

- Non Elective activity 12%
- Elective activity 4%
- Emergency Department attendances 4%

In addition; national shortages of medical and nursing professionals resulted in a substantial number of clinical workforce vacancies which were covered by locum and agency staff.

These two items together led to a significant over spend against the approved expenditure budget; and resulted in a revised mid-year forecast deficit of £5.2 million after taking into account a range of mitigating actions.

The Trust ended the year with an overall net deficit of £5.232 million. This position included an income over achievement of £4 million, relating to additional ‘winter resilience’ funding together with additional income in relation to pass through drug costs; off-set by an expenditure over spend of £7.3 million which related mainly to premium staff costs, additional drug and clinical supply costs, and costs associated with outsourcing activity to the independent sector.

The Trust has delivered cash releasing efficiency savings of £7.5 million, with further productivity and cost avoidance savings recorded above this level.

The Trust set an ambitious capital programme for 2014/15, and delivered well against this. However, delays in the Christchurch Development due to environmental issues led to a significant underspend against both the initial plan and mid-year reforecast.

Despite the most challenging year in its history, including reporting a significant deficit; the Trust ended the year in a comparably strong financial position, and reported a Continuity of Services Risk Rating of 3.
4. **2015/16 FINANCIAL PERFORMANCE**

Activity during the first two months of the new financial year saw additional elective activity (2% above budget) off-setting reduced emergency department attendances (3% below budget) and reduced non elective admissions (1% below budget). Outpatient activity was broadly in line with plan meaning that overall, activity is currently 1% below budget year to date.

Despite activity being below budget; the Trust reports an adverse financial position as at 31 May with a year to date net over spend of £202,000.

Further and immediate action must be taken to ensure that costs are contained within the agreed budget lines. Where this is not possible, additional savings opportunities must be identified to ensure that these unavoidable cost pressures are managed within the agreed financial plan. Continued over spends of this scale will cause serious financial challenges for the Trust both in the current and future years.

Income has over achieved by £45,000 to date, with reduced private patient income off-set by additional public health related income and non patient related income.

Expenditure reports an over spend of £247,000 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; and 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. Cost improvement schemes delivered savings of £597,000, against a target of £592,000.

Capital spend reports an over spend of £98,000, reflecting the timing of agreed capital commitments. 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.

5. **RECOMMENDATION**

Members are asked to note the Trust’s financial performance for the quarter ending 31 May 2015.
## Key Financials

<table>
<thead>
<tr>
<th></th>
<th>2013/14 YTD Actual</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance £’000</th>
<th>Variance £’000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Surplus/ (Deficit)</strong></td>
<td>£558 (£1,900)</td>
<td>(5,232)</td>
<td>(3,332)</td>
<td>175%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>£11,875</td>
<td>12,097</td>
<td>7,080</td>
<td>(5,017)</td>
<td>(41%)</td>
<td></td>
</tr>
<tr>
<td><strong>Transformation Programme</strong></td>
<td>£8,798</td>
<td>7,408</td>
<td>7,521</td>
<td>113</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td><strong>Capital Expenditure</strong></td>
<td>£9,736</td>
<td>20,226</td>
<td>17,240</td>
<td>(2,986)</td>
<td>(15%)</td>
<td></td>
</tr>
</tbody>
</table>

## Activity

<table>
<thead>
<tr>
<th></th>
<th>2013/14 YTD Actual</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance £’000</th>
<th>Variance £’000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective</strong></td>
<td>£67,086</td>
<td>66,883</td>
<td>69,288</td>
<td>2,405</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td>£282,533</td>
<td>337,738</td>
<td>332,993</td>
<td>(4,745)</td>
<td>(1%)</td>
<td></td>
</tr>
<tr>
<td><strong>Non Elective</strong></td>
<td>£28,493</td>
<td>29,019</td>
<td>32,441</td>
<td>3,422</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Department Attendances</strong></td>
<td>£83,187</td>
<td>83,240</td>
<td>86,727</td>
<td>3,487</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td><strong>Total PbR Activity</strong></td>
<td>£461,299</td>
<td>516,880</td>
<td>521,449</td>
<td>4,569</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

## Income

<table>
<thead>
<tr>
<th></th>
<th>2013/14 YTD Actual</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance £’000</th>
<th>Variance £’000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective</strong></td>
<td>£72,606</td>
<td>69,394</td>
<td>70,144</td>
<td>749</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td>£31,273</td>
<td>32,043</td>
<td>32,047</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Non Elective</strong></td>
<td>£51,264</td>
<td>54,288</td>
<td>54,668</td>
<td>380</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Department Attendances</strong></td>
<td>£7,107</td>
<td>8,111</td>
<td>8,490</td>
<td>79</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td><strong>Non PbR</strong></td>
<td>£68,673</td>
<td>69,883</td>
<td>69,626</td>
<td>(257)</td>
<td>(0%)</td>
<td></td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>£26,538</td>
<td>29,019</td>
<td>29,305</td>
<td>2,889</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td><strong>Interest</strong></td>
<td>£2,026</td>
<td>1,834</td>
<td>1,952</td>
<td>118</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>£260,236</td>
<td>262,419</td>
<td>266,381</td>
<td>3,961</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

## Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2013/14 YTD Actual</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance £’000</th>
<th>Variance £’000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay</strong></td>
<td>£154,875</td>
<td>160,383</td>
<td>164,217</td>
<td>(3,834)</td>
<td>(2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Supplies</strong></td>
<td>£36,533</td>
<td>34,629</td>
<td>36,014</td>
<td>(1,384)</td>
<td>(4%)</td>
<td></td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td>£26,049</td>
<td>27,750</td>
<td>29,122</td>
<td>(1,373)</td>
<td>(5%)</td>
<td></td>
</tr>
<tr>
<td><strong>Other Non Pay Expenditure</strong></td>
<td>£27,953</td>
<td>25,043</td>
<td>27,355</td>
<td>(2,312)</td>
<td>(9%)</td>
<td></td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>£2,027</td>
<td>1,938</td>
<td>2,197</td>
<td>(262)</td>
<td>(7%)</td>
<td></td>
</tr>
<tr>
<td><strong>Depreciation</strong></td>
<td>£7,107</td>
<td>9,188</td>
<td>8,111</td>
<td>1,077</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td><strong>PDC Dividends Payable</strong></td>
<td>£2,026</td>
<td>1,834</td>
<td>1,952</td>
<td>118</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>£259,678</td>
<td>264,319</td>
<td>271,613</td>
<td>(7,294)</td>
<td>(3%)</td>
<td></td>
</tr>
</tbody>
</table>

## Statement of Financial Position

<table>
<thead>
<tr>
<th></th>
<th>2013/14 YTD Actual</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance £’000</th>
<th>Variance £’000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non Current Assets</strong></td>
<td>£159,375</td>
<td>170,877</td>
<td>170,783</td>
<td>(94)</td>
<td>(0%)</td>
<td></td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td>£69,727</td>
<td>65,657</td>
<td>65,218</td>
<td>(439)</td>
<td>(1%)</td>
<td></td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td>£30,925</td>
<td>25,755</td>
<td>27,809</td>
<td>(2,054)</td>
<td>(8%)</td>
<td></td>
</tr>
<tr>
<td><strong>Non Current Liabilities</strong></td>
<td>£3,000</td>
<td>17,705</td>
<td>15,482</td>
<td>2,223</td>
<td>(13%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td>£195,177</td>
<td>193,274</td>
<td>192,710</td>
<td>(564)</td>
<td>(0%)</td>
<td></td>
</tr>
<tr>
<td><strong>Public Dividend Capital</strong></td>
<td>£78,674</td>
<td>78,674</td>
<td>79,665</td>
<td>991</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td><strong>Revaluation Reserve</strong></td>
<td>£73,002</td>
<td>72,999</td>
<td>72,364</td>
<td>(635)</td>
<td>(1%)</td>
<td></td>
</tr>
<tr>
<td><strong>Income and Expenditure Reserve</strong></td>
<td>£43,501</td>
<td>41,601</td>
<td>40,681</td>
<td>(920)</td>
<td>(2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Taxpayers Equity</strong></td>
<td>£195,177</td>
<td>193,274</td>
<td>192,710</td>
<td>(564)</td>
<td>(0%)</td>
<td></td>
</tr>
</tbody>
</table>

## Continuity of Service Risk Rating

<table>
<thead>
<tr>
<th></th>
<th>2013/14 YTD Actual</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Risk Rating</th>
<th>Weighted Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Debt Service Cover</strong></td>
<td>£2.86x</td>
<td>2.28x</td>
<td>1.64x</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Liquidity</strong></td>
<td>£48.9</td>
<td>50.8</td>
<td>42.9</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

## Continuity of Service Risk Rating

<table>
<thead>
<tr>
<th></th>
<th>2013/14 YTD Actual</th>
<th>Risk Rating</th>
<th>Weighted Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Debt Service Cover</strong></td>
<td>£2.86x</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Liquidity</strong></td>
<td>£48.9</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
### Details of previous discussion and/or dissemination:
The Constitution Committee, which is a task and finish group of the Board of Directors and the Council of Governors, met on 25 June 2015 to discuss the recent review of the constitution by the Trust Secretary and proposed amendments.

### Key Purpose:

<table>
<thead>
<tr>
<th>Patient Engagement</th>
<th>Governance</th>
<th>Performance</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Action Required by Council of Governors:
- Approve the proposed amendments to the Constitution.

### Summary:
Good governance practice requires the Trust to undertake a review of the constitution each year. The constitution was last reviewed and amendments agreed in July 2014.

Any amendments to the constitution need to be agreed by both the Board of Directors and the Council of Governors.

The constitution with proposed amendments identified as track changes is attached and has been discussed in detail by the Constitution Committee. The Constitution
Committee would like to recommend to the Council of Governors that the proposed amendments are accepted. This version of the constitution will be uploaded to the Trust’s website and also sent to Monitor for information.

The Board of Directors will be asked to agree the proposed amendments at its meeting later in July 2015.
Narrative to support proposed Constitution amendments

It is good practice to review the Trust’s constitution once a year. The last time the constitution was reviewed was in the Spring of 2014 which led to the July 2014 version being published on the Trust’s website and shared with Monitor. In May 2015, due to the Standing Financial Instructions being reviewed and taking on some issues that had been addressed in the Board Standing Orders previously, some amendments to the constitution were required and agreed. This was to avoid conflict in the guidance for issues such as tendering. Unfortunately a full review of the constitution was not possible at that time.

Attached is the constitution which has been reviewed in detail. Proposed amendments (additions and deletions) are highlighted. Below is a narrative of the rationale for all proposed amendments. It is envisaged that the proposed amendments have been agreed by the Constitution Working Group and this paper recommends acceptance to both the Council of Governors and the Board of Directors at their July meetings. Following agreement a new and up to date version of the constitution will be uploaded to the website and shared with Monitor soon after.

<table>
<thead>
<tr>
<th>Page</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Common amendments are to ensure that all paragraphs are numbered and to remove abbreviations such as SO for Standing Order.</td>
</tr>
<tr>
<td>4</td>
<td>Governors are asked to note paragraph 1.5 and the interpretation of gender throughout the Constitution</td>
</tr>
<tr>
<td>4</td>
<td>Definition of Chairperson included Subsequent references to Chairman amended to Chairperson</td>
</tr>
<tr>
<td>5</td>
<td>Definition moved from Annex 8, Appendix 5</td>
</tr>
<tr>
<td>5</td>
<td>Definition provided for Health Services in England for clarity in Para 3</td>
</tr>
<tr>
<td>5</td>
<td>Definition of Lead Governor provided for clarity</td>
</tr>
<tr>
<td>6</td>
<td>Definition of Senior Independent Director included for clarity</td>
</tr>
<tr>
<td>8</td>
<td>Unnecessary word</td>
</tr>
<tr>
<td>10</td>
<td>Moved for clarity and flow in reading</td>
</tr>
<tr>
<td>13</td>
<td>Provide clarity on the role</td>
</tr>
<tr>
<td>21</td>
<td>Moved from Annex 8, Appendix 5</td>
</tr>
<tr>
<td>22</td>
<td>New clause inserted to provide clarification on the process for disputes between Governors</td>
</tr>
<tr>
<td>23</td>
<td>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</td>
</tr>
<tr>
<td>37</td>
<td>Consistency</td>
</tr>
<tr>
<td>63</td>
<td>Reduce cross referencing issues</td>
</tr>
<tr>
<td>73</td>
<td>Cross referenced to Para 14.8</td>
</tr>
<tr>
<td>75</td>
<td>Deputy Chairman amended to Lead Governor (throughout document)</td>
</tr>
<tr>
<td>Page</td>
<td>Rationale</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td>75</td>
<td>Definition of Trust Secretary included for clarity (also defined at pg 7)</td>
</tr>
<tr>
<td>80</td>
<td>Sense</td>
</tr>
<tr>
<td>81</td>
<td>Further option added</td>
</tr>
<tr>
<td>83</td>
<td>Added definition</td>
</tr>
<tr>
<td>84</td>
<td>Clarity and to update the action for the current practice</td>
</tr>
<tr>
<td>85</td>
<td>Clause inserted providing a timescale and clarity of the process</td>
</tr>
<tr>
<td>86</td>
<td>Clarity</td>
</tr>
<tr>
<td>88</td>
<td>Opportunity for action should the event occur</td>
</tr>
<tr>
<td>89</td>
<td>Update the action for the current practice</td>
</tr>
<tr>
<td>90</td>
<td>Update to match best practice</td>
</tr>
<tr>
<td>91</td>
<td>Current name of committee</td>
</tr>
<tr>
<td>94</td>
<td>Best practice and clarity</td>
</tr>
<tr>
<td>95</td>
<td>Remove Board committees that are not required by Statute. Additional wording provides Board opportunity to create sub committees as and when required.</td>
</tr>
<tr>
<td>101</td>
<td>Update to current practice</td>
</tr>
<tr>
<td>103</td>
<td>Update to current practice</td>
</tr>
<tr>
<td>104</td>
<td>Clarity</td>
</tr>
<tr>
<td>105</td>
<td>Reduce cross referencing. Added at the request of the Counter Fraud Specialist to provide clarity</td>
</tr>
<tr>
<td>106</td>
<td>Added at the request of the Counter Fraud Specialist to provide clarity</td>
</tr>
<tr>
<td>107</td>
<td>Added at the request of the Counter Fraud Specialist to provide clarity</td>
</tr>
<tr>
<td>108</td>
<td>Add clarity</td>
</tr>
<tr>
<td>115</td>
<td>Update to current practice</td>
</tr>
<tr>
<td>Pp118-119</td>
<td>Moved to other more relevant parts of the document</td>
</tr>
</tbody>
</table>
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ANNEX 7 - STANDING ORDERS - BOARD OF DIRECTORS

1 INTERPRETATION AND DEFINITIONS
2 THE TRUST
3 MEETINGS OF THE BOARD OF DIRECTORS
4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION
5 COMMITTEES
6 DECLARATION OF INTERESTS AND REGISTER OF INTERESTS
7 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST
8 STANDARDS OF BUSINESS CONDUCT
9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS
10 SIGNATURE OF DOCUMENTS
11 STANDING ORDERS

ANNEX 8 – FURTHER PROVISIONS
1. Trust Commitment
1.1 The Trust shall exercise its functions effectively, efficiently and economically
2. Representative Membership
3. Co-operation with NHS Bodies
4. Respect for rights of people
5. Openness
6. Prohibiting distribution

Deleted: ANNEX 8 – FURTHER PROVISIONS
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.
Chairperson 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.
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.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elected Governor</td>
<td>means each Governor elected by the Public Constituency and the classes of the Staff Constituency.</td>
</tr>
<tr>
<td>Executive Director</td>
<td>means an executive director on the Board of Directors of the Trust.</td>
</tr>
<tr>
<td>Financial Year</td>
<td>means each successive period of twelve months beginning with 1 April.</td>
</tr>
<tr>
<td>Governor</td>
<td>means a member of the Council of Governors.</td>
</tr>
<tr>
<td>Head Office</td>
<td>The Trust's head office is at the Royal Bournemouth Hospital, Castle Lane East, Bournemouth BH7 7DW.</td>
</tr>
<tr>
<td>Health Service in England</td>
<td>means the provision of Health Care in line with NHS core principles; that care should be universal,</td>
</tr>
<tr>
<td></td>
<td>comprehensive and free at the point of need.</td>
</tr>
<tr>
<td>Lead Governor</td>
<td>means one (1) Governor appointed by the Council of Governors to lead the Council of Governors and to</td>
</tr>
<tr>
<td></td>
<td>communicate directly with Monitor in certain circumstances.</td>
</tr>
<tr>
<td>Local Authority Governor</td>
<td>means a Governor appointed by the local authorities listed in Annex 3 whose area includes the whole</td>
</tr>
<tr>
<td></td>
<td>or part of the Trust.</td>
</tr>
<tr>
<td>Members' Meetings</td>
<td>means the Annual Members' Meeting and any Special Members' Meeting.</td>
</tr>
<tr>
<td>Monitor</td>
<td>is the body corporate known as Monitor, as provided by section 61 of the 2012 Act.</td>
</tr>
<tr>
<td>NHS Body</td>
<td>means an NHS foundation trust, the NHS Commissioning Board, an NHS trust, a clinical commissioning</td>
</tr>
<tr>
<td></td>
<td>group, a special health authority or a Local Health Board.</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td>means an non-executive director on the Board of Directors of the Trust.</td>
</tr>
<tr>
<td>Panel</td>
<td>is defined in paragraph 19 of this Constitution.</td>
</tr>
<tr>
<td>Partner</td>
<td>means, in relation to another person, a member of the same household living together as a family unit.</td>
</tr>
<tr>
<td>Partnership Governor</td>
<td>means a Governor appointed by a Partnership Organisation.</td>
</tr>
<tr>
<td>Partnership Organisation</td>
<td>means those organisations specified in Annex 3 of this Constitution as Partnership Organisations,</td>
</tr>
<tr>
<td></td>
<td>which are specified organisations for the purposes of sub-paragraph 9(7) of Schedule 7 of the 2006</td>
</tr>
<tr>
<td></td>
<td>Act, as amended by the 2012 Act.</td>
</tr>
<tr>
<td>Public Constituency</td>
<td>means that part of the Trust's membership consisting of members living in the area of the Trust</td>
</tr>
<tr>
<td></td>
<td>specified in Annex 1.</td>
</tr>
</tbody>
</table>
Public Governor means a Governor elected by the Public Constituency.

Secretary means 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.

Senior Independent Director means the non-executive Director appointed by the Board of Directors in accordance with paragraph 29.3 of this Constitution.

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 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.

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;

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

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;

15.1.4 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 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.


16.1 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.

Deleted: <#>Governors must be at least 18 years of age at the date they are nominated for election or appointment.
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 Chairperson of the Trust (i.e. the 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 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 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 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 Chairperson of the Trust and the other Non-Executive Directors.

26.2 Removal of the 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-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, of a Non-Executive Directors as Vice-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 Chairperson and at least two other Non-Executive Directors shall appoint or remove the Chief
28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the 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 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.
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 Chairperson on advice of the Secretary, and such other advice as the Chairperson may see fit to obtain, shall seek to resolve the dispute;

46.3.2 If the 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 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

<table>
<thead>
<tr>
<th>Name of Area</th>
<th>Description</th>
<th>Minimum Number of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bournemouth and Poole</td>
<td>The electoral area covered by Bournemouth and Poole Borough Councils</td>
<td>4</td>
</tr>
<tr>
<td>Christchurch and Dorset County</td>
<td>The electoral areas covered by Christchurch Borough Council and the rest of Dorset County Council</td>
<td>4</td>
</tr>
<tr>
<td>New Forest, Hampshire and Salisbury</td>
<td>The following electoral divisions covered by New Forest Council: 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</td>
<td>4</td>
</tr>
</tbody>
</table>
The following electoral divisions covered by Wiltshire Council:
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

The following electoral divisions covered by Hampshire County Council:
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

The following electoral divisions covered by Southampton City Council:
<table>
<thead>
<tr>
<th>Redbridge</th>
<th>Coxford</th>
<th>Bassett</th>
<th>Millbrook</th>
<th>Shirley</th>
<th>Portswood</th>
<th>Swaythling</th>
<th>Freemantle</th>
<th>Bargate</th>
<th>Bevois</th>
<th>Bitterne Park</th>
<th>Harefield</th>
<th>Peartree</th>
<th>Sholing</th>
<th>Woolston</th>
</tr>
</thead>
</table>

Constitution
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<table>
<thead>
<tr>
<th>Name of Class</th>
<th>Minimum Number of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>4</td>
</tr>
<tr>
<td>Nursing, Midwifery and Healthcare Assistants</td>
<td>4</td>
</tr>
<tr>
<td>Estates and Ancillary Services</td>
<td>4</td>
</tr>
<tr>
<td>Allied Health Professions, Scientific and Technical</td>
<td>4</td>
</tr>
<tr>
<td>Administrative, Clerical and Management</td>
<td>4</td>
</tr>
</tbody>
</table>
ANNEX 3 - COMPOSITION OF THE COUNCIL OF GOVERNORS

1. Public Elected Governors

There are 18 Governors in the Public Constituency.

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bournemouth and Poole</td>
<td>9</td>
</tr>
<tr>
<td>Christchurch and Dorset County</td>
<td>6</td>
</tr>
<tr>
<td>New Forest, Hampshire and Salisbury</td>
<td>3</td>
</tr>
</tbody>
</table>

2. Staff Elected Governors

There are five Governors in the Staff Constituency from the following Staff Classes:

<table>
<thead>
<tr>
<th>Staff Class</th>
<th>Number of Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>1</td>
</tr>
<tr>
<td>Nursing, Midwifery and Healthcare Assistants</td>
<td>1</td>
</tr>
<tr>
<td>Estates and Ancillary Services</td>
<td>1</td>
</tr>
<tr>
<td>Allied Health Professions, Scientific and Technical</td>
<td>1</td>
</tr>
<tr>
<td>Administrative, Clerical and Management</td>
<td>1</td>
</tr>
</tbody>
</table>

3. Appointed Governors

There are six Appointed Governors.

<table>
<thead>
<tr>
<th>Appointing Organisation</th>
<th>Number of Governors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Authority Governors</td>
<td></td>
</tr>
<tr>
<td>Bournemouth Borough Council</td>
<td>1</td>
</tr>
<tr>
<td>Borough of Poole</td>
<td>1</td>
</tr>
<tr>
<td>Dorset County Council</td>
<td>1</td>
</tr>
<tr>
<td>Partnership Organisations</td>
<td></td>
</tr>
<tr>
<td>Bournemouth University</td>
<td>1</td>
</tr>
<tr>
<td>NHS Dorset Clinical Commissioning Group</td>
<td>1</td>
</tr>
<tr>
<td>The Royal Bournemouth and Christchurch Hospitals Volunteers Group</td>
<td>1</td>
</tr>
</tbody>
</table>

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.
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4. Returning officer
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6. Expenditure
7. Duty of co-operation

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9. Nomination of candidates
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11. Declaration of interests
12. Declaration of eligibility
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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 fulfill 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:

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

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;

(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,
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 used more than once, the returning officer shall:

(1) place the document or documents in a separate packet.

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 Chairperson of the NHS Trust, or
   (ii) in any other case, to the 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 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 Chairperson of the corporation.
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 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 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 period 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 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 vacancies**

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

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;

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 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:

**Chairperson** means the Chairperson of the Trust.

**Lead Governor 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.

**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 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 **Chairperson of the Meeting**

At any meeting of the Council of Governors, the Chairperson, if present, shall preside. If the Chairperson is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest the Vice-Chairperson shall preside. If the Chairperson and Vice-Chairperson 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 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 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 Chairperson 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 Chairperson 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 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 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 2.4.2** for inclusion of agenda items. Instead, there will be an item for Questions on Notice, which is subject to **Standing 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 Chairperson by behaving improperly or offensively or deliberately obstructs business, the Chairperson 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 Chairperson 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, 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 Chairperson, 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 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 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 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 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 **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 Chairperson of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

2.9 **Attendance**

The names of the 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.

2.10.3 If the 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 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 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 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 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, 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 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 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 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, within 28 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.

6.2.9 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 Chairperson 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.

Deleted: Chairman

Deleted: 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 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 SFI s.

Officer means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

SFI s 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-Chairperson - Where the 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 Chairperson owing to illness, absence from England and Wales or any other cause, references to the Chairperson in these SOs shall, so long as there is no Chairperson able to perform his duties, be taken to include references to the Vice-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 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 Chairperson of the Meeting

3.2.1 At any meeting of the Trust, the Chairperson, if present, shall preside. If the Chairperson is absent from the meeting the Vice-Chairperson shall preside. If the Chairperson and Vice-Chairperson are absent such Non-Executive Director as the Directors present shall choose shall preside.
3.2 If the Chairperson is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chairperson, if present, shall preside. If the Chairperson and Vice-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 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 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 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.

3.4 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 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 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 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 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 Chairperson to propose a Motion to the same effect within six months; however the 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 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 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-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 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 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 Chairperson or the Vice-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 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 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 Chairperson after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairperson 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
- Nomination and Remuneration Committee
- and such other Committees as the Board of Directors determines are required to discharge the Board of Directors’ 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 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.

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.

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 Chairperson 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
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 partners, 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 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
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 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 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.

[Deleted: building, engineering, property or capital]

[Deleted: Chairman]

[[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 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 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 Chairperson of the Trust, or in their absence the Lead Governor, of the Council of Governors, or in their absence one of the other governors from the Public Constituency shall act as Chairperson at all Members’ Meetings of the Trust. If neither the Chairperson nor the 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 Chairperson and if there is only one such governor present and willing to act they shall be 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 Chairperson of the meeting is to have a second or casting vote.

1.15 The result of any vote will be declared by the 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 Members' Meeting where they will be considered to have been signed by the person presiding at it. The approved 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 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 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 Chairperson

3.1 The removal of the 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 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 5: Further Provisions - General

Dispute Resolution Procedures

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.

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.

In the event of dispute between the Council of Governors and the Board of Directors or between a Governor and the Council of Governors:

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.

If the Chairman is unable to resolve the dispute he shall appoint a special...

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:

- acting as a Secretary to the Council of Governors and the Board of Directors, and any committees;
- summoning and attending all Members’ Meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings.

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.
<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>15 July 2015 – Part 1</th>
</tr>
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<tbody>
<tr>
<td>Subject:</td>
<td>Governor Code of Conduct</td>
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<tr>
<td>Section:</td>
<td>Decision</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Sarah Anderson, Trust Secretary</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td>Governors for comment</td>
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<td>Key Purpose:</td>
<td>Patient Engagement</td>
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<td>Action Required by Council of Governors:</td>
<td>To approve the code of conduct</td>
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<tr>
<td>Summary:</td>
<td>It is good governance practice for the code of conduct to be reviewed on a regular basis. The code of conduct was reviewed and amendments made to bring it in line with best practice and to reflect some recent developments. Paragraph 5.2 of the CoG Standing Orders require governors to sign a copy of the code of conduct annually.</td>
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<tr>
<td>Strategic Goals &amp; Objectives:</td>
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<tr>
<td>Links to CQC Registration:</td>
<td>(Outcome reference)</td>
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1. INTRODUCTION
Governors are a key aspect of the Trust’s corporate governance process and, as such, governors need to be able to demonstrate the highest possible standards of conduct and behaviour within the Trust. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the Trust). Adherence to this code of conduct will ensure that the Trust inspires confidence amongst its patients, staff, health service partners, suppliers and funders. The Council of Governors has an integral role in supporting the Board of Directors in promoting the Trust’s vision and values to members, patients and the public and ensuring these are embedded in the work of the Trust and in supporting the Trust in the delivery of its objectives.

The code of conduct forms part of a framework to promote the highest possible standards of conduct and behaviour within the Trust and should be read in conjunction with:

- the NHS Constitution;
- Monitor’s NHS Foundation Trust Code of Governance;
- the Trust’s licence;
- the Trust’s Constitution; and
- the Standing Orders for the Council of Governors.

The code of conduct applies at all times when governors are carrying out the business of the Trust or representing the Trust.

2. PRINCIPLES OF PUBLIC LIFE

The Seven Principles of Public Life, set out by the Nolan Committee, provide the basis for this code of conduct.

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

3. CONFIDENTIALITY
Governors must respect the confidentiality of the information that they receive and comply with the Trust’s confidentiality policies and act with discretion and care in their role. Governors must not disclose any confidential information, except in specified lawful circumstances, and must not seek to prevent a person from gaining access to information to which they are legally entitled. The Trust will endeavour to highlight all confidential information but governors should confirm this with the Trust Secretary’s office if there is any doubt as to whether information is confidential.

Nothing said in this code of conduct precludes governors from making a protected disclosure within the meaning of the Public Disclosure Act 1998. The Trust Secretary should be consulted for guidance.

Governors must respect the confidentiality of patients, members and the general public when engaging with comments, concerns or complaints.

Information on the public register (name and membership constituency and/or class) is available for inspection by governors through the Trust Secretary’s office but any correspondence with members will be sent by the Trust.

4. REGISTER AND CONFLICT OF INTERESTS
Governors are required to register all relevant interests on the Trust’s register of interests for the Council of Governors and to manage any potential conflict of interest in accordance with the provisions of the Trust’s Constitution and the Standing Orders for the Council of Governors. It is the responsibility of each governor to provide an update to their register entry if their interests change. Failure to register a relevant interest in a timely manner may constitute a breach of this code of conduct.
Governors have a duty act with integrity and objectivity in the best interests of the Trust, without any expectation of personal benefit, and to avoid situations where there may be a potential, real or perceived, conflict of interest. Governors must declare the nature and extent of any interest at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Trust Chairman to advise whether it is necessary for the governor to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this code of conduct.

Governors have a duty to avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Governors should not use their position for personal advantage or seek to gain preferential treatment. Governors must not accept gifts or inducements from any third party by reason of being a governor or for doing (or not doing) anything in that capacity. Governors must not offer a benefit to a third party by reason of being a governor for doing (or not doing) anything in that capacity.

5. FIT AND PROPER PERSON

It is a condition of the Trust’s licence that each governor serving on the Council of Governors is a ‘fit and proper person’ as defined in the Trust’s licence (see appendix A). Governors must certify on appointment, and each year that they are/remain a fit and proper person. If circumstances change so that a governor can no longer be regarded as a fit and proper person or if it comes to light that a governor is not a fit and proper person they are suspended from being a governor with immediate effect pending confirmation and any appeal. Where it is confirmed that a governor is no longer a fit and proper person their membership of the Council of Governors is terminated.

6. ROLE AND RESPONSIBILITIES OF THE GOVERNORS

The role of the Council of Governors is to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors and represent the interests of the members of the Trust as a whole and the interests of the public. The role is set out in detail in the Trust’s Constitution, Monitor’s Code of Governance for NHS Foundation Trusts and in Monitor’s guide for NHS foundation trust governors.

The Council of Governors represents the interests of all the Trust’s members, not just the constituency that elected, or the external body that appointed, individual governors.

In carrying out its work the Council of Governors needs to take account of and respect the statutory duties and liabilities of the Board of Directors and individual directors.

In fulfilling their roles and responsibilities individual governors must:

- abide by the Trust’s rules, policies and procedures, including the Trust’s Constitution, Standing Orders, Standing Financial Instructions and Trust’s Public Interest Disclosure Policy;
- support the Trust in the delivery of its objectives, in particular those relating to NHS foundation trust status and developing a successful trust;
- act in the best interests of the Trust at all times;
• contribute to the work of the Council of Governors in order for it to fulfil its role and functions as defined in the Constitution;
• seek to ensure that membership of the constituency or appointing organisation, that elected/appointed them are properly informed and that their views are fed back to the Trust;
• recognise that the role of the Council of Governors is a collective one and that governors must support decisions made by the Council of Governors, as recorded in the minutes, even if this goes against their own wishes;
• recognise that the Council of Governors has no managerial role within the Foundation Trust;
• support and assist the Chief Executive, as the Accounting Officer of the Trust in his responsibility to answer to Monitor.

7. PERSONAL CONDUCT

Governors are expected to conduct themselves in a manner that reflects positively on the Trust and not conduct themselves in a way which could reasonably be regarded as bringing their role, the Council of Governors or the Trust into disrepute. Specifically governors must:
• treat fellow governors and Trust staff with respect, even when there are differences of opinion, and ensure that statements about colleagues are consistent, fair and unbiased and are properly founded;
• not conduct themselves in way which could be viewed as unfair, discriminatory or bullying;
• not seek to use their position improperly to confer an advantage or disadvantage on any person;
• comply with the Trust’s rules on the use of its resources;
• respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies;
• accept responsibility for their own actions;
• not make, permit or knowingly allow to be made, any untrue or misleading statement relating to their own duties or the functions of the Foundation Trust;
• have regard to advice provided by the Chairman and the Trust Secretary pursuant to their statutory duties.

8. COMMUNICATING WITH THE PUBLIC

Governors should be fully aware of their representative functions and should not become personally involved in patient or public matters that should rightly be handled by the appropriate member of Trust staff.

Governors are accountable to the membership or appointing organisation and should demonstrate this. They should attend events and provide opportunities to interface with the members or appointing organisations they represent in order to best understand their views. When presented with a comment, concern or complaint from a member, patient or the general public, governors should encourage the individual to raise the concern or complaint with the Trust directly; this will be via the PALS. The governor might wish to flag a generic concern around a specific service with the Trust Secretary’s office so that governors can identify trends. Where the governor acts as a conduit for forwarding public comments, concerns and complaints to the Trust, this will be through the Trust’s
Secretary’s office. The Trust will then deal with the issue direct with the member, patient or general public and the governor will not be informed of the outcome due to patient confidentiality. In some circumstances the Trust Secretary will seek to be informed of a generic outcome.

Governors must seek the permission of the Head of Communications before making comment to or responding to the media.

9. MONITOR

In general, formal contact with Monitor will be through directors or the Trust Secretary, as appropriate. This does not prevent the Lead Governor nominated by the Council of Governors communicating with Monitor in instances when the normal channels of communication are not appropriate and there is a real risk that the Trust may be in significant breach of its licence.

10. INTERACTION WITH THE TRUST

Governors may wish, as part of their role, to visit Trust premises. However, governors will recognise that, as the Trust buildings are busy facilities and the Trust has a responsibility to ensure the well-being and safety of patients, it is important for visits to be planned to coincide with operational requirements and may need to be conducted in groups to maximise staff availability.

When the governors wish to visit the premises of the Trust in a formal (governor) capacity as opposed to individuals in a personal capacity (i.e. as a patient or patient relative/friend), they should liaise with the Trust Secretary’s Office to make the necessary arrangements. At all times, governors will be expected to comply with the Trust’s Policy for Accessing Clinical Areas for Governors.

The Trust will make every effort to accommodate the request of the governor, but may not always be able to agree to support specific dates, times or site visits.

Governors are reminded that the Council of Governors and the Board of Directors have a common purpose in the delivery of the Trust’s objectives. Governors should therefore discuss issues or concerns around the Trust’s strategy or performance, its governance or risks with the Chairman and Vice-Chairman/Senior Independent Director in the first instance or with the other non-executive directors as appropriate. Governors are encouraged to submit resolutions at Council of Governors meetings or to use their statutory powers of veto and removal only in circumstances where other forms of discussion and mediation have not resolved a particular matter.

Questions from governors should be submitted to the Trust Secretary’s office, preferably in writing, who will share the responses with all governors for the benefit of the Council of Governors as a whole. Likewise the Trust Secretary will provide a generic (no patient detail) summary of comments, concerns or complaints raised with the Trust through the governors to each Council of Governor meeting.

11. MEETINGS OF THE COUNCIL OF GOVERNORS
Governors have a responsibility to attend Council of Governors meetings and the Annual Members’ Meeting. When this is not possible apologies should be submitted to the Trust Secretary’s office in advance of the meeting. Where apologies have not been received a governor’s non-attendance will be recorded in the minutes of the meeting. Absence from two consecutive meetings may result in the governor’s attendance being reviewed by the NED Nomination and Remuneration Committee in accordance with the process set out in the Trust’s constitution. This may lead to the governor being removed from their position, if the grounds for absence are not regarded as satisfactory by the Council of Governors.

Governors are expected to attend for the duration of each meeting.

12. TRAINING AND DEVELOPMENT

The Trust is committed to providing appropriate training and development opportunities for governors to enable them to carry out their role and responsibilities effectively. Governors are expected to attend training and development programmes that have been identified as appropriate for the governors, individually or collectively. To that end governors will participate in any appraisal process and any skills audit carried out by the Trust.

The Governor Training Committee is responsible for governor training and development, and individual governors are invited to speak to the Committee Chairman about further information or training needs.

13. UNDERTAKING AND COMPLIANCE

All governors are required to confirm that they will comply with the provisions of this code of conduct in all respects.

Failure to comply with the code of conduct may lead to the governor being disqualified or removed from office in accordance with the Trust’s Constitution and Standing Orders of the Council of Governors. Where misconduct takes place the Trust Chairman may be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.

Three-quarters of the governors present at a Council of Governors will be required to vote to make a formal charge of non-compliance or misconduct.

14. INTERPRETATION, REVISION AND REVIEW

Questions and concerns about the application of this code of conduct should be raised with the Trust Secretary. At meetings the Chairman will be the final arbiter of the interpretation of the code of conduct.

The code of conduct has been approved by the Council of Governors. The Trust Secretary will lead periodically a review of the code of conduct. The Council of Governors will agree any amendments or revisions to the code of conduct.
COUNCIL OF GOVERNORS

CODE OF CONDUCT

ACCEPTANCE STATEMENT

I have read and accept the Council of Governors’ Code of Conduct in respect of my appointment as a governor of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

___________________________________________________

Signed

___________________________________________________

Name

___ / ___ / 20___

Date
Extract from the Trust’s Licence re ‘Fit and Proper Person’

**Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)**

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.

2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.

3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.

4. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.

5. In this Condition an unfit person is:

   (a) an individual;
      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or
      (ii) 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; or
      (iii) who within the preceding five years has been convicted in the British Islands of any offence and 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; or
      (iv) who is subject to an unexpired disqualification order made under the Company Directors’ Disqualification Act 1986; or

   (b) a body corporate, or a body corporate with a parent body corporate:
      (i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or
      (ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or
      (iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or
      (iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or
      (v) which passes any resolution for winding up, or
      (vi) which becomes subject to an order of a Court for winding up
# Council of Governors

## Meeting Date and Part:
15 July 2015 – Part 1

## Subject:
Council of Governor Committees – terms of reference

## Section:
Decision

## Author of Paper:
Sarah Anderson, Trust Secretary

## Details of previous discussion and/or dissemination:
The terms of reference have been discussed and agreed within the individual governor-led committees

## Key Purpose:
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<th>Strategy</th>
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## Action Required by Council of Governors:
- Approve the terms of reference for the:
  - Governor involvement with patient and public engagement (GIPPE) committee
  - Membership development committee (MDC)
  - Governor training committee (GTC)
  - NED Nomination and Remuneration Committee
- Approve the establishment of a Strategy Committee and its terms of reference
- Note that the Scrutiny Committee has been dissolved and survey work will be managed through the GIPPE Committee

## Summary:
The governance structure of the Council of Governors and its committees has been reviewed by the Trust Secretary. Where appropriate the committees or their chairs have been consulted and have agreed the proposed terms of reference.
The NED Nomination Committee and NED Remuneration Committee have been combined into one committee – the NED Nomination and Remuneration Committee. This will ensure greater efficiency in the way that the business of the two committees is conducted as there was some duplication between the two committees.

The Governor Workshop on 30 March 2015 proposed that a Strategy Committee be established to consider strategic issues on behalf of the Council of Governors. Terms of reference for this committee have been developed.

The governance structure of the Board of Directors is also being reviewed.
GOVERNOR INVOLVEMENT with PATIENT and PUBLIC ENGAGEMENT COMMITTEE

Terms of Reference

The Governor Involvement with Patient and Public Engagement Committee (the Committee) is a committee established by and responsible to the Council of Governors. The primary aim of the Committee is to identify, and where appropriate improve, patient experience.

1. Membership

1.1 The membership of the Committee will consist of the following:

- Six governors including one staff governor

In addition, the following will attend the Committee to provide advice as required:

- One Non-Executive Director
- Trust Secretary or their representative
- Deputy Director of Nursing and Midwifery
- Head of Patient Engagement
- PALS Manager
- Complaints Manager

1.2 Only members of the Committee have the right to attend Committee meetings. The Committee Chairman may invite other governors or any other individual to attend all or part of any meeting, as and when the Committee Chairman considers it appropriate.

1.3 The Committee Chairman shall be a governor and will be elected by the Committee from amongst its membership annually.

1.4 All governor appointments will be made by self-nomination and a vote will be taken by the Council of Governors if there are more nominees than vacancies. The ballot will be organised by the Trust Secretary in accordance with a process agreed by the Council of Governors.

1.5 Appointments to the Committee shall be for a period of two years, which may be extended for one further three year period. The Council of Governors may choose to make appointments for a period of not more than one year greater or less than the period specified in order to
ensure some continuity of membership of the Committee when vacancies arise. However, only those governors who have served at least one year as members of the Council of Governors shall be eligible for membership of this Committee.

2. Secretary

2.1 The Trust Secretary or their representative shall act as the Secretary of the Committee.

3. Quorum

3.1 A quorum will be three members of the Committee.

4. Frequency of meetings

4.1 Meetings are to be held quarterly and at such other times as may be required.

5. Notice of meetings

5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman.

5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their representative.

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Where possible, the supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of meetings

6.1 The Secretary of the Committee shall record action notes of the proceedings of all Committee meetings. They shall also record the names of those present and in attendance.

6.2 Action notes of Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee. The Secretary of the Committee shall aim to prepare the action notes within one week of the meeting date.

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7. **Duties**

The Committee shall:

7.1 Oversee the development of any governor-led patient surveys/questionnaires and other work to gain patients' views. This work may be undertaken within the hospital or wider community;

7.2 Work with the Clinical Audit Department to gain approval for governor surveys/questionnaires and other work to be undertaken;

7.3 Work with the governors undertaking the survey/questionnaires and other work to ensure that the outcomes of the work are reported to the Council of Governors and from there to the relevant Board sub-committee;

7.4 Work with the governor-led Membership Development Committee to ensure that recruitment and general engagement work is incorporated into the work of the Committee as required;

7.5 Ensure that patient experience issues are reported to the Council of Governors and flagged to the Trust through the Trust Secretary's office in a timely manner;

7.6 Work with HealthWatch and other external stakeholders to understand and improve the patient experience within the Trust.

8. **Reporting responsibilities**

8.1 The Committee is a Committee of the Council of Governors and is accountable to it.

8.2 A report by the Committee Chairman shall be submitted to the Council of Governors at the Council of Governors' meeting following the Committee meeting. The action notes of the Committee meetings shall be available to governors who are not members of the Committee on request to the Committee Chairman through the Trust Secretary's Office.

8.3 The Committee shall make whatever recommendations to the Council of Governors it deems appropriate on any area within its remit where action or improvement is needed.

9. **Other**

9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at

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maximum effectiveness. The Committee will report on its performance and recommend any changes it considers necessary to the terms of reference to the Council of Governors for approval.

10. **Authority**

10.1 The Committee is authorised to assist the Council of Governors in carrying out its functions.

10.2 None of the powers of the Council of Governors are delegated to this Committee.
MEMBERSHIP DEVELOPMENT COMMITTEE

Terms of Reference

The Membership Development Committee (the Committee) is a committee established by and responsible to the Council of Governors. The primary aim of the Committee is to develop the Trust’s membership by increasing engagement with existing members and recruiting new members.

1. Membership

1.1 The membership of the Committee will consist of the following:

- Deputy Chairman of the Council of Governors
- One public governor from each constituency
- One staff governor
- One Appointed Governor
- Any two other Governors

In addition, the following will attend the committee to provide advice as required:

- Governor Co-ordinator
- Trust Secretary
- Head of Communications
- One Non-Executive Director

1.2 Only members of the Committee have the right to attend Committee meetings. The Committee Chairman may invite governors or other individuals to attend for all or part of any meeting, as and when the Committee Chairman considers it appropriate.

1.3 The Committee Chairman shall be a governor and will be elected by the Committee from amongst its membership annually.

1.4 All governor appointments will be made by self-nomination and a vote will be taken by the Council of Governors if there are more nominees than vacancies. The ballot will be organised by the Trust Secretary in accordance with a process agreed by the Council of Governors.

1.5 Appointments to the Committee shall be for a period of two years, which may be extended for one further three year period. The Council of Governors may choose to make appointments for a

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period of not more than one year greater or less than the period specified in order to ensure some continuity of membership of the Committee when vacancies arise. However, only those governors who have served at least one year as members of the Council of Governors shall be eligible for membership of this Committee.

2. Secretary

2.1 The Trust Secretary or their representative shall act as the Secretary of the Committee.

3. Quorum

3.1 A quorum will be four members of the Committee.

4. Frequency of meetings

4.1 Meetings are to be held quarterly and at such other times as may be required.

5. Notice of meetings

5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman.

5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their representative.

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Where possible, the supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of meetings

6.1 The Secretary of the Committee shall record action notes of the proceedings of all Committee meetings. They shall also record the names of those present and in attendance.

6.2 Action notes of Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee. The Secretary of the Committee shall aim to prepare the action notes within one week of the meeting date.

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7. **Duties**

The Committee shall:

7.1 **Build and develop the membership in line with the Trust’s Membership Development Strategy.**

7.2 **Increase the active participation of members so they can benefit fully from their membership and contribute to the development of the Trust and are encouraged to stand as Governors.**

7.3 **Receive membership information to identify where recruitment and engagement needs to be focused.**

7.4 **Identify activities and events to attend to engage with existing and prospective members and co-ordinate governors able to support these events.**

7.5 **Evaluate progress on the aims and objectives for membership as defined in the Membership Development Strategy.**

7.6 **Review the format and content of the Annual Members’ Meeting to ensure maximum attendance and effective engagement with members.**

8. **Reporting responsibilities**

8.1 The **Committee** is a Committee of the Council of Governors and is accountable to it.

8.2 A report by the Committee **Chairman** shall be submitted to the Council of Governors at the Council of Governors’ meeting following the Committee meeting. The action notes of the Committee meetings shall be available to governors who are not members of the Committee on request to the Committee Chairman through the Trust Secretary’s Office.

8.3 The Committee shall make whatever recommendations to the Council of Governors it deems appropriate on any area within its remit where action or improvement is needed.

8.4 The Committee shall compile a report on its activities to be included in the Trust’s annual plan.

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9. Other

9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness. The Committee will report on its performance and recommend any changes it considers necessary to the terms of reference to the Council of Governors for approval.

10. Authority

10.1 The Committee is authorised to assist the Council of Governors in carrying out its functions.

10.2 None of the powers of the Council of Governors are delegated to this Committee.
GOVERNOR TRAINING COMMITTEE

Terms of Reference

The Governor Training Committee (the Committee) is a committee established by and responsible to the Council of Governors. The primary aim of the Committee is to identify and arrange training for the Council of Governors.

1. Membership

1.1 The membership of the Committee will consist of the following:

Seven governors

In addition, the following will attend the committee to provide advice as required:

One Non-Executive Director
Trust Secretary or their representative

1.2 Only members of the Committee have the right to attend Committee meetings. The Committee Chairman may invite governors or other individuals to attend for all or part of any meeting, as and when the Committee Chairman considers it appropriate.

1.3 The Committee Chairman shall be a governor and will be elected by the Committee from amongst its membership annually.

1.4 All governor appointments will be made by self-nomination and a vote will be taken by the Council of Governors if there are more nominees than vacancies. The ballot will be organised by the Trust Secretary in accordance with a process agreed by the Council of Governors.

1.5 Appointments to the Committee shall be for a period of two years, which may be extended for one further three year period. The Council of Governors may choose to make appointments for a period of not more than one year greater or less than the period specified in order to ensure some continuity of membership of the Committee when vacancies arise. However, only those governors who have served at least one year as members of the Council of Governors shall be eligible for membership of this Committee.

2. Secretary

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2.1 The Trust Secretary or their representative shall act as the Secretary of the Committee.

3. Quorum

3.1 A quorum will be three members of the Committee.

4. Frequency of meetings

4.1 Meetings are to be held every other month and at such other times as may be required.

5. Notice of meetings

5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman.

5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their representative.

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend, no later than 5 working days before the date of the meeting. Where possible, the supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

6.1 The Secretary of the Committee shall record action notes of the proceedings of all Committee meetings. They shall also record the names of those present and in attendance.

6.2 Action notes of the Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee. The Secretary of the Committee shall aim to prepare the action notes within one week of the meeting date.

7. Duties

7.1 The Board of Directors has a legal responsibility to ensure that the governors have the skills and knowledge, and receive the information they require, to undertake their role effectively.

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Therefore the Committee shall:

7.2 determine what the governors require and request this from the Trust;
7.3 ensure adequate training and other development activities are provided to new and established governors both at induction and on an ongoing basis;
7.4 keep the training provision under review to ensure it remains effective and enables governors to fulfil their roles and responsibilities as set out in the Trust’s Governor Roles and Responsibilities document;
7.5 ensure that appropriate mentoring and support is available for new governors;
7.6 review the joint away days for the Council of Governors and the Board of Directors to ensure maximum effectiveness.

8. Reporting Responsibilities

8.1 The Committee is a Committee of the Council of Governors and is accountable to it.
8.2 A report by the Committee Chairman shall be submitted to the Council of Governors at the Council of Governors’ meeting following the Committee meeting. The action notes of the Committee meetings shall be available to governors who are not members of the Committee on request to the Committee Chairman through the Trust Secretary’s Office.
8.3 The Committee shall make whatever recommendations to the Council of Governors it deems appropriate on any area within its remit where action or improvement is needed.

9. Other

9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness. The Committee will report on its performance and recommend any changes it considers necessary to the terms of reference to the Council of Governors for approval.

10. Authority

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10.1 The Committee is authorised to assist the Council of Governors in carrying out its functions.

10.2 None of the powers of the Council of Governors are delegated to this Committee.
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

NON-EXECUTIVE DIRECTOR NOMINATION AND REMUNERATION COMMITTEE

Terms of Reference

The Non-Executive Director Nomination and Remuneration Committee (the Committee) is a committee established by and responsible to the Council of Governors. The primary aim of the Committee is to appoint non-executive directors (including the Chairman) and ensure that their remuneration and terms of service are appropriate.

1. Membership

1.1 The Committee will consist of the following:

- Trust Chairman
- Deputy Chairman of the Governors
- Four Governors

In addition, the following will attend the Committee to provide advice as required:

- Director of Human Resources, who will also act as the interface between the Committee and the non-executive directors as appropriate
- Chief Executive
- External independent advisers
- Trust Secretary or their representative.

1.2 Only members of the Committee have the right to attend Committee meetings. The Committee Chairman may invite other governors or any other individuals to attend all or part of any meeting, as and when the Committee Chairman considers it appropriate.

1.3 The Committee Chairman shall be the Trust Chairman. Where the Committee Chairman has a conflict of interest, for example when the Committee is considering the Chairman’s re-appointment or remuneration, the Committee will be chaired by the Deputy Chairman of the Council of Governors.

1.4 All governor appointments will be made by self-nomination and a vote will be taken by the Council of Governors if there are more nominees than

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vacancies. The ballot will be organised by the Trust Secretary in accordance with a process agreed by the Council of Governors.

1.5 Appointments to the Committee shall be for a period of three years, which may be extended for one further three year period. The Council of Governors may choose to make appointments for a period of not more than one year greater or less than the period specified in order to ensure some continuity of membership of the Committee when vacancies arise. However, only those governors who have served at least one year as members of the Council of Governors shall be eligible for membership of this Committee.

1.6 The Chairman of the Trust, or any non-executive director in attendance at the meeting, will withdraw from discussions concerning their own re-appointment, remuneration or terms of service.

2. Secretary

2.1 The Trust Secretary or their representative will act as the Secretary of the Committee.

3. Quorum

3.1 A quorum will be three members, two of whom must be public governors.

3.2 When deciding on the nomination or remuneration of the Chairman the Deputy Chairman of the Council of Governors and two members must be present.

4. Frequency of meetings

4.1 Meetings are to be held as required, but at least twice in each financial year. Generally this will be in the autumn to consider the timetable for appraisal and spring to consider the outcome of appraisal and remuneration to be paid to the non-executive directors.

5. Notice of meetings

5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman.

5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their representative.

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5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Where possible, the supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

5.4 The Committee Chairman may, in exceptional circumstances progress the business of the Committee, and make relevant decisions out of Committee, providing that:

- The discussion and chronology are recorded and reported to the Committee within 10 working days.
- At least two other members’ opinions are sought and documented prior to ratification by the Council of Governors.

6. Minutes of meetings

6.1 The Secretary of the Committee shall minute the proceedings of all Committee meetings. They shall also record the names of those present and in attendance.

6.2 Minutes of the Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee (unless a conflict of interest exists). The Secretary of the Committee shall aim to prepare the minutes within one week of the meeting date.

6.3 The Committee shall report to the Council of Governors after each meeting to gain approval of its recommendations for appointments, remuneration and terms of service.

7. Duties

The Committee shall:

Nomination role
7.1 Periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors and, having regard to the views of the Board of Directors and ‘Policy for the Composition of Non-Executive Directors on the Board’, make recommendations to the Council of Governors with regard to the outcome of the review.

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7.2 Review the results of the Board of Directors’ performance evaluation process that relate to the composition of the Board of Directors.

7.3 Review annually the time commitment requirement for non-executive directors.

7.4 Give consideration to succession planning for non-executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board of Directors in the future.

7.5 Make recommendations to the Council of Governors concerning plans for succession, particularly for the key role of Chairman.

7.6 Keep the leadership needs of the Trust under review at non-executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

7.7 Keep up-to-date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.

7.8 Agree with the Council of Governors a clear process for the nomination of a non-executive director. The process shall include the use of open advertising and/or the services of external advisers to facilitate the search.

7.9 Take into account the views of the Board of Directors on the qualifications, skills and experience required for each position.

7.10 For each appointment of a non-executive director, consider the advice of the Board of Directors and prepare a description of the role and capabilities and expected time commitment required.

7.11 Consider candidates on merit and in light of the guidance in the ‘Policy for the Composition of Non-Executive Directors on the Board’ taking care to ensure that appointees have enough time available to devote to the position.

7.12 Identify and nominate suitable candidates to fill vacant posts, for appointment by the Council of Governors.

7.13 Ensure that a proposed non-executive director’s other significant commitments are disclosed to the Council of Governors before

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appointment and that any changes to their commitments are reported to the Council of Governors as they arise.

7.14 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

7.15 Ensure that on appointment non-executive directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside Board of Director meetings.

7.16 Advise the Council of Governors in respect of the re-appointment of any non-executive director at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required. Any term beyond six years must be subject to a particularly rigorous review.

7.17 Advise the Council of Governors in regard to any matters relating to the removal of office of a non-executive director.

7.18 Make recommendations to the Council of Governors on the membership of committees as appropriate, in consultation with the chairs of those committees.

**Remuneration role**

7.19 Recommend to the Council of Governors a remuneration and terms of service policy for non-executive directors, taking into account the views of the Chairman (except in respect of his own remuneration and terms of service) and the Chief Executive and any external advisers.

7.20 In accordance with all relevant laws and regulations, recommend to the Council of Governors the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors.

7.21 Agree the process and receive and evaluate reports about the performance of individual non-executive directors. The Chairman will appraise the non-executive directors. The Senior Independent Director and the Deputy Chairman of the Council of Governors shall facilitate the Chairman’s appraisal and feedback to the Committee. The office of the

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Director of Human Resources will help facilitate the appraisal process which should be completed by June.

7.22 Consider the evaluation output from appraisals when reviewing remuneration levels.

7.23 In adhering to all relevant laws and regulations establish levels of remuneration which:
- are sufficient to attract, retain and motivate non-executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;
- reflect the time commitment and responsibilities of the roles;
- take into account appropriate benchmarking and market-testing, while ensuring that increases are not made where Trust or individual performance do not justify them. The remuneration of non-executive directors will be reviewed annually with a more detailed benchmarking exercise taking place every three years (the next detailed benchmarking is scheduled for 2017/18);
- are sensitive to pay and employment conditions elsewhere in the Trust.

7.24 Oversee other related arrangements for non-executive directors.

**Governor performance**

7.25 Monitor the attendance of governors at meetings of the Council of Governors and recommend appropriate action, as set out in the constitution, to the Council of Governors.

8. Reporting responsibilities

8.1 The Committee is a Committee of the Council of Governors and is accountable to it.

8.2 A report by the Committee Chairman shall be submitted to the Council of Governors at the Part 2 Council of Governors’ meeting following the Committee meeting. This will allow governors the opportunity to make comment, which might be inappropriate in the setting of a meeting in public.
8.3 The Committee shall make whatever recommendations to the Council of Governors it deems appropriate on any area within its remit where action or improvement is needed. All recommendations of the Committee require ratification by the Council of Governors.

8.4 The Committee shall make a statement in the annual report about its activities, the process used to make appointments and explain if external advice or open advertising has not been used.

8.5 All members of the Committee are required to observe the strictest confidence regarding any information relating to the work of the Trust and its employees, including its non-executive directors. Members are required not to disclose any confidential information either during or after their term of membership unless expressly authorised to do so or required in the proper performance of their duties or as required by law. The obligation will cease only when such information comes into the public domain other than through unauthorised disclosure. Failure to comply with these requirements could result in the termination of membership of the Committee.

9. Other

9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness. The Committee will report on its performance and recommend any changes it considers necessary to the terms of reference to the Council of Governors for approval.

10. Authority

10.1 The Committee is authorised to assist the Council of Governors in carrying out its functions.

10.2 None of the powers of the Council of Governors are delegated to this Committee.

10.3 The Committee is authorised by the Council of Governors, subject to approval by the Board of Directors, to request professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions.

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10.4 The Committee is also authorised to request such internal information as is necessary and expedient to fulfil its functions.
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

STRATEGY COMMITTEE

Terms of Reference

The Strategy Committee (the Committee) is a committee established by and responsible to the Council of Governors. The primary aim of the Committee is to review the Trust’s Annual Plan (its strategic plan) and Annual Report documents on behalf of the Council of Governors.

1. Membership

1.1 The membership of the Committee will consist of the following:

- Four governors

In addition, the following will attend the Committee to provide advice as required:

- Chief Operating Officer
- Director of Finance
- Chief Executive
- Trust Secretary or their representative.

1.2 Only members of the Committee have the right to attend Committee meetings. The Committee Chairman may invite other governors or any other individuals to attend all or part of any meeting, as and when the Committee Chairman considers it appropriate.

1.3 The Committee Chairman shall be a governor and will be elected by the Committee from amongst its membership annually.

1.4 All governor appointments will be made by self-nomination and a vote will be taken by the Council of Governors if there are more nominees than vacancies. The ballot will be organised by the Trust Secretary in accordance with a process agreed by the Council of Governors.

1.5 Appointments to the Committee shall be for a period of three years, which may be extended for one further three year period. The Council of Governors may choose to make appointments for a period of not more than one year greater or less than the period specified in order to ensure some continuity of membership of the Committee when vacancies arise. However, only those governors who have served at least one year as

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members of the Council of Governors shall be eligible for membership of this Committee.

2. Secretary

2.1 The Trust Secretary or their representative will act as the Secretary of the Committee.

3. Quorum

3.1 A quorum will be three members, two of whom must be public governors.

4. Frequency of meetings

4.1 Meetings are to be held as required, but at least twice in each financial year. Generally this will be in the autumn to consider the outline for the Trust’s annual plan and spring to consider the content of the annual report.

5. Notice of meetings

5.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chairman.

5.2 The Committee Chairman will agree the agenda and papers to be circulated with the Trust Secretary or their representative.

5.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Where possible, the supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of meetings

6.1 The Secretary of the Committee shall record action notes of the proceedings of all Committee meetings. They shall also record the names of those present and in attendance.

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6.2 Action notes of the Committee meetings shall be agreed by the Committee Chairman prior to being circulated to all members of the Committee. The Secretary of the Committee shall aim to prepare the action notes within one week of the meeting date.

7. Duties

The Committee shall:

7.1 provide views gained from engagement with Trust members on the issues to be considered in the annual plan and comment on a draft.

7.2 review an early draft of the annual report to ensure that the work of the Council of Governors is accurately represented and to provide comment on other sections.

7.3 coordinate the governors’ comments on the quality account and provide a formal response from the Council of Governors to the Trust.

7.4 prepare topics for further scrutiny with non-executive directors and arrange sessions where a dialogue can be had (i.e. non-executive directors held to account for the performance of the Board of Directors).

8. Reporting responsibilities

8.1 The Committee is a Committee of the Council of Governors and is accountable to it.

8.2 A report by the Committee Chairman shall be submitted to the Council of Governors at the Council of Governors’ meeting following the Committee meeting. The action notes of the Committee meetings shall be available to governors who are not members of the Committee on request to the Committee Chairman through the Trust Secretary's Office.

8.3 The Committee shall make whatever recommendations to the Council of Governors it deems appropriate on any area within its remit where action or improvement is needed.

9. Other

9.1 The Committee shall, at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness. The Committee will report on its performance and recommend any

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changes it considers necessary to the terms of reference to the Council of Governors for approval.

10. Authority

10.1 The Committee is authorised to assist the Council of Governors in carrying out its functions.

10.2 None of the powers of the Council of Governors are delegated to this Committee.
## COUNCIL OF GOVERNORS

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<tr>
<th>Meeting Date and Part:</th>
<th>15 July 2015 – Part 1</th>
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<tbody>
<tr>
<td>Subject:</td>
<td>Report from the NED Remuneration and NED Nomination Committees – meeting held on 18 June 2015</td>
</tr>
<tr>
<td>Section:</td>
<td>Information</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Sarah Anderson, Trust Secretary</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td>The NED Remuneration Committee coordinates the governor input into the appraisal process for all non-executive directors and the chairman each year. All governors had the opportunity to contribute. Each year the Committee receives the outcomes of the appraisals.</td>
</tr>
<tr>
<td>Key Purpose:</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Action Required by Council of Governors:</td>
<td>Note the appraisal outcomes of the non-executive directors and chairman</td>
</tr>
<tr>
<td></td>
<td>Note that the NED Remuneration Committee had no concerns on governor attendance at meetings</td>
</tr>
<tr>
<td></td>
<td>Approve the NED Nomination Committee recommendation that Steven Peacock be appointed as the Vice-Chairman to the Trust</td>
</tr>
<tr>
<td></td>
<td>Note that the Committees approved the terms of reference for a combined committee</td>
</tr>
<tr>
<td>Summary:</td>
<td>The Chairman fed back on the issues discussed with the non-executive directors as part of their appraisal. The NED Remuneration Committee was generally</td>
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satisfied with the issues discussed and objectives set for non-executives in 2015/16. However, some further comments were identified and the Chairman will raise these with the non-executive directors concerned.

NED Remuneration Committee noted that the Trust Secretary had not identified any concerns with regard to governors’ attendance at meetings.

Two non-executive directors expressed interest in becoming the Vice-Chairman of the Trust. The NED Nomination Committee reviewed the expressions of interest and would like to recommend that Steven Peacock be appointed to this position.

Both Committees reviewed the proposed terms of reference for a combined committee and would like to recommend approval of the terms of reference to the Council of Governors.
### COUNCIL OF GOVERNORS

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<th>Meeting Date and Part:</th>
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<tr>
<td>Subject:</td>
<td>Council of Governor Meeting Dates</td>
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<tr>
<td>Section:</td>
<td>Decision</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Sarah Anderson, Trust Secretary</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td>None.</td>
</tr>
<tr>
<td>Key Purpose:</td>
<td>Patient Engagement</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Action Required by Council of Governors:</td>
<td>• Agree the meeting dates and times for 2016/17.</td>
</tr>
<tr>
<td>Summary:</td>
<td>The Council of Governors meets quarterly and proposed dates for the meetings in 2016 and to the end of the 2016/17 financial year have been identified as:</td>
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- Wednesday 17 February 2016
- Wednesday 13 April 2016
- Thursday 21 July 2016
- Wednesday 12 October 2016
- Thursday 12 January 2017

The Council of Governor meetings are held in public and therefore should be accessible to many of the Trust’s members and other stakeholders. The meetings have traditionally been held during the working day. This excludes many of our potentially interested...
stakeholders as people who work and who have school age children are excluded from attending given the time of the meeting. Holding meetings during the late afternoon and evening could exclude some of the older stakeholders as they are unwilling to go out in the dark and may be reliant on public transport which may have ceased running in the evening.

In order to be more inclusive it seems appropriate to vary the time of the day when meetings are held so that more people are given the opportunity to attend.

In addition, all governors are volunteers and should be drawn from the members to present a representative slice of our patients and public. Again the timing of meetings could be excluding some members from putting themselves forward as governors as they work or have child-minding commitments and are unable to attend meetings during the working day.

The Council of Governors is requested to consider varying the time of its meetings such that more members can attend and the governor role is attractive to a wider slice of the membership.
**COUNCIL OF GOVERNORS**

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<tr>
<td>Section:</td>
<td>Information and Discussion</td>
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<tr>
<td>Author of Paper:</td>
<td>Matthew Hepenstal / Sue Barratt, Deliottes</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td></td>
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<tr>
<td>Key Purpose:</td>
<td>Patient Engagement</td>
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<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Action Required by Council of Governors:</td>
<td>To note</td>
</tr>
<tr>
<td>Summary:</td>
<td></td>
</tr>
<tr>
<td>Strategic Goals &amp; Objectives:</td>
<td></td>
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<tr>
<td>Links to CQC Registration:</td>
<td>(Outcome reference)</td>
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The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Annual Report and Accounts 2014/15

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.
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Message from the Chair

"Excellent care for our patients reflecting the care we expect for our family"

Our Annual Report for 2014/15 reflects our continuing mission to save lives and change lives, putting care for our patients at the heart of all we do. After probably the most challenging year in the history of this Trust, our staff, volunteers and patients have combined together to support progress, innovation and renewal within our hospitals. This report looks back on the past year, but also forward to the different challenges that lie ahead, both at a national and local level.

Safe services, caring and responsive

At the start of 2014, I emphasised that we needed to demonstrate courage and resolve to address the areas identified by the Care Quality Commission (CQC) report. I emphasised the need for courage to challenge, to do things differently and to be intolerant of poor standards, while confident and proud of the outstanding work that has been delivered within our hospitals. I am delighted that following months of exceptionally hard work by all to tackle perceived deficiencies, the CQC follow-up inspection report was strong and confirmed its view that services at the Royal Bournemouth Hospital are safe, effective, caring and responsive to patient needs, and the organisation is well led. You will find more information as you read the report.

While this has been a central priority through the year, it is important to emphasise that there is not, nor can there be, any sense of complacency. The challenges to recruit staff are ongoing and our staff are critical to the ultimate continued success of our hospitals.

A better environment for patients

While this report details some of the many improvements delivered over the year, few initiatives offer such a visible and tangible evidence of the priority in which our patients are regarded as the transformation of a ward - a good example being that of Ward 26. The design changes - including a communal area with comfortable chairs and a screen showing appropriate images - has provided a welcome opportunity for patients to socialise. The attractive bays have been very well received and staff have also acknowledged that this investment in facilities is beneficial for their morale.
The many initiatives to enhance the environment for our patients are impressive and include our new Bournemouth Birth Centre. The purpose-designed, midwife-led centre offers state-of-the-art facilities and an opportunity for partners to stay overnight to support mothers and has already received outstanding feedback from parents.

Innovation

Over the year it has been pleasing to see numerous examples of commitment to providing expert care, as well as developing services for the future. Statistics published by the British Cardiovascular Intervention Society showed impressive results for patients here. Most recently the Service has expanded to offer emergency treatment to patients presenting with a heart attack caused by a blocked artery with the aim of unblocking the artery within 60 minutes of arrival, 24 hours a day. Our cardiac specialists are also able to monitor patients who may suffer from irregular heartbeats using insertable cardiac monitors which can be inserted in 45 seconds, with no need for surgery.

I was also very pleased during the year to support the 25th anniversary celebrations for the Cardiac Rehabilitation service, originally started by one of our consultants. The service, run from Bournemouth Heart Club, sees some 2,000 new referrals a year, while some 4,000 people attend Heart Club exercise classes each month. This service exemplifies the approach we are seeking for our patients - excellent clinical results, using new approaches and advanced technology, then helping people return to health: saving lives and changing lives.

Much focus over the year has been on reviewing our patients’ pathways for unscheduled care. The innovation of BREATH - our Bournemouth Rapid Evaluation Assessment Treatment Hub - is yet another example of commitment to improvement, offering our patients even more timely senior assessment and supporting better outcomes.

The Trust has invested very heavily in delivering quality patient care and is aware that public money is constrained, and further transformation of services must be achieved going forward.

Our volunteers

We are very fortunate in the support we receive from our many volunteers and those who provide a very significant charitable contribution. I would like to take this opportunity to emphasise how much their commitment is appreciated. Over the year charitable funds have assisted in purchasing equipment, including monitors and a treadmill machine, through to supporting a social worker and psychological support nurse for our cancer ward. Volunteers take on many and varied roles within our hospitals, from administration through to patient/mealtime companions.

Our governors are also volunteers and this year, as ever, they have given countless hours to the Trust and to their responsibilities for governance. This is a challenging task and we are indebted to them all for their work, which is focused on seeking assurance that we are fulfilling our responsibilities to patients and that they, as a Council, are able to express and reflect the views of their constituents and Trust members.
Looking ahead

Looking ahead, it is prudent to plan for significant change. A critical factor in encouraging and leading change will be to promote good communication throughout the organisation and to ensure staff are well supported in their daily tasks, with prospects of realistic and welcome personal development, aligned to the objectives of the organisation. I am encouraged by the work undertaken in support of a refreshed vision and values and the introduction of a new appraisal system, which ensures our staff are recognised as integral to improvement and the best patient care. I am very pleased that staff tell me they welcome the newly launched values based appraisal process which offers the prospect of a real focus on developing our staff as our greatest asset. I wish to thank all staff for their candour, and note how essential it is going forward for staff to get involved with improvements in our hospitals.

During the year, we saw some changes on the Board of Directors. We welcomed two new non-executive directors and also saw a change of Chief Operating Officer. The Board is very much committed to the agreed vision and values and it will be essential over coming months to ensure those values are demonstrated in everyday behaviours.

While we currently await the outcome of a Clinical Services Review being carried out by Dorset Clinical Commissioning Group, we appreciate that, whatever the decision, there is a very active and influential role for us to play in designing and delivering health care services for local people in future. This Trust has much to offer in delivering expert, accessible clinical care and is both clinically and geographically well placed to respond to the needs identified in the Clinical Services Review.

In summary, we are resolute in our vision to provide excellent care for our patients, reflecting the care we expect for our family. We have made immense progress over the year, but have more to do to ensure that our hospitals are able to continue to save lives and change lives.

Thank you for your continued support.

Jane Stichbury
Chairman
28 May 2015
Message from the Chief Executive

In this my sixteenth Annual Report, I want to begin by expressing my thanks, firstly to our patients and the wider community for their ongoing support, feedback and appreciation of the care and services we provide. Secondly, I want to pay tribute to our staff for their unstinting professionalism and commitment, consistently providing high-quality, safe and compassionate care to our patients.

During the last year, the NHS has seen an unprecedented level of demand for its services. Often this has been most evident in the number of patients requiring emergency admission, many of these patients are vulnerable, frail and elderly with multiple co-morbidities. Accident and emergency departments have also borne the brunt of a substantial increase in the number of patients presenting for treatment. This trend reflects a multiplicity of underlying issues, an increasingly frail and elderly population, the pressures faced by colleagues in primary care, the absence of sufficient alternatives to allow patients to be cared for more independently in their home setting, the pressures on social care, the shrinkage of the nursing and residential home care sector and finally the changes, which have been made to out of hours services, including 111.

Hospitals in turn have responded remarkably well to this upsurge in demand for their services. Here at the Royal Bournemouth Hospital we saw a 12% increase in the number of patients requiring emergency admission over the last year. We have been able to respond and accommodate this increased need for admission through some important changes in how we provide services. During the last 18 months we have focused on strengthening the provision of seven day services. In turn, we have expanded our consultant workforce by 15% enabling many more routine services to be provided at weekends. This allows more patients to be discharged home from hospital at weekends, regularised investigations and tests to continue to run and it provides for a safer hospital overall. We have also changed fundamentally some of our care processes. This has been seen particularly within elderly care where the length of time patients spend in hospital has been reduced from on average 14 to 11 days. We have introduced new ways of working, such as the Bournemouth Rapid Evaluation Assessment Treatment Hub (BREATH), which ensures patients receive early assessment by a team of experienced doctors and nurses leading to patients spending less time waiting within our Emergency Department.

Crucially, we have also introduced a range of ambulatory care services to enable more patients to be treated without recourse to admission and to support patients being discharged as soon as possible. This has led to improvements in the flow of patients through our Acute Medical Unit and helped improve the flow of patients to the correct wards ensuring safer care.
Significant time and effort has also been focused on promoting a more integrated approach to hospital, community and social care. We have worked hard to develop a trusted assessor model which means patients can have their health and social care needs assessed more quickly, thus focusing on the importance of ensuring patients have ready access to rehabilitation, both within hospital and also following their discharge from hospital. Over the last year, we have also developed our own interim care pilot where we provide nursing and therapist input to patients living in their own homes awaiting packages of care. Going forward, we will work with partners in social care to ensure patients have a more responsive service meeting their needs when they leave hospital.

These are all important examples of how we continue to focus on improving the care patients receive and enhancing the patient experience. We have developed a specific improvement methodology to help drive continued improvements in care and this is being used to support the new priorities we have set for ourselves for the coming year:

- improving the management of patients with sepsis
- reducing the level of mortality as a result of emergency laparotomy procedures
- aiding the smooth discharge of patients from hospital
- uniform use of surgical checklists so that there are no ‘never events’ associated with a failure to use such checklists
- implementing the National Institute of Healthcare and Excellence (NICE) guidance for patients referred with suspected gastrointestinal cancer

Within the Trust, we have launched a new appraisal system and the objectives we have set for 2015/16 will form the basis for individual and team based objective setting for all staff. Those objectives centre on:

- **Quality** - providing safe, effective and compassionate care
- **Improvement** - using the quality and improvement methodology to support achievement of the Trust priorities of sepsis, procedure checklist, simple discharge, emergency laparotomy, and cancer referral pathways, or locally agreed improvement priorities

- **Strategy and Partnerships** - to have a clear strategy that responds to the Clinical Services Review and provides a basis for maintaining viable high quality services through until its implementation.
- **Staff** - focusing on good organisational health with a positive development and learning culture, strong leadership and team work
- **Performance** - delivering the performance required to maintain access to elective diagnostic and emergency services
- **Value for Money** - staying within budget, using resources wisely and cutting waste to allow the maximum funding to go to front line patient care

An important part of the external verification of the quality of care we provide has been the detailed re-inspection by the Care Quality Commission (CQC) which took place in August 2014. The CQC provided a positive endorsement of the action that we had taken to improve and strengthen our services since its previous inspection visit. It commented:

“We found increases in staffing levels and increased support for junior doctors. The appointment of clinical matrons and support for ward sisters to focus on leadership and supervision of staff on the wards now supported planning and the delivery of safe and effective care. The speed of access to diagnostics and the Stroke Unit had improved.”

It also commented that staff were proud of the improvements achieved since the last inspection and while this is encouraging, it is important that we continue to do everything we can to embed and sustain the continued drive to improve the quality of the care and services we offer our patients.

The last year has seen significant construction work occurring both at Christchurch Hospital and on the Royal Bournemouth Hospital site. A new cancer and blood disorders unit, together with a women’s health facility is now in the final stages of construction at the Royal Bournemouth Hospital. Part funded through the Jigsaw charitable funds and the generous
support and donations of local residents, the new unit will open in the autumn and provide a state-of-the-art facility for women and those suffering from blood disorders. A major investment programme is also underway at Christchurch Hospital with the re-provision of outpatient, diagnostic and day hospital facilities. The existing facilities at Christchurch Hospital will be complemented by a GP surgery, an NHS dentist, a 60 bedded nursing home and assisted living accommodation. We are creating a health hub for the population of Christchurch and the surrounding areas.

Continued investment is also taking place to ensure our facilities are fit for purpose and we have the most up-to-date equipment to provide safe care to our patients. The Radiology Department is an outstanding example of this, with our scanners offering world leading imaging to support the diagnosis of a range of conditions.

Despite all of this, the local NHS is under sustained pressure. There is a need to change the way in which care and services are provided and we need to plan these changes as a whole health system involving not only colleagues in hospital care but also those providing primary, community and social services. The Dorset Clinical Commissioning Group (CCG) is leading a clinical review of services in Dorset. This will generate new options for the provision of services and will lead to some fundamental changes in the way that hospital care is to be delivered in the future. The drivers for these changes include:

- in Dorset, an anticipated system-wide deficit of between £250m and £300m by 2021 if the current models of care and patterns of provision remain unchanged
- acknowledgement that emergency services across the whole of Dorset are currently not able to fully comply with Sir Bruce Keogh’s recommendations and guidance for the future delivery of emergency care and without so doing we risk the ongoing care being sub-optimal
- the building demographics with a 30% increase in the number of residents aged over 75 projected for Dorset by 2023 with the concomitant health needs and requirements this will bring

- clear manpower constraints particularly affecting medical and nursing staff preventing a natural expansion in services to keep pace with the projected demand, even if funding was available to support service expansion. The need to find ways to address this constraint is crucial to offer robust, high-quality services 24 hours a day, seven days a week

- the unsustainable increase in emergency admissions, relating particularly to the care of the frail elderly and the associated difficulties that currently pertain to offering full and comprehensive social care support to these patients

As a consequence, we are likely to develop new models of care, focused on the concentration of some emergency services on a single site in Dorset, to ensure that we are able to fully comply with national guidelines for providing consultant delivered care, 24 hours a day, seven days a week. It is anticipated that within the east of Dorset more elective or routine services will be concentrated on one hospital site and we will look to realise opportunities to properly and appropriately integrate primary, community and hospital services wherever there are clear advantages for local people of doing so. It is anticipated that the Dorset CCG will consult on these proposals in the autumn of 2015.

In concluding, I wanted to assure you of my determination and indeed that of all colleagues working within the Trust to ensure that we continue to provide high quality care for all of our patients and that we offer a service to be proud of not just locally but nationally.

Mr A Spotswood
Chief Executive
28 May 2015
Highlights of the year

There have been many examples throughout the year where we have performed well, delivered high quality care, and where staff have gone above and beyond for our patients.

**Ward transformed to benefit dementia patients**

One of our wards underwent a major renovation to improve the environment for patients who have dementia and the quality of their care.

The bays, reception area, facilities and staff offices in Ward 26 were transformed over a period of six weeks by staff who attended specialist courses led by The King’s Fund to learn what design changes would make wards safer and less confusing for those with dementia.

Dementia affects a staggering 820,000 people in the UK and last year around 2,600 patients with dementia were treated in our hospitals.

A new reception desk has been introduced at the ward entrance along with smaller nursing desks in each bay. A communal area has been created with comfortable chairs and a screen showing appropriate images, giving patients the opportunity to socialise and interact.

Each bay has a flower theme with distinctive images of poppies, bluebells and daisies on the entrance doors, helping to orientate patients back to their own bay and bed.

Ward sister Claire Charville said: “Patient feedback has been extremely encouraging. They feel the bays are a lot more attractive and comfortable to be in. Staff also feel a lot happier working here, and this has enhanced morale and improved the atmosphere.”
Hospital at the forefront of cardiac monitoring technology

Our Cardiac Specialists can now monitor patients who suffer from blackouts or irregular heartbeats via state-of-the-art devices that can be inserted in just 45 seconds, with no need for surgery.

The Insertable Cardiac Monitors (ICM), which are slightly bigger than a match stick, are implanted into a patient’s chest and monitor their heart activity 24-hours a day for up to three years.

If the ICM detects any abnormalities, it alerts a wireless receiver in the patient’s house and automatically transmits the data directly to a secure server alerting their hospital. Doctors are then able to analyse the information and determine what may be causing the problem, or refer the patient to the hospital for treatment.

The new monitor is a tenth of the size of the one previously used, making it much more comfortable and less noticeable under the skin.

Consultant cardiologist Mark Sopher said:

“This is a major advance in ECG monitoring and will improve the quality of patient care.”

Patient celebrates 105th birthday!

Staff on our Stroke Unit helped celebrate the 105th birthday of one of the hospital’s oldest ever patients.

Bournemouth resident Brenda Stockwell was presented with a cake by Ward Sister Nikki Manns and her team to celebrate the momentous occasion.

Brenda, who was born in Lancashire in 1909, said: “The nursing staff and doctors here are fantastic. Everyone seemed to know it was my birthday and I have been sung ‘the song’ and presented with a lovely cake. They are extremely caring and thoughtful.”

Local firm chosen for Christchurch Hospital works

Christchurch-based construction company Stan Randell and Co were chosen to work on the redevelopment of Christchurch Hospital bringing up to 50 local workers and subcontractors on site.

The hospital is undergoing a multi-million pound redevelopment which will secure NHS services and ensure it remains a key part of the community for years to come.

Stan Randell and Co will deliver both the refurbishment of the existing Outpatients Department and the new extension in which a new GP surgery, retail pharmacy and X-Ray Department will be located.

The company has a long history with the Trust having been involved in a number of projects at the Royal Bournemouth Hospital and the demolition of the Royal Victoria Hospital in Boscombe over 20 years ago.
Celebrating 1,000 cardiac rehabilitation courses

Our Cardiac Rehabilitation Service celebrated its 25th anniversary in October 2014 and provided its 1,000th rehabilitation course.

Cardiologist Dr Adrian Rozkovec initiated the service in 1989, with the help of specialist cardiac rehabilitation nurse, Sister Vicky Sievey. It is run from the Bournemouth Heart Club - a charity formed by the first patients attending the seven week rehabilitation course.

The service receives 2,000 new NHS referrals every year and some 4,000 people attend the Bournemouth Heart Club’s exercise classes each month, making Bournemouth one of the largest cardiac rehabilitation centres in the country.

“You mended my heart and now you will be in my heart forever more…”

A cardiac rehabilitation patient

Inspiring the next generation

Year 12 students were given an insight into the different careers available in the NHS as part of a special event in November.

The free careers open day saw 100 pupils from 12 schools across Bournemouth, Poole, Ringwood and Purbeck areas attend talks by hospital staff and visit information stands set up by different departments.

The students were able to try their hands at resuscitation, test their knowledge and skills with a number of themed quizzes and questionnaires, and ask staff questions on their roles and typical working days.

Kyle Cox, aged 16, said: “The wide range of jobs in the NHS has really surprised me. I wasn’t aware of half the careers available. It is also great that the majority of the stands are interactive and enable you to get a feel of a particular area.”

“The wide range of jobs in the NHS has really surprised me…”

Heart attack patients receiving top treatment

Statistics published by the British Cardiovascular Intervention Society show that patients treated at our hospital for narrowed or blocked coronary arteries experienced significantly less complications than the national average.

The impressive results are down to the success of the Percutaneous Coronary Intervention (PCI) service which was introduced in our hospital back in 2005.

More recently, the service has seen a major expansion to offer emergency treatment to patients presenting with a heart attack caused by a blocked artery. These patients are taken straight to our cardiac catheter lab for life-saving treatment. The aim is to unblock the artery within 60 minutes of the patients’ arrival, 24 hours a day.
Consultant Interventional Cardiologist, Dr Suneel Talwar, said: “This is the gold-standard treatment for heart attacks, currently available worldwide, and we are proud to offer this to our patients at our state-of-the-art centre.”

“We are proud to offer gold standard treatment to our patients at our state-of-the-art centre…”

**New Birth Centre delivered**

Our new midwife-led Bournemouth Birth Centre opened its doors for the first time in November.

Hosting two spacious birthing suites with en-suite bathrooms, ‘quick-fill’ birthing pools and an additional overnight room, the new unit demonstrates our commitment to providing high quality ‘home from home’ births for new mums.

The purpose built facility boasts hidden technology, sound proofing, air conditioning and variable lighting to create a welcoming atmosphere. It also has dedicated car parking bays for parents and visitors and pull-out beds so dads and birthing partners can stay overnight.

The first baby to be born in the centre was Oliver Newbery who now has a room named in his honour.

Newly qualified midwife Katie Winwood said: “I feel very honoured to work in the new suite because it’s completely centred round the women giving birth.”

“We have an amazing team of midwives here so it’s really exciting to be part of this new venture…”
Providing seven-day services

A number of our departments have adopted seven-day working to ensure patients get timely, high-quality care no matter what day of the week.

A seven-day CT scanning service is supporting earlier diagnosis for patients and preventing a backlog of scans. It is of particular benefit for stroke and transient ischemic attack (TIA) patients where rapid diagnosis is essential to recovery.

Our Speech and Language Therapy Team is leading the way in Dorset as the first to offer a seven-day service, enabling patients to be assessed more quickly and ensuring they can eat and drink safely which in turn speeds up their recovery.

In gastroenterology, a consultant is on site every day and can review patients wherever they are in the hospital. If an endoscopy is needed on a weekend or bank holiday, that consultant can contact the on call Endoscopy Team and carry out the clinical procedure without delay.

Earl Williams, Consultant Physician and Gastroenterologist, said: “Patients feel a lot happier throughout their treatment as the consultant they have seen during the week is more likely to be treating them at the weekend, and this continuity is helpful during their time in hospital.”

Success in unscheduled care

Some 43 patients every day are now being treated in ambulatory care who would otherwise be admitted to a bed. Ambulatory care is available in acute medicine, surgery and older peoples’ medicine and allows many patients to be seen and treated the same day.

We have also managed to reduce the average length of stay across unscheduled care by nearly one day for every patient.

Patient Nigel Jones said: “I have been singing the praises of RBH to friends, family and pretty much anyone who’s prepared to listen. My profession is business improvement. A part of this involves looking at how businesses can save time, resource and money and improve delivery and quality performance to their customers. It seems to me you have done just that with ambulatory care.

“I do hope this shining light in the NHS continues.”
Faster treatment for Emergency Department patients

A faster treatment service for our Emergency Department (ED) patients was trialled successfully at the Royal Bournemouth Hospital in January.

**BREATHT** - Bournemouth Rapid Evaluation Assessment Treatment Hub - sees patients who arrive by ambulance transferred straight into a ‘hub’ where a dedicated senior doctor directs a team of nurses in heart monitoring and taking necessary blood samples or x-rays. This allows ED staff to design a plan of action for a patient’s urgent care within 20 minutes of their arrival.

After visiting the BREATH hub, patients are streamed to the most appropriate service for them, including the majors, minors and outpatients departments, or to ambulatory care.

Support from volunteers and charity

Throughout the year we were extremely fortunate to receive the support of approximately 800 volunteers, including our partnership volunteer organisations.

Over the last 12 months, we have been reviewing and extending the number and role of our valuable volunteers. Volunteers’ roles are diversifying and training and development continues to support them in their work.

Our volunteers go through a robust recruitment process to provide board assurance, attend mandatory training in line with national recommendations, and attend specialist training events to support their tasks.

Volunteers’ duties are wide and varied and include:

- main receptions meet and greet
- ward support, providing patient visitors
- administration support
- driving the indoor train
- surveying patients for real-time patient feedback
- meal companions to help those in need of minimal support at mealtimes
Highlights of the year

- patient companions for those with cognitive impairment
- mealtime assistants to help feed patients who have been carefully selected by clinical staff
- gardening

We were fortunate to also receive great support from a number of hospital charities to improve both the patient experience and working lives of staff, above and beyond what the NHS can afford. We would like to thank them for their continued efforts and support for our hospitals.

- Bournemouth Hospital Charity
- Friends of the Eye Unit
- League of Friends Bournemouth
- Christchurch Hospital League of Friends
- Macmillan Caring Locally
- Royal Voluntary Service
- Appeal Shop
- Hospital Radio Bedside
- Red Cross
- Bournemouth Heart Club

Friends of the Eye Unit

The Friends of the Eye Unit enjoyed another productive year for the benefit of our Eye Unit.

The Friends’ AGM in July was very successful, enabling them to recruit a number of new members, and a decision to increase the annual subscription from £1 to £3 was approved.

The Friends hosted a popular gift bag stall at the Bournemouth League of Friends’ Christmas Fair on 15 November and in December, made the usual pre-Christmas visits to patients with greetings, Christmas cards and diaries.

During the year the group were pleased to contribute in excess of £54,000 towards new and replacement equipment in the unit, together with the funding of other amenities for the ongoing benefit of patients and staff.

League of Friends Bournemouth

Over the past year the league held a number of events, including its annual Christmas fair and monthly coffee mornings, to raise valuable funds to benefit the hospital, staff and patients.

League volunteers run a goods counter in the main atrium of the Royal Bournemouth Hospital, which is open five days a week and goes from strength to strength. The counter is dependent upon the wonderful donations provided by its knitters, sewers and craft makers who produce the gifts sold on the counter.

Donations to the league have provided £49,500 of funding to a range of areas across the hospital, including:

- equipment for Ward 1
- 11 patient x-ray trolleys
- eight blood pressure monitors
- televisions for waiting areas
- one resus cart

Macmillan Caring Locally

During the year, Macmillan Caring Locally continued its support of services at the Macmillan Unit at Christchurch Hospital by funding the costs of the community specialist palliative care sisters, Royal Bournemouth Hospital palliative care service, the Macmillan Day Centre, the Macmillan rehabilitation team, the family support team and welfare benefits advice.
Macmillan Caring Locally also funded a two-year pilot project at the Macmillan Unit, to recruit and train volunteers for new roles supporting patients on the ward, and in the community.

There are plans in place to rebuild the Macmillan Unit at Christchurch Hospital and the charity has continued its commitment to contribute at least £4.5m to this project. It is hoped the new unit will be completed in 2017.

**Bournemouth Hospital Charity**

Bournemouth Hospital Charity aims to raise money to benefit our staff and patients by providing funding above and beyond what the NHS alone can afford.

The money the charity raises is used to enhance the already excellent care received by patients at the hospitals and is provided by the local community and businesses.

Highlights for the year have been the annual Twilight Walk for Women - which raised over £20,000 for equipment in our Women’s Health Unit, part of the Jigsaw Building - and our Pedal Power event which raised over £6,000 for our Cardiac Unit and saw men, women and children take to the New Forest and cycle distances as far as 100km.

One example of funding provided by the charity was the £36,000, NASA-invented AlterG treadmill machine used by our Physiotherapy Department.

It is used by patients with a lower limb disorders, for example, patients with arthritis of the knee joint and some patients with lower back pain.

James Creasy, Senior Physiotherapist, said: “We are one of only a handful of NHS hospitals that own a machine and this is thanks to Bournemouth Hospital Charity. The AlterG will benefit thousands of patients and we are very lucky to have this resource for our patients.”

Physio patient, Phil Ducker regularly uses the AlterG machine as part of his treatment. Phil has Charcot Marie Tooth Disease (CMT), a degenerate condition which affects his legs and feet.

He said: “The AlterG has improved the muscle mass in my legs and has increased my confidence. Because of this machine, I feel that I can fight my degenerative disease - it has really given me hope.”
Jigsaw Building

The construction of the new Jigsaw Building is now in full swing. Once complete, this fantastic facility will be home to two very important units which will provide more space for rapidly expanding outpatient and day care treatments and ensure patients receive better privacy and dignity.

The ground floor of the building will be home to a brand new Cancer and Blood Disorders Unit including a wonderfully bright and spacious chemotherapy suite. The first floor will see women’s health come under one roof, providing a single location for both breast cancer patients and gynaecology patients, including early pregnancy.

Jane Stichbury, Trust Chairman, said: “The Jigsaw Building is a really exciting development for the hospital and indeed the community.”

The Bishop of Southampton blessed the foundation stone of the new Jigsaw Building in July 2014. Robin Scott, former Jigsaw Chairman, and Dr Rachel Hall, Consultant Hematologist, laid the foundation stone before the Rt Reverend Jonathan Frost carried out the blessing.

The Jigsaw Building is funded through donations and fundraising from two Jigsaw appeals, as well as NHS investment. Construction work will be completed by early September 2015.

To find out how to get involved in any of our fundraising projects including the Jigsaw Building log on to www.bournemouthhospitalcharity.org.uk.

Non-NHS activity

Private patient services at the Trust are provided by the Bournemouth Private Clinic Limited. Monies generated from its surplus are donated through The Bournemouth Healthcare Trust to purchase medical equipment, improve patient facilities and support staff welfare and training.
Chaplaincy

We are always struck by the way the whole of life happens within the vicinity of the hospital boundaries, from birth to death, sleep, work, eat and rest and for our chaplains it is a privilege to be regularly called upon to be part of that life cycle.

In July last year, the blessing of the foundation stone of the new Jigsaw Building, by the Bishop of Southampton, highlighted not only the dedicated work of those who had brought the project to that crucial stage, but also the heart of the Trust that spirituality is still a key part of many a staff member and patients’ journey. Our chaplains are grateful for the support of the Chief Executive, Chairman and Board of the Trust in their acknowledgement of the importance of spirituality in healthcare.

This year we said goodbye to Rev. Brian Williams after 11 years of service in the Trust and it was so fitting that within his last hour here he was asked to bless the new Maternity Unit where a baby was born that night.

The Chaplaincy Team has employed a new senior chaplain, Rev. David Flower and has also welcomed Catholic priest Father Darryl Jordan. He originates from Texas and his larger than life character has been welcomed around the Trust. The chaplains all express their thanks to the faith leaders from around the area for regularly coming in, within their busy schedules, to see their own members and also visiting those we as chaplains ask them to visit.

“\n\nWe are always struck by the way the whole of life happens within the vicinity of the hospital boundaries…” \n
Finally, a series of “thank yous” for others who have supported the Chaplaincy Team this year - the volunteers who come on a Sunday afternoon to bring patients to the worship service and the work of the team of St. Vincent de Paul; the Band of the Boscombe Salvation Army lifts the spirits on the wards on the first Sunday of the month and also supports the two carol services at Christmas; the choirs of St. Johns Church, Moordown, the Poole and Parkstone Singers, All Saints Church, Southbourne and Muscliffe Community Choir have really touched hearts with their choral support and have been very gratefully received; and finally for the support of the League of Friends.

The Chaplaincy Team looks forward to another year of serving the Trust.
Strategic Report

Located about three miles apart on the south coast, the Royal Bournemouth and Christchurch hospitals are close to the New Forest in the east and the Jurassic coastline in the west. Also part of our organisation is a Sterile Supply Department in Poole.

The hospitals became an NHS foundation trust on 1 April 2005. NHS foundation trusts are not-for-profit, public benefit corporations that were created to devolve decision-making from central government to local organisations and communities. We are still part of the NHS and strive to live up to its values, as set out in the Constitution. The Trust was issued with a provider licence by Monitor on 1 April 2013, which replaced the Trust’s terms of authorisation.

We provide a wide range of hospital and community-based care to a population of around 550,000, which rises during the summer months, in the Dorset, New Forest and south Wiltshire areas. Our business model is based on the national Payment by Results methodology for managing expenditure within the context of agreed contracts with commissioners. We must manage our reference costs within the national tariff system to allow us to invest appropriately in the staff and wider infrastructure to provide safe and effective patient care.

We monitor our performance against a range of performance objectives and targets, some of which are set by us but others reflect national targets and those set by commissioners. Details of the performance on key performance, safety and quality objectives is set out in the Operational Review, starting on page 25. For the first time in our history as a foundation trust, a planned deficit of £1.9m was agreed in recognition of the continued operational and financial pressures faced by the NHS. Although we did not achieve this plan, reporting a final deficit of £5.2m, we ended the year in a strong financial position when compared to the foundation trust sector.

As a result of the national payment mechanism for foundation trusts, we are required to achieve a cost improvement plan target of around 4% each year. Savings of £7.5m were achieved during 2014/15 and were assessed throughout the year to ensure that there was no adverse impact on the quality of care provided to patients.

At the end of 2014/15 we employed 4,356 members of staff who cared for and treated:

- 238,352 outpatients (follow up) appointments
- 137,414 new outpatients
- 112,141 inpatients
- 87,015 attendances in the Emergency Department

Our vision to put our patients first, while striving to deliver the best quality healthcare, is the focus for both the organisation and our staff individually. We aim to do this by achieving our goals to:

- offer patient-centred services by providing high quality, responsive, accessible, safe, effective and timely care
- promote and improve the quality of life of our patients
- strive towards excellence in the services and care we provide
- be the provider of choice for local patients and GPs
- listen to, support, motivate and develop our staff
• work with partner organisations to improve the health of local people
• maintain financial stability enabling the Trust to invest in and develop services for patients

In 2015, we got the views of our staff and patients to reshape our vision going forward.

We had six options that we asked them to vote on, letting us know which one was most important to them.

The option chosen was the one created by our Change Leaders:

**Excellent care for our patients reflecting the care we expect for our family**

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

**The Royal Bournemouth Hospital**

The Royal Bournemouth Hospital (RBH) is an acute hospital, which opened in 1992. It is recognised locally by its blue roof and is located on a large green field site close to the main roads that link with the New Forest, Southampton, Salisbury, Winchester, Christchurch and Poole.

The hospital has a 24-hour Emergency Department, which sees around 60,000 patients a year, and a large Day of Surgery Admissions Unit (the Sandbourne Suite).

A purpose built Ophthalmic Unit is located on site as well as a state-of-the-art Cardiology Unit (the Dorset Heart Centre) and award winning orthopaedic service providing hip and knee replacements (the Derwent Unit). RBH also provides district-wide services for cardiac interventions, vascular surgery and urology.

Outpatient clinics are provided for oral surgery, paediatrics, plastic surgery, ENT (ear, nose and throat), cardiothoracic and neurology.

**Christchurch Hospital**

Christchurch Hospital provides a pleasant environment for rehabilitation and a range of outpatient services. An all-age rehabilitation service has been developed, particularly in the award-winning Day Hospital. Most patients are elderly, reflecting the local population. There is an excellent infrastructure to support rehabilitation with superb physiotherapy and occupational therapy facilities.

Outpatient clinics have expanded over recent years and include gastroenterology, breast, oncology, plastic surgery, ophthalmology, podiatry and medicine for the elderly. Dermatology and rheumatology outpatient services are also provided at Christchurch Hospital together with phlebotomy (blood taking) services, diagnostic services and palliative care (the Macmillan Unit).

The hospital is currently undergoing a multi-million pound investment which will secure NHS services on site and ensure the hospital remains a key part of the community for years to come. Many patient services are being improved, a new entrance and X-ray Department will be built and a new GP surgery, a pharmacy and community clinics will be brought on site. A quality nursing home and senior living accommodation are also being built as part of the project.

**Bournemouth Hospital Charity**

The financial statements of the Trust have been consolidated this year to include the Bournemouth Hospital Charity. Further information on the Bournemouth Hospital Charity and its consolidation in the accounts can be found on page 17 of the Financial Statements.
How we are run

As a foundation trust, we are accountable to Monitor, the regulator for health services in England that ensures the governance and performance of the organisation is sufficient and in line with the conditions of its provider licence. We are also accountable to local people through our Council of Governors and members. In addition, there is a large range of inspection and regulatory bodies, including the Care Quality Commission (CQC).

The Council of Governors, which represents around 15,000 members, is made up of members of the public, staff and appointed governors. They ensure members’ views are heard and are fed back to our Board of Directors, and members and the public are kept up to date with developments within the hospitals. You can read more about the work of governors and details of our membership from page 160.

Our Board of Directors is made up of full-time executives, who are responsible for the day-to-day running of the organisation and part-time non-executive directors. Much of this work is done by the executive directors who work closely with the clinical leaders and managers throughout the hospitals. The Board also works closely with the Council of Governors.

We also work closely with a range of key health partners to develop and deliver our services, such as clinical commissioning groups and social services.

You can read more about the Board of Directors and Council of Governors in the Directors’ Report from page 145.

Operational Review

Performance Overview

Trusts across the country and in Dorset have continued to experience significant pressure from the demand on their urgent care services. We have been no exception and have seen an increase of 11.9% on emergency admissions compared to the previous year. This has also been in the context of a 7% increase in outpatient referrals and an increase in referrals to cancer services. While we have coped well, these increases have had a direct impact on our ability to maintain performance against some of the national targets.

Patient experience

As the year progressed, we found the Emergency Department (ED) four hour target from arrival increasingly challenging, particularly as the complexity of patients arriving at the hospital increased during the winter. Surrounding services, such as social care, have also been under significant pressure with more delays in discharging patients from the hospital who need a package of ongoing care. We also saw a rise in the number of patients arriving by ambulance, with more patients being brought into our ED than last year.

Positively, in order to cope with the increasing demands on our services, we prioritised the development of our urgent care services supported by our Unscheduled Care Improvement Programme. This has seen further developments in senior medical and specialist nursing staff at the ‘front door’ and at the weekends and in the evenings. Ambulatory care services have been developed to avoid people staying in hospital unnecessarily overnight. Significant improvements are also underway in our Older Persons’ services with the development of short stay wards supported by nurse practitioners and dedicated consultant staff.

In the latter part of the year, we implemented a rapid assessment process in our ED, which has begun to see a reduction in delays for patients being treated there.
We continued to work jointly with our local Clinical Commissioning Group and other health and social care organisations to further progress key areas of service. These include locality based, multi-professional teams that support patients in their community with the aim of avoiding unnecessary admission to hospital and our interim care arrangements and primary care support into the hospital.

During 2014/15, many trusts saw increases to their waiting lists, due to demand and also the need for hospital capacity to be available for urgent care provision. National support was made available from July 2014 to help trusts to reduce the overall waiting list and treat the longest waiting patients. This has meant that since July, a higher proportion of longer waiting patients were treated leading to a below 90% performance against the target. However, an improved position was seen in the fourth quarter.
The increasing referral demand together with some particular pressures in some specialities and in our endoscopy services also meant that as the year progressed, we saw a reduction in our performance for patients who do not need to be admitted for their treatment. However, recovery plans through the latter part of the year and into next year are improving this position.

**Safety**

Despite the pressures on the Trust, we continued to perform well against the national infection control standards, achieving the national MRSA objective and being well below the Monitor ‘deminimis’ target of six. We also achieved our national target for clostridium difficile.
Quality

One of the particular areas of challenge for the Trust in 2014/15 was against the local stroke service indicators. We have been undertaking a programme of improvements across our stroke service and saw an improving position at the latter end of the year. This work continues in order to establish a sustainable position going forward.

The Trust continued to perform well against the brain imaging target with more than 90% of patients being scanned within 24-hours and we also provided thrombolysis for appropriate and eligible patients.

We now participate in the national Stroke Audit. Early audit data showed positive results compared to other trusts for our occupational therapy and speech therapy provision for stroke patients as well as on our discharge processes, including our local Early Supported Discharge Service.
During 2014/15, we continued to experience the year-on-year growth in fast track referrals to our cancer services, partly due to a series of national campaigns.

This has presented a challenge to our two week wait from referral to appointment target, particularly where patients choose not to attend the hospital within that time. In the latter part of the year, improvements in the way in which we manage our capacity for these referrals together with closer working with patients and GPs in relation to their choice of appointment led to an improvement in our performance.

In the first half of the year, we performed well against the 62 day from referral to treatment and 31 day from decision to treatment standards. However, the increased demand through the year, together with some unexpected loss of capacity, unfortunately meant that a small number of patients waited longer for their treatments. We increased surgical capacity, particularly through the implementation of 'robotic prostatectomy weeks', in the latter part of the year to focus on treating these patients. This led to a reduction in performance during this time.
Investing in services

We have continued to invest in our clinical services, patient and visitor amenities, hospital infrastructure and staff facilities over the last 12 months, with a total capital spend for the year in excess of £12m. Developments have included:

- development of the Bournemouth Birth Centre, a new purpose-designed midwife-led unit for hospital births, which opened in November 2014
- construction work on the Jigsaw Building, a major new Women’s Health and Blood Disorders facility (scheduled for completion in September 2015)
- consolidation of orthopaedic inpatient services in refurbished accommodation on Ward 7
- refurbishment of Ward 26, incorporating various measures designed to create a dementia-friendly environment
- creation of side rooms in the Coronary Care Unit (CCU) to improve patient privacy and dignity and to enhance infection control on this unit
- alterations, refurbishment and new signage in the Emergency Department to improve layout, flow and wayfinding in this busy department
- refurbishment of the reception and waiting area for blood tests in the Pathology Department to provide a more welcoming and comfortable setting for patients
- installation of waiting shelters at the main hospital entrance for people awaiting pick-up
- development of a new Aseptic Unit, for the processing of pharmaceutical products in sterile conditions
- upgrading the Clinical Engineering Department and Medical Equipment Library to improve our facilities for the decontamination, repair and storage of medical equipment
- demolition, enabling measures and construction works at Christchurch Hospital in support of the planned redevelopment of the site
- purchase of a new staff accommodation block at Abbotsbury House to add to our residential stock, plus the ongoing refurbishment of our existing on-site staff residences

We are also working with Bournemouth Borough Council to try to establish solutions to the problems arising from local traffic congestion. We recognise the inconvenience and uncertainty caused to our patients, visitors and staff as a result of the sometimes extended delays arising from severe
peak-time traffic congestion around the Royal Bournemouth Hospital. We are determined to ensure that all possible measures are taken to alleviate this problem, including both short-term adjustments to traffic signals and bus lanes and longer term infrastructure plans including the creation of a new road junction linking the hospital with the Wessex Way.

CQC inspection - our improvement journey

Services at the Royal Bournemouth Hospital are safe, effective, caring and responsive to patient needs and the organisation is well-led. These were the findings of the Care Quality Commission’s (CQC) follow up inspection, which took place in August 2014 and were published in November. All four compliance actions that were in place, following an initial inspection in October 2013, were also lifted.

As a Trust we recognise the huge progress made since the original inspection, but acknowledge that we are on an improvement journey to ensuring we provide consistently high quality care across all areas of our hospitals.

We would like to thank our patients and the public for continuing to tell us when we get it right - this is appreciated by our staff and when we could do better. This has informed our improvement and will continue to do so in the future as we make the changes that we need to.

Below is a summary of improvements found by the CQC inspectors.

Safe services

What the CQC said:
- staffing levels have increased on wards and recruitment is ongoing
- pressure ulcers and falls are reducing
- bay-based nursing has been introduced
- safety and effectiveness of the accident and emergency service had improved
- escalation beds no longer in use

What we have been doing:
- we have a ongoing recruitment programme and have recruited over 100 qualified nurses. This includes a number of overseas nurses who are now working on our wards. Our ward staffing is reviewed at every shift to ensure safe staffing levels are in place to care for the range of patients on that particular ward
- we have appointed over 30 consultants in a range of specialties in medicine, radiology, surgery and care of the elderly. These include replacement and new appointments. This is the largest increase in consultant investment made by the Trust
- we launched our PACT (Pressure Area Care Together) ulcer prevention and management strategy. All relevant documentation and supporting information for staff about preventing pressure ulcers is now easily accessed. Each clinical area has a PACT folder containing guidance and standard procedures

Effective services

What the CQC said:
- patients with dementia received good care with staff routinely receiving training
- more robust security arrangements are in place (in the Emergency Department)
- patients with a suspected stroke are more timely assessed before being admitted to the Stroke Unit
- improved management and flow of patients through the hospital

Our Ambulatory Care Service has proved successful
What we have been doing:

- new clinics for unscheduled care - not all patients admitted to hospital as an emergency need to be an inpatient to receive their treatment. A number of new emergency care clinics have started and some 43 patients every day are now being treated in ambulatory care who would otherwise be admitted to a bed. Ambulatory care is available in acute medicine, surgery and older peoples’ medicine and allows many patients to be seen and treated the same day.

Caring services

What the CQC said:

- patients and relatives on wards, in the Emergency Department and in outpatients were overwhelmingly positive about the caring attitude of staff
- privacy and dignity promoted in all areas visited by inspectors
- patients were happy with the care and treatment they received. They felt the care was safe, there were sufficient staff and they were treated with respect and dignity.

What we have been doing:

- we launched a new privacy and dignity policy which includes a set of pledges to our patients which are communicated on our wards
- we worked with Healthwatch Dorset to hear the experiences of patients and the public. We are reviewing your feedback so that we can respond and improve
- our wards have received improved Friends and Family Test scores from patients who are asked if they would recommend our hospital to their friends and family.

Responsive to patient needs

What the CQC said:

- complaints and patients stories are used for learning and improving services
- responsive to individual needs

What we have been doing:

- positive and negative feedback from monthly surveys are displayed on each ward together with what had been done in response to the feedback.
- Ward 22 became a short stay elderly care ward and has reduced the length of stay for patients to five days
- patients now have their condition monitored via an electronic system which automatically alerts staff if they start to deteriorate. Using a handheld device similar to an iPhone, nurses record and monitor a patient’s observations, for example blood pressure and heart rate, on a system called VitalPAC Nurse. The software then generates a score - the higher the score, the more the patient has deteriorated, and the sooner an appropriately skilled clinician is able to respond. This enables staff to prioritise treatment for the sickest patients.
- an electronic system to speed up venous thromboembolism (VTE) assessments has been introduced on all our wards. Patients staying in hospital have a VTE assessment due to the increased risk of blood clots, particularly after surgery or for those who may be bedbound for longer than usual. As well as providing live information, the new system, using an iPad, is quick and easy to complete and avoids nurses having to leave a patient’s bedside to find a computer to log the information. Our matrons can look at all their patients and identify any gaps in assessment and act on this.

VitalPAC Nurse is an electronic system used to monitor patients.
Well-led

What the CQC said:
- there is strengthened clinical leadership
- staff morale has improved
- there is a higher expectation from staff that they would be listened to and any concerns addressed
- improved support for junior doctors
- strong clinical leadership in all areas visited
- staff were positive about the new management structure and felt supported by their managers and their senior managers

What we have been doing:
- a new clinical management structure has been introduced with the appointment of 14 matrons
- elderly care consultants are now in the hospital at weekends, as opposed to being on call, meaning junior doctors can speak to a senior consultant face to face for advice and assistance
- the executive team regularly visits wards and departments at weekends and out of hours
- staff developed a new set of values for the organisation; communicate, teamwork, improvement and pride
Clinical strategy

Over the summer of 2014, the Trust developed a five year strategy. At a similar time, Dorset’s Clinical Commissioning Group commissioned a Clinical Services Review (CSR). Both of these exercises took into account the significant factors affecting health services now and in future. The factors considered in the CSR’s “The need to change” document included:

- changing population health needs
- new treatments
- increasing population expectations
- financial challenges

The CSR programme is in the process of developing an agreed shortlist of options which will be put out to formal public consultation over the summer of 2015.

In addition to the drivers above, there is a further factor that is increasingly problematic, especially locally. Dorset has one of the oldest population demographics in the country and one of the smallest working age populations. This is shown in the chart below.

This makes it difficult to continue to staff health services in the way they have been staffed in the past. A key part of our strategy and the CSR is therefore to ensure that we maximise the use of the expertise and experience of the clinicians we have locally. In addition, we need to consider the type of roles that we need in the future and to seek opportunities to update roles, both to adapt to the developing needs of the population, but also to ensure these roles are as attractive as possible to existing and potential staff.

At a national level, the recent NHS Five Year Forward View (5YFV) outlined some approaches to addressing the above issues, emphasising a requirement for a much higher level of integration across all health organisations.
Specifically a number of new organisational models were suggested including larger primary care organisations based around GP practices, but with responsibility for community, GP and potentially, social services. This model, entitled Multispecialty Community Providers, envisages an organisation covering a substantial number of GP practices with the potential to employ consultants in a variety of specialties, take over the majority of outpatient consultations and potentially run community hospitals. An alternative also suggested was the Primary and Acute Care Systems whereby primary care and secondary care organisations integrate so that one organisation provides care for patients throughout their pathway. In both scenarios there is potential for the new organisation to take over the care for a given population and to be funded on a capitation basis.

All the indications, from both the NHS 5YFV and from the indications of health policy after the May 2015 election, suggest that much more integration is likely to be encouraged or mandated. Potentially the output from the local CSR may coincide with the above models being put into practice, but this is unlikely to be before 2017; therefore, there is a need for us to continue to deliver sustainable high quality services in the interim.

Our strategy recognised the above external factors, but also provided a focus on several internal priorities as indicated in the diagram below. Many of these had work programmes already established, for example we have seen an increased number of staff participating in leadership programmes and we have continued to develop the Trust vision and values with a view to them becoming part of our recruitment and appraisal approaches in 2015/16.

We also took the opportunity to present the strategy to the directorate and departments across the Trust and to seek contributions to its further development.

In summary the key parts of our strategy are:

**External**
- Play an active role in the reorganisation of health services across Dorset
- Support the integration of primary (GP/community) and secondary (hospital) care services

**Internal**
- Enhance our organisational capability, especially in leadership, strategic planning and organisational development
- Continue to improve the clinical performance of the hospital, delivering high quality, more efficient services
Developing our organisation

This year we have been working with our staff to develop our understanding of the Trust values - Communicate, Teamwork, Pride and Improve - to ensure they are at the heart of everything we do.

We have been collaborating with culture and behaviour experts Talent Works to develop a behaviour framework based on our values which clearly articulates what behaviour we expect from each other and towards our patients. This will be incorporated into our new values based appraisal process.

This year, our ward sisters and charge nurses have been taking part in our Time to Lead Leadership Development programme, which has been designed to equip them with key leadership skills and tools, an understanding of what it means to be a leader in our hospitals, and giving them support through coaches and action learning sets.

We have over 20 Change Leaders who are representatives from across our directorates and staff groups who actively support change initiatives and make sure that key messages to and from our staff are delivered.

We have also used the opportunity of the new Friends and Family Test for staff to ask some additional questions in our quarterly Staff Impressions online surveys. The results from these have included a wealth of free text comments and the identification of some key themes.

In December, we held a Workforce Planning event with all our senior managers to get them thinking differently about workforce challenges. Lots of new ideas were generated and our care groups are now developing strategic workforce plans in response to these.

Our focus now moves to using the behaviour framework to refine our approach to values-based recruitment and we hope to use the development plans identified at appraisal to develop our approach to talent management.
Going concern

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for at least the next 12 months. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Principal risks and uncertainties for the future

As with all organisations, we work in an environment where there are certain risks and uncertainties. These include:

- future service reconfiguration in the county
- general election - potential changes in policy
- £8-10m recurrent savings every year, for at least the next five years
- public finances are not expected to improve until at least mid-way through the next Parliament (i.e. 2017/18) when it is assumed the NHS will be deep into crisis mode, requiring extra resources or a fundamental change to the NHS’s founding principles
- commissioners (internationally) perceive hospital systems as tending towards being reactive, centralised and high cost, and the default, or barrier, rather than the solution to the future population health needs. The strategic context is that NHS hospital funding is declining, along with the wider public sector. Even if wider NHS funding picks up, there will be a drive to spend it elsewhere, and an assumption of a smaller acute sector, fitting the hot/warm model
- key commissioning trends are away from hospitals: moving from reactive to proactive healthcare, in community settings and in particular avoiding emergency hospital admissions
- workforce trends - nursing shortage, specialist consultants and reducing junior doctor numbers
- involvement of the Competition Commission in all service reconfiguration
- increasing quality standards against a backdrop of reduced funding for hospitals

End of year financial position

Monitor assigns each NHS foundation trust a risk rating for governance and for finance.

The financial risk rating is known as the ‘continuity of service risk rating’, and is calculated on the basis of a liquidity measure and a capital servicing capacity measure, both of which are indicators of financial robustness. The continuity of service risk rating is the rounded average of the two indicators and is measured on a scale of one to four, with four being the highest.

The governance risk rating comprises three levels:

- a green rating if no governance concern is evident
- where Monitor identifies potential material causes for concern with the trust’s governance in one or more of the categories (requiring further information or formal investigation), it will replace a trust’s green rating with a description of the issue and the steps (formal or informal) it is taking to address it
- a red rating if Monitor decides to take regulatory action

The Trust’s financial risk rating is currently a three and its information governance risk rating is under review.

Trends and factors affecting the future

- an aging population, unhealthy lifestyles, new technology and rising quality expectations all require more for less
Business continuity and resilience planning

Within our responsibilities under the Civil Contingencies Act 2004, the following plans are in place to ensure our organisation remains resilient to any emergency situation:

- Major Incident Plan
- Business Continuity Plan
- Chemical, Biological, Radiological, Nuclear and explosive (CBRNe) Plan
- Pandemic Influenza Plan (including ebola, MERs)
- Mass Prophylaxis Plan

We continue to identify national and local community risks as detailed in the national and local community registers and plan appropriately to address any of these risks that may have an impact to the wider community, such as a major incident scenario or an infection outbreak. Preparation for a potential ebola outbreak has been the main focus of work over the last year with extensive training and resources being deployed.

Another exceptionally important aspect of our planning is business continuity. If we experience issues providing our usual services in the usual way - for example as a result of loss of infrastructure due to fire or a flood on site - we have plans in place that enable us to relocate services in a timely professional manner to ensure we can still provide services for the local community, providing reassurance to them.

We continue working with our multi-agency partners across Dorset, Hampshire and the Isle of Wight in planning for any major emergency within these areas. These other agencies include all blue light services, local authorities and utility companies. This work is essential in ensuring a safer Dorset.

We also look forward to working with the newly formed Civil Contingency Unit.

Patient care improvement

Our Quality Strategy details the aims, objectives, timescales, responsibilities and monitoring processes of how we will achieve high quality care for all. It is the driver for delivering healthcare that is safe, clinically effective and a positive experience for all those involved.

Key improvements in patient care have been centred both around structure and direct interventions, which positively impact on all aspects of quality. You can read more about these in the Quality Report from page 65.

Our activities over the year included:

- continued development to nursing documents
- development and implementation of patient property lockers and refined documentation
- Patient Property Management policy developed for launch in 2015
- patient feedback boards for the public to view our actions for improvement and LCD screens for patient information and education. This is informed by our Patient Experience Cards - more than 30,500 cards were completed over the year and in excess of 15,500 comments left
- maintenance and improvements to the ward ‘scorecard’ and staffing key performance indicators, which are reviewed monthly by key stakeholders and ward clinical leaders
- large increase in the number of volunteers trained as mealtime assistants to aid patients with feeding, encouraging fluids and ensuring mealtimes are a sociable event
- monitoring of the patient experience through implementation of the Friends and Family Test, Real Time Patient Feedback, Patient Experience Cards and volunteer companions
• actions to improve patient experience approved by the Patient Experience and Communications Committee (PECC) - includes Patient Experience Templates, Friends and Family Test, Patient Information and Care Campaign Audits. These all have quality indicators which are regularly reviewed
• implementation of three-tiered training packages for staff working with patients who have dementia
• monthly action plans from wards to address patient feedback
• one-to-one interviews with complainants to understand their experience and review the process and change accordingly
• focus groups to understand patient perception and influence improvements, including improved written information and staff education to ensure improved communication
• Carer and Young Peoples’ forum resulting in carers information sheet and staff education on the young person’s perspective through perceptorship training
• development of a disability awareness video for staff training
• Patient Opinion and NHS Choices comments are directed, where necessary investigated, and replies are within set criteria
• stakeholder events - these have included wide stakeholder and partnership agencies to inform the patient experience strategy
• learning disabilities events - actions include the development of a Friends and Family Test for those with learning disabilities in partnership with Bournemouth People First
• NHS Change Day to enable staff and volunteers to pledge their support to improving the patient experience and to gather patient experience feedback
• work in partnership with Healthwatch - this has resulted in an independent public and patient survey and report. The report suggested areas for improvement which we have positively responded to
• training of volunteers to: provide support in the event of a major incident; offer bedside friendship to those nearing the end of their life and their families; and as dementia support volunteers
• implementation of the Friends and Family Test to all outpatient departments and improvement in the amount of people responding to the Emergency Department survey

High standards for patient information

In February 2015, we were awarded the Information Standard by the Royal Society for Public Health for the health and care information we produce for patients. The Information Standard is a certification scheme commissioned by NHS England which assesses whether the information we produce is clear, accurate, evidence-based, and up to date, and that a robust system is in place for the approval and recording of information.

We produce a range of information for patients; from leaflets detailing what exercises they should do to patient films for our website. Achieving the accreditation means all information produced can now carry the Information Standard quality mark - a clear indication that it is accurate and reliable.

You can find out more about the Information Standard at www.theinformationstandard.org

Our Patient Information Group approves all patient information and continued to approve a high number of leaflets to support patient care.

The Patient Information Monitoring Group meets quarterly to ensure the quality of information and to monitor areas of risk and governance. The following has also been carried out throughout the year:
• staff training has taken place on how to produce good quality patient information and the approval process
Welcome to Ward 17

Welcome to Ward 17 where we aim to provide the highest standard of care. We truly care to be a start and will make sure your comfort in your care as much as possible.

Karen Alborough
Sr. Karen Alborough
01202 303626
sarwhitmarsh@rbch.nhs.uk

If you would like a copy of your clinic letter, please ask

Our Vision

The Royal Bournemouth Hospital,

www.rbch.nhs.uk

The best quality healthcare.

Food and drink

This leaflet aims to tell you why food and drink are important

Lack of fluid/drinks - dehydration can cause:

- sunken eyes
- sleepiness/tiredness
- feeling dizzy/light headedness
- weight loss
- dry, sticky mouth and skin
- reduced energy levels
- difficulty keeping warm
- increased risk of falls
- slower wound healing
- kidney damage
- prolonged. You could also be at risk of complications. It is important that you know what the problems

Food and drink rounds every day and fresh water is available throughout the day.

You will be shown how to use this and assisted throughout your stay.

How do I order my meals?

You can do this directly with those looking after you or contact our Patient Advice and Liaison Service (PALS) and they will make sure your appreciation reaches the right people.

Concerns, complaints and compliments

If you feel we have provided a good service to you or those close to you, please let us know.

You can do this directly with those looking after you or contact the Patient Advice and Liaison Service (PALS) and they will make sure your appreciation reaches the right people.

If you are unhappy with the service or treatment you have received, please:

- Talk to the person in charge of your care, such as the doctor, nurse in charge, or the head of department. Explain your concern and ask if they can help. It is best to do this while you’re still there so we can make it right.

PALS

Telephone: 01202 704886
Email: pals@rbch.nhs.uk

Complaints

Complaints Manager

Royal Bournemouth Hospital

Castle Lane East

Bournemouth, BH7 7DW

Telephone: 01202 704452
Email: complaints@rbch.nhs.uk

Complainants are also advised about clinical confidentiality and the support available to them from the Independent Complaints Advocacy Service (ICAS).

Each complaint is investigated by the directorates concerned and, where appropriate, the advice of a clinician from another area is obtained. This evidence forms the basis for a response to the complainant from the Chief Executive.

Further details of the complaints we received can be found in the Quality Report from page 65.
Our strength is our staff

We are a significant employer in the area, employing 4,356 whole time equivalents as of 31 March, 2015. Staff turnover is below the national average and generally staff regard the Trust as a good place to work - as demonstrated in staff surveys carried out during the year (further details of which can be found over the next few pages).

Recognising our own staff

Throughout the year, a key focus has been on improving our recognition of our employees who are clearly demonstrating our values. We launched #ThankYou! which encourages patients and staff to identify colleagues who have made a difference and more than 370 individuals have received a “thank you”. We launched our Monthly 5 Stars in June and have singled out five individuals or teams each month since. We also held a special afternoon tea this year for nearly 100 members of staff.

Each year we also recognise the hard work and commitment of our own staff over the previous 12 months through a staff awards evening. In 2014 the awards were renamed the ‘Pride Awards’ to reflect one of our four key values and we saw some outstanding examples of staff going the extra mile to ensure patients received the best care and experience possible. Here are our winners:

Award:
Award for Patient Experience
Winner:
Saran Wylie, Ward Clerk, Ward 4

Saran’s communication skills with our dementia patients, visitors and her colleagues are excellent. She is very personable, easily builds rapport with both patients and families and is a highly valued member of the Ward 4 team. Saran is pro-active in trying to improve patient experiences while in hospital as well as discharge planning. She has put together a reminiscence box and designed her own crosswords for the patients. Saran also organises the volunteers on the ward, giving them support in identifying the patients in most need of their company and ideas of activities to do with them.

National and regional recognition

Throughout the year we have seen individuals and departments across our hospitals recognised for their commitment to patients and for the excellent services they provide, both nationally and locally.

- We scooped two national accolades for our environmental sustainability work at the 2014 NHS Sustainability Day Awards. Our staff have been working hard to reduce the Trust’s carbon footprint and is now ‘zero waste to landfill’, marking a significant milestone in its sustainable waste story. Read more on page 58.

- Our Eye Unit was shortlisted for the Macular Society’s Award for Excellence. The honour highlights exceptionally good practice in the care of people who are suffering from macular degeneration, the most common cause of sight loss in the UK. The unit was nominated for the award by patients for the second year running.

- BJ Waltho, qualified nurse of 36 years and Associate Director of Operations for our Trust was elected Vice Chair of Congress for the Royal College of Nursing. The annual debating forum is the nursing showcase of the year for thousands of nurses, midwives, healthcare assistants and nursing students and it is the first time anyone from the Trust has been awarded such a significant role.

- Our Sunshine Midwifery Team were highly commended for providing excellent care for parents and babies in their first 1,000 days. The team provides care to vulnerable women and was recognised for its work at the All-Party Parliamentary Group on Maternity’s First 1,000 Days Awards, held at the House of Commons.
Award: **Award for Teamwork**

**Winner:** Cardiology sisters and charge nurses

The cardiology ward sisters, charge nurses and their deputies have pulled together exceptionally as a team to support each other and provide an improved cardiology service to patients. For example, senior nurses in the Coronary Care Unit (CCU) and wards 21 and 24 have swapped to provide specialist skills for on-the-ward training and education. Ward 21 and Ward 24 have had a number of new staff who required competency in looking after patients who go for procedures. Ward 23 agreed for staff to spend a week with them gaining the experience in CCU prior to starting on their ward. The catheter lab sister always provides support to wards whenever they have any spare time in the catheter labs. If the catheter labs are struggling to provide support for the pacing room, CCU will always stand in for them if they are able to.

The team is not a conventional team in that they do not work alongside each other every day, which is what makes their commitment to work as a senior team to support each other and each other’s patients so exceptional.

Award: **Improving Lives Award**

**Winner:** Dr Sue Hazel, Sister Michelle Richards and the Ward 22 team

Ward 22 team was nominated for the changes made when the traditional ward became a short stay elderly care unit. Michelle and Sue motivated the full multi-disciplinary team to ensure they fully understood the benefits. Patients receive a full geriatric assessment in an environment that is better for them and are able to return home sooner; reducing the risks associated with a stay in hospital. The team has responded well to the change and there have been many positive comments from patients, relatives and carers alike. The length of stay within elderly care has decreased from 16 days to 12 days since the change in the function of the unit, with no loss in the quality of the care given. On Ward 22, the length of stay has changed from 16 to five days.

Award: **Behind the Scenes Award**

**Winner:** PACS and IT

A new PACS system was installed to view radiology images across the whole organisation. It required many different disciplines working together to switch a mission critical IT system from one supplier to another. Close cooperation between Radiology and IT and other areas of the Trust was needed. Over the weekend of the go live, a team of about 20 staff were in the hospital all weekend, nearly 24 hours per day to ensure that, come Monday morning, the new system was operating correctly and had the right data in it. This team showed enormous dedication to the task of getting this right, despite being incredibly tired and fatigued from hours of work. For some, this work had gone on for weeks beforehand and weeks afterwards. On go live day, teams were sent across the Trust to ensure all users were not experiencing any issues and help if anyone could not use the system. This change went incredibly well with very few incidents being reported after go live.
Award: **Award for Improving Patient Safety**
Winner: **Andrew Humphreys, Charge Nurse Coronary Care Unit**

Within four months of being made an acting Band 6, Andy was promoted to a Band 7, when the clinical leader left. He has completely overhauled the way that the CCU is managed with the aim of improving patient safety. He has worked tirelessly to improve infection control standards in the unit. He has redesigned spaces, increased training, reduced clutter, maximised storage, updated policies and implemented new monitoring. Since all of the changes have been put into place, there have been no further MSSA infections. This is a credit to his dedication and hard work, which would be an achievement for anybody but a massive achievement for someone with so little previous management experience.

Award: **Learning and Development Award**
Winner: **Marie Miller, Practice Educator, Ward 10/11**

Marie is the practice educator for the haematology/oncology service; providing training and support to staff within a highly stressful environment and caring for cancer patients on a daily basis. During the last year, Marie has led the introduction of a new prescribing system for the delivery of chemotherapy. This has meant liaising with Poole and Dorchester hospitals, which also share the system, arranging training and assisting in the training of all staff who will use the system. Throughout delays in the project beyond our control, Marie has persevered, kept everyone on track and showed great determination to deliver on an essential development for the safe delivery of chemotherapy. This has been accomplished without Marie asking for more hours and she has done much of this work in her own time.

Award: **Award for Improvement**
Winner: **Jade Spicer, Radiology Administration Manager, Tina Gunatillake, Sonographer, Kerry Terry, Clerical officer, Jean McCarthy, Clerical officer and Sarah Oliver, Directorate Manager for Radiology/Head of Radiography**

From day one that each patient is referred to the Trust we have 62 days to begin treatment. The biggest daily challenge is accessing MRI and biopsy in a timely way, sometimes with delays of up to 30 days. This team has been instrumental in removing this 30 day delay. The average pathway for our patients from referral to diagnosis is now around 32 days. Changes to how bookings take place ensure that these patients receive an MRI on the same day as their outpatient appointment - there are now evening slots.
Since April 2014, 34 patients have completed their pathway with only one 62-day breach. Patients can now be confident that they can receive their non-cancer/cancer diagnosis within 30 days of their referral. Other patient benefits include a reduction in the number of visits to hospital confidence in a well-managed, well-run diagnostic service.

Award: Inspirational Leadership Award
Winner: Belinda Hewett, Sister, Ward 3

Since arriving on Ward 3, Belinda has improved the quality of care, staff morale, and the reputation of Ward 3. She has instilled quality, patient-centred, safe timely care into every aspect of the team. Friends and Family Test data and Safety Thermometer scores have improved to reflect this.

The team feel supported in their roles and she involves all disciplines in her improvements. Belinda has also reduced complaints on the ward despite the negative view that was held by the public and other staff members after the CQC visit.

Belinda never appeared phased by the challenge; the daily bed pressures, the constant staffing pressures, and in the early days the multiple visits both internally and from outside the organisation. Belinda was open about the weaknesses still to be addressed, but on a daily basis celebrated the positives with the staff, management and the patients. By always being able to look at negative feedback as an opportunity to improve - and never let the staff feel it was just someone else ‘having a go’ - Belinda truly inspired the team to want to do the best for the patients.

Award: Unsung Hero Award
Winner: Lamin Sidibeh, Housekeeping, Ward 11

Lamin has been working on Ward 11 and is an extremely well valued member of the ward team. He executes his daily job with the utmost enthusiasm and efficiency. Not only does he carry out his job to the highest standard but he does so in a cheerful manner. He is considerate of both patients and staff alike and is remembered by the patients often as being a valued part of their inpatient stay.

Nothing is too much of a problem and he is always happy to help. His attention to detail along with his learning through enhanced training has made him so aware of the importance of cleanliness for patient care. Lamin being a perfectionist at times expects the same standards from his colleagues. He treats each and every patient with dignity, respect and kindness.

Award: Wave 105 Community Award
Winner: Beryl Parker for her charitable work

This was a new award sponsored by Wave 105 FM. It thanks a very special member of our community who has supported either the Royal Bournemouth or Christchurch hospitals.
Award: **Chairman’s Award**  
Winner: **Belinda Hewett, Sister, Ward 3**

This award was presented to the overall achiever from all of our winners, as chosen by the Board of Directors.

**Informing and consulting our staff**

During 2014/15, we consulted our staff and staff side representatives on a number of issues, including:

<table>
<thead>
<tr>
<th>Consultation</th>
<th>Number of staff affected</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portering - change to 17 week rota</td>
<td>17</td>
<td>March 2014</td>
</tr>
<tr>
<td>Portering, Christchurch - hospital closure and departmental restructure</td>
<td>10</td>
<td>March 2014</td>
</tr>
<tr>
<td>Thoracic REDS team restructure</td>
<td>51</td>
<td>June 2014</td>
</tr>
<tr>
<td>Education and Training Department restructure</td>
<td>14</td>
<td>July 2014</td>
</tr>
<tr>
<td>Senior Management team restructure into Care Groups</td>
<td>20</td>
<td>July 2014</td>
</tr>
<tr>
<td>Housekeeping - removal of tea break</td>
<td>143</td>
<td>August/September 2014</td>
</tr>
<tr>
<td>Finance management team restructure to align with Care Groups</td>
<td>12</td>
<td>September 2014</td>
</tr>
<tr>
<td>Commercial Services - Logistics/Stores - TUPE back of 29 Poole Hospital staff</td>
<td>64</td>
<td>October 2014</td>
</tr>
<tr>
<td>Estates management - TUPE back of Poole Hospital staff</td>
<td>3</td>
<td>October 2014</td>
</tr>
<tr>
<td>PMO pathology project</td>
<td>7</td>
<td>November 2014</td>
</tr>
<tr>
<td>Pharmacy outpatients restructure</td>
<td>3</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Electronic patient notes (eDM)</td>
<td>70</td>
<td>January 2015</td>
</tr>
</tbody>
</table>
As well as formal consultation, we also make a range of information about the organisation available to staff, such as our performance, good news, events and developments, as well as ensuring good internal communications.

This is carried out through:

- regular meetings with staff side representatives
- bi-monthly staff newsletter - ‘Buzzword’
- monthly Core Brief
- a well-used intranet site
- an induction for new staff - held monthly
- open day for staff and members of the public
- briefings at directorate and ward level as and when needed
- a summary from each Board of Directors’ meeting
- internal briefing system via leaders in the organisation
- a weekly bulletin for staff circulated via global email
- monthly face-to-face leaders’ briefing with the Chief Executive
- monthly Focus on Quality bulletin sent to all staff

We also have awareness stands outside the staff restaurant, poster campaigns, directorate and departmental meetings. You can read more about how we engage with staff on page 50.

**Recruitment**

This year has been a busy one for recruitment, with the challenges of a national shortage of qualified nurses together with shortages in specialist clinical roles and estates. A collaborative working group with recruitment leads from other local trusts has been set up to discuss ongoing recruitment issues and collaborative working.

For us, the early part of the year was taken up with overseas recruitment resulting in more than 40 nurses joining us from Spain, Portugal and Italy and further overseas recruitment is in the pipeline. We also have strong links with Bournemouth University and held a recruitment day in May which led to 28 students joining our hospitals.

In July, a recruitment day aimed at qualified nurses and clinical staff also attracted a number of other potential candidates who were invited to apply on the day. Some 39 healthcare assistants (HCA) were recruited following the event, and a further 40 were offered jobs after a HCA recruitment day in February.

This year we have been on the road and taking part in recruitment events, including the London Job Show at Westfield shopping centre in February 2015, where more than 180 people showed an interest in relocating to the south coast. We also headed north to Glasgow for the first of four Royal College of Nursing Career events in April.

We know there are many qualified nurses living in Dorset who are not currently working in hospitals. Therefore, we established our Return to Acute Nursing programme to encourage qualified nurses working in nursing homes to join our team and a pilot programme started in March 2015.

We have also amended our relocation expenses terms and conditions of service to include rental property to assist with the recruitment of staff from further afield.

**Retention**

We know our strength is our staff and it is important that we retain the great individuals we have. An incentive payment of 2% of basic salary was agreed for all qualified nurses and healthcare assistants within Older Persons Medicine to assist with recruitment and retention. This is a six month pilot that will be evaluated before potentially being rolled out to other ‘difficult to recruit to’ areas.
A band 5 nursing retention and incentive audit was carried out at the end of 2014 to collate views on what the best incentive would be to recognise a senior staff nurse. This work is ongoing. A small retention group has also been set up to discuss ideas to retain staff.

We have organised a number of events this year to ensure our new members of staff are given the opportunity to talk to matrons, sisters and board members about their experiences with us and any issues they may have.

A ‘talk to us’ poster has also been put up in all clinical areas, highlighting to staff that if they have any issues, they can talk to matrons outside of their immediate area, including to make requests to move to different wards within our hospitals.

**Staff health and wellbeing**

Our Valuing Staff and Wellbeing group continued to work with staff to improve wellbeing through health education, increased exercise, healthier eating and lifestyles. Research shows that a happier and healthier workforce leads to a better patient experience, which has been one of the main motivating factors for this work. A programme of wellbeing days themed in line with national awareness initiatives has taken place and our Occupational Health and Dietetics teams have been on hand each month to check blood pressures, BMI and provide dietary advice.

- January detox for a healthy liver
- February in love, healthier hearts
- March to recharge for sleep, nutrition and hydration
- April, bowel health
- May on the way, national walking month
- June, healthy living for men
- July, healthy living for women
- August, relaxation and sexual health
- September, work life balance
- October back care
- November mindfulness
- December, festive health

A health and wellbeing survey was completed by 47 employees providing a picture of their current health. While the majority of staff perceived themselves as being sufficiently active and rated their health as good, almost half reported to be overweight or obese. A large proportion of staff indicated they aspired to lifestyle changes for better health. Respondents favoured exercise options during their lunch break or after working hours. In response to this survey, a number of initiatives were made available to staff:

- lunchtime walks and cardio tennis sessions on site
- healthier options in the staff restaurant
- corporate membership of BH Live was promoted, with over 400 staff taking up membership
- the Employee Assistance Programme vitality portal, which has been accessed by around 600 staff. This provides advice on all aspects of a healthy lifestyle, including diet, exercise and sleep patterns
- fit for work programmes, organised by the staff physiotherapy service
- a lifestyle improvement programme (MOVE), which gave the choice of organised group sessions or a flexible on-line programme
- managing pressure sessions

**MOVE**

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Outcomes of the MOVE programme showed that on average participants increased their overall activity time by two hours 15 minutes per week; reduced their weight by 2.5kg and waist circumference by 6cm. Most participants increased their intake of fruit and vegetables. Major improvements in mood were also demonstrated with five participants who started the programme with moderate or severe depression improving their depression scores to low mood or depression. Follow up after six months showed that most had regained some weight and reduced their level of exercise, indicating the need for continuing support in future health and wellbeing plans.
Improving health through the Responsibility Deal

This year we signed up to the Department of Health Responsibility Deal, which invites participants to make pledges to improve staff wellbeing. Each pledge is monitored and reported on during the following year.

Our Valuing Staff and Wellbeing group has started to work in partnership with Active Dorset and Bournemouth Borough Council to promote the Living Well Active Workplace project. The project went live in January 2015 with an online workplace challenge, which will be followed up by workplace talks, free taster sessions and to achieve sustainability, training and support for workplace active champions. The group also report on musculo-skeletal and mental health sickness absence quarterly. The Occupational Health and Human Resources teams have continued to support managers in the management of sickness absence, with additional support being provided by the Staff Physiotherapy Service, which has recently introduced a new self-referral system. Waiting times for appointments have been reduced from seven to two days for urgent referrals and 30 to 6.5 days for routine appointments. This will be further audited to analyse staff satisfaction and return to work rates.

Our Employee Assistance Programme also provided support to staff, with 387 members of staff using the service during 2014, among which were 133 new cases.

2014 Staff Survey

The Staff Survey continues to be undertaken on behalf of the Trust by the Picker Institute, which sent out survey letters to our staff via the internal postal system from September to the beginning of December 2014. This year the Picker Institute was commissioned by a total of 50 trusts.

Staff completing the survey returned it to the Picker Institute in a freepost envelope. Non-responders were sent a reminder card after three weeks and another questionnaire after a further three weeks. Reminders were also displayed on the Trust website, screensavers, noticeboards and via email communications.

A random selection of 850 employees, from those employed at the Trust on 1 September 2013, were invited to complete and return a staff survey questionnaire. Of these, 840 were eligible to complete the survey. The remaining 10 staff were ineligible due to long term sickness or having recently left the Trust.

The staff survey questionnaire content is agreed nationally. We used the core questions for acute trusts. The questionnaire included questions grouped in the following topics:
- personal development
- job
- management
- the organisation
- health, wellbeing and safety at work
- background information

Previous years have shown that the Staff Survey is a consistent indication of staff opinion and action plans undertaken following the surveys have resulted in statistically significant improvements in the following year.
Staff engagement

NHS Employers ‘Staff Engagement Toolkit’ has shown a strong link between staff engagement and Trust performance, including quality of services, financial management and patient satisfaction.

**Overall staff engagement**
*(the higher the score the better)*

<table>
<thead>
<tr>
<th>Scale summary score</th>
<th>Trust score 2014</th>
<th>Trust score 2013</th>
<th>National 2014 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Poorly engaged staff</td>
<td>3.74</td>
<td>3.79</td>
<td>3.74</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Highly engaged staff</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Our score of 3.74 was average when compared to acute trusts of a similar size. The chart below shows how we compare with other acute trusts on each of the sub-dimensions of staff engagement.

<table>
<thead>
<tr>
<th>OVERALL STAFF ENGAGEMENT</th>
<th>Change since 2013 survey</th>
<th>Ranking, compared with all acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF22. Staff ability to contribute towards improvements at work</td>
<td>• No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF24. Staff recommendation of the trust as a place to work or receive treatment</td>
<td>• No change</td>
<td>✓ Above (better than) average</td>
</tr>
<tr>
<td>(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF25. Staff motivation at work</td>
<td>• No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Response rate**

Our 2014 response rate was 48.7%, which although lower than last year was above average when compared to other trusts. The average ‘Picker’ response rate was 41.6%. It is thought that response rates may have been adversely affected by the frequency of surveying staff for the Friends and Family Tests.

**Comparable results**

Compared to the 2013 Staff Survey, we scored significantly better on one question and significantly worse on one question.

<table>
<thead>
<tr>
<th>Significantly improvement on the following questions:</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff having equality and diversity training in the last 12 months</td>
<td>52%</td>
<td>61%</td>
</tr>
</tbody>
</table>
Significantly deterioration on the following questions:

<table>
<thead>
<tr>
<th>Percentage of staff reporting good communication between senior management and staff</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
</table>

Top five ranking scores

- **KF13.** Percentage of staff reporting errors, near misses or incidents witnessed in the last month
  
  (the higher the score the better)

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>94%</td>
</tr>
</tbody>
</table>

- **KF29.** Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department
  
  (the higher the score the better)

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>63%</td>
</tr>
</tbody>
</table>

- **KF3.** Work pressure felt by staff
  
  (the lower the score the better)

<table>
<thead>
<tr>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>2.96</td>
</tr>
</tbody>
</table>

- **KF5.** Percentage of staff working extra hours
  
  (the lower the score the better)

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>68%</td>
</tr>
</tbody>
</table>

- **KF15.** Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice
  
  (the higher the score the better)

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>72%</td>
</tr>
</tbody>
</table>
Bottom five ranking scores

! KF17. Percentage of staff experiencing physical violence from staff in last 12 months

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>National 2014 average for acute trusts</td>
</tr>
</tbody>
</table>

! KF20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>National 2014 average for acute trusts</td>
</tr>
</tbody>
</table>

! KF10. Percentage of staff receiving health and safety training in last 12 months

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>National 2014 average for acute trusts</td>
</tr>
</tbody>
</table>

! KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>National 2014 average for acute trusts</td>
</tr>
</tbody>
</table>

! KF7. Percentage of staff appraised in last 12 months

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>National 2014 average for acute trusts</td>
</tr>
</tbody>
</table>

These results will inform our corporate action plan, as follows:

**Key priorities for improvement**

- Action to be taken against staff who exhibit physical violence against others.
- Health and wellbeing initiatives for staff to include fitness to work and mental health awareness.
- Physical violence from patients/service users, their relatives or others to be firmly addressed.
- Health and safety training sessions to be monitored and poor attendance to be reported to directorates for follow up.
- Launch of new appraisal system in 2015, with robust follow-up for managers who fail to complete appraisals for staff.
- Senior managers to make themselves better known to staff.
### Staff pledges

The staff pledges are taken from the NHS Constitution which was first published in 2009. Our scores remained unchanged in many areas; although overall performance declined when compared to all acute trusts in 2014.

<table>
<thead>
<tr>
<th>STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.</th>
<th>Change since 2013 survey</th>
<th>Ranking, compared with all acute trusts in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1. % feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>• No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>KF2. % agreeing that their role makes a difference to patients</td>
<td>• No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>* KF3. Work pressure felt by staff</td>
<td>• No change</td>
<td>✔ Lowest (best) 20%</td>
</tr>
<tr>
<td>KF4. Effective team working</td>
<td>• No change</td>
<td>✔ Above (better than) average</td>
</tr>
<tr>
<td>* KF5. % working extra hours</td>
<td>• No change</td>
<td>✔ Lowest (best) 20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.</th>
<th>Change since 2013 survey</th>
<th>Ranking, compared with all acute trusts in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF6. % receiving job-relevant training, learning or development in last 12 mths</td>
<td>• No change</td>
<td>• Average</td>
</tr>
<tr>
<td>KF7. % appraised in last 12 mths</td>
<td>• No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>KF8. % having well structured appraisals in last 12 mths</td>
<td>• No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>KF9. Support from immediate managers</td>
<td>• No change</td>
<td>• Average</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.</th>
<th>Change since 2013 survey</th>
<th>Ranking, compared with all acute trusts in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF10. % receiving health and safety training in last 12 mths</td>
<td>• No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>* KF11. % suffering work-related stress in last 12 mths</td>
<td>• No change</td>
<td>• Average</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Errors and incidents</th>
<th>Change since 2013 survey</th>
<th>Ranking, compared with all acute trusts in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>* KF12. % witnessing potentially harmful errors, near misses or incidents in last mth</td>
<td>• No change</td>
<td>! Above (worse than) average</td>
</tr>
<tr>
<td>KF13. % reporting errors, near misses or incidents witnessed in the last mth</td>
<td>• No change</td>
<td>✔ Highest (best) 20%</td>
</tr>
<tr>
<td>KF14. Fairness and effectiveness of incident reporting procedures</td>
<td>• No change</td>
<td>✔ Above (better than) average</td>
</tr>
<tr>
<td>KF15. % agreeing that they would feel secure raising concerns about unsafe clinical practice</td>
<td>--</td>
<td>✔ Above (better than) average</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Violence and harassment</th>
<th>Change since 2013 survey</th>
<th>Ranking, compared with all acute trusts in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>* KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths</td>
<td>• No change</td>
<td>! Above (worse than) average</td>
</tr>
<tr>
<td>* KF17. % experiencing physical violence from staff in last 12 mths</td>
<td>• No change</td>
<td>! Highest (worst) 20%</td>
</tr>
<tr>
<td>* KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths</td>
<td>• No change</td>
<td>! Above (worse than) average</td>
</tr>
<tr>
<td>* KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths</td>
<td>• No change</td>
<td>! Above (worse than) average</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and well-being</th>
<th>Change since 2013 survey</th>
<th>Ranking, compared with all acute trusts in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>* KF20. % feeling pressure in last 3 mths to attend work when feeling unwell</td>
<td>• No change</td>
<td>! Above (worse than) average</td>
</tr>
</tbody>
</table>
Staff pledges

The staff pledges are taken from the NHS constitution which was first published in 2009. Our scores remained unchanged in many areas; although overall performance declined when compared to all acute trusts in 2014.

<table>
<thead>
<tr>
<th>STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF21. % reporting good communication between senior management and staff</td>
</tr>
<tr>
<td>Change since 2013 survey: ! Decrease (worse than 13)</td>
</tr>
<tr>
<td>Ranking, compared with all acute trusts in 2014: ! Below (worse than) average</td>
</tr>
<tr>
<td>KF22. % able to contribute towards improvements at work</td>
</tr>
<tr>
<td>• No change</td>
</tr>
<tr>
<td>! Below (worse than) average</td>
</tr>
</tbody>
</table>

**ADDITIONAL THEME: Staff satisfaction**

| KF23. Staff job satisfaction |
| • No change |
| • Average |

| KF24. Staff recommendation of the trust as a place to work or receive treatment |
| • No change |
| ✓ Above (better than) average |

| KF25. Staff motivation at work |
| • No change |
| ! Below (worse than) average |

**ADDITIONAL THEME: Equality and diversity**

| KF26. % having equality and diversity training in last 12 mths |
| ✓ Increase (better than 13) |
| • Average |

| KF27. % believing the trust provides equal opportunities for career progression or promotion |
| • No change |
| ✓ Above (better than) average |

| * KF28. % experiencing discrimination at work in last 12 mths |
| • No change |
| ! Above (worse than) average |

**ADDITIONAL THEME: Patient experience measures**

<p>| Patient/Service user experience Feedback |</p>
<table>
<thead>
<tr>
<th>KF29. % agreeing feedback from patients/service users is used to make informed decisions in their directorate/department</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Highest (best) 20%</td>
</tr>
</tbody>
</table>

**Friends and Family questions**

The following scores are the unweighted responses which feed into the key findings below for staff recommending our Trust as a place to work or receive treatment:

<table>
<thead>
<tr>
<th>Q12a</th>
<th>&quot;Care of patients / service users is my organisation's top priority&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Trust in 2014</td>
<td>68</td>
</tr>
<tr>
<td>Average (median) for acute trusts</td>
<td>70</td>
</tr>
<tr>
<td>Your Trust in 2013</td>
<td>69</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q12b</th>
<th>&quot;My organisation acts on concerns raised by patients / service users&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>73</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td></td>
</tr>
<tr>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q12c</th>
<th>&quot;I would recommend my organisation as a place to work&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>64</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q12d</th>
<th>&quot;If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KF24</th>
<th>Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.71</td>
<td></td>
</tr>
<tr>
<td>3.67</td>
<td></td>
</tr>
<tr>
<td>3.73</td>
<td></td>
</tr>
</tbody>
</table>
KEY FINDING 23. Staff job satisfaction

KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment

KEY FINDING 25. Staff motivation at work

ADDITIONAL THEME: Equality and diversity

KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months

KEY FINDING 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

KEY FINDING 28. Percentage of staff experiencing discrimination at work in last 12 months

ADDITIONAL THEME: Patient experience measures

Patient/Service user experience Feedback

KEY FINDING 29. Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department

Team/job scores

<table>
<thead>
<tr>
<th>Question</th>
<th>% 2014</th>
<th>% 2013</th>
<th>Average trusts 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Q4b) Team members have a set of shared objectives</td>
<td>78</td>
<td>79</td>
<td>78</td>
</tr>
<tr>
<td>(Q4c) Team members meet to discuss the team’s effectiveness</td>
<td>57</td>
<td>65</td>
<td>59</td>
</tr>
<tr>
<td>(Q4d) Team members have to communicate closely with each other to achieve the team’s objectives</td>
<td>82</td>
<td>81</td>
<td>79</td>
</tr>
<tr>
<td>(Q6a) I have clear, planned goals and objectives</td>
<td>74</td>
<td>77</td>
<td>75</td>
</tr>
<tr>
<td>(Q6b) I always know what work responsibilities are</td>
<td>86</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td>(Q7c) I am involved in deciding changes that affect work</td>
<td>55</td>
<td>60</td>
<td>53</td>
</tr>
<tr>
<td>(Q7d) I am able to make improvements in my area of work</td>
<td>55</td>
<td>58</td>
<td>56</td>
</tr>
<tr>
<td>(Q7e) I am able to meet conflicting demands on my time at work</td>
<td>40</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>(Q7g) Not enough staff to do my job properly</td>
<td>66</td>
<td>67</td>
<td>71</td>
</tr>
<tr>
<td>(Q9a) I am satisfied with the quality of care I give</td>
<td>83</td>
<td>82</td>
<td>83</td>
</tr>
<tr>
<td>(Q9b) I feel my role makes a difference to patients/service users</td>
<td>89</td>
<td>91</td>
<td>91</td>
</tr>
<tr>
<td>(Q3a) I have had an appraisal in last 12 months</td>
<td>82</td>
<td>84</td>
<td>85</td>
</tr>
<tr>
<td>(Q3b) Appraisal was helpful in improving how to do job</td>
<td>53</td>
<td>55</td>
<td>53</td>
</tr>
</tbody>
</table>

The above scores have remained fairly static, with those in red being more than 3% worse than 2013.
Recommendations

- A Care Group specific report to be made available to all our Directors of Operations and Heads of Nursing, to enable the development of individual action plans for half yearly reviews.
- The full report to be made available to Directors of Operations and Heads of Nursing for benchmarking purposes.
- 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.
- Results to be communicated to staff via various media, e.g. a health and wellbeing event, leaflet and corporate communications.
- A corporate plan is developed for the main points of concern, as described above.

Outcomes from last year’s Corporate Action Plan

<table>
<thead>
<tr>
<th>Action Plan from 2013 Staff Survey</th>
<th>Action taken</th>
<th>2014 survey outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers to ensure that all staff attend bullying and harassment (B and H) awareness training</td>
<td>B and H session included in mandatory training. Additional sessions taken to individual departments upon request from managers</td>
<td>3% improvement in number of staff experiencing B and H from colleagues or managers (25%) Of those, an improvement of 5% in reporting B and H</td>
</tr>
<tr>
<td>Taking action when staff are bullied, harassed or abused by patients or visitors</td>
<td>Monitoring of employee relation cases - grievance and B and H cases investigated and action taken where appropriate</td>
<td></td>
</tr>
<tr>
<td>Taking action against staff who bully or harass others</td>
<td>B and H awareness session at Health and Wellbeing event</td>
<td></td>
</tr>
<tr>
<td>Encourage staff to report bullying and harassment from all sources</td>
<td>Stop B and H leaflet printed for distribution to staff at above sessions</td>
<td></td>
</tr>
<tr>
<td>Recruitment is instigated by managers in a timely way and progressed as quickly as possible to ensure adequate staff are available at all times</td>
<td>Various recruitment campaigns throughout the year, as detailed in recruitment section on page 47</td>
<td>43% said there were not sufficient staff to do their job properly, an improvement of 3% 5% less staff working extra hours</td>
</tr>
<tr>
<td>Ensuring all staff attend diversity training</td>
<td>Additional diversity training sessions were offered to staff</td>
<td>9% improvement in staff saying they had received training (61%)</td>
</tr>
<tr>
<td>Work with staff to reduce work related stress and help them develop coping strategies when feeling under pressure</td>
<td>Health and wellbeing awareness sessions and events. Increased sickness management and support from EAP</td>
<td>2% reduction in staff who report experiencing work related stress in last 12 months</td>
</tr>
</tbody>
</table>
Equality and diversity

Equality, diversity and inclusion continue to be at the heart of the NHS strategy and investing in a diverse NHS workforce enables us to deliver a more inclusive service and improve patient care.

We recognise that equality means treating everyone with equal dignity and respect and having the opportunity to fulfil their potential irrespective of any protected personal characteristics. In doing so, it acknowledges that diversity is about recognising that people have different needs, situations and goals and that an individual’s experiences within the workplace should make them feel valued and included. Achieving equality requires the removal of the discriminatory barriers that limit what people can do and can be, eliminating harassment and victimisation.

We are committed to ensuring that people do not experience inequality through discrimination or disadvantage imposed by other individuals, groups, institutions or systems in terms of:

- outcomes - related to both health care and/or employment
- access - related to clinical services and/or employment and promotion opportunities
- the degree of independence they have to make decisions affecting their lives
- treatment - related to both clinical care and employment

The Equality Act 2010 brings together several pieces of anti-discrimination legislation and requires equal treatment in access to employment as well as private and public services, regardless of the nine protected characteristics. These are age, disability, gender reassignment, marriage or civil partnership, maternity or pregnancy, race, religion or belief, sex and sexual orientation.

Decisions made in relation to these characteristics are made in a fair and transparent way. As a public sector organisation, there are some additional equality duties which we are committed to achieving. This means that we must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between different people when carrying out their duties, tackling prejudice and promoting understanding
- ensure that policies and services are appropriate and accessible to all meeting their different needs

Having due regard to these areas means that we can provide an efficient and effective service while enhancing the patient experience. There are also some specific duties that we are required to adhere to. We must be transparent about how we are responding to the Equality Duty; publishing relevant, proportionate information showing compliance with the Equality Duty on an annual basis. We must also set and monitor equality objectives. This information must be available to staff, service users and the general public. Our website - www.rbch.nhs.uk - publishes information on how we believe the organisation meets these duties and this information is updated regularly. This includes information on recruitment and retention and development and support of disabled employees.


The table below sets out the gender breakdown of the Trust’s employees as at 31 March 2015:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Senior Managers</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Employees</td>
<td>1,033</td>
<td>3,323</td>
</tr>
</tbody>
</table>
Sustainability Report

Sustainability has become increasingly important as the impact of peoples’ lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As a part of the NHS, public health and the social care system, it is our duty to contribute towards the target set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction 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 our activities on the environment, and in doing so reinforcing our 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 are:

- energy, water and carbon management
- sustainable procurement and food
- low carbon travel, transport and access
- waste reduction and recycling
- green spaces
- staff engagement and communication
- buildings and site design
- organisational and workforce development
- partnership and networks
- governance, IT and finance

We regularly review 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 and we have been progressing in a number of areas over the last couple of years.

Celebrating our successes in 2014/15

Over the year, we were formally recognised for our approach to sustainability, receiving two awards for our work.

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

Energy, water and carbon management

We have been investing in energy efficient lighting across our hospital sites. LED lights have been installed in several ward environments, main corridors, a number of office areas, accommodation refurbishments, and in all car parks at the Royal Bournemouth Hospital.
**Sustainable procurement and food**

We acknowledge the importance of sustainable procurement and its role as an agent for change in the broader sustainable development agenda. We recognise our responsibility to carry out procurement activities in an environmentally and socially responsible manner, and the Procurement Steering Board approved a Trust Sustainable Procurement Policy, and associated action plan, in December 2014.

The Commercial Services Department ensures all suppliers are asked to provide information on environmental performance during the pre-qualification questionnaires process and are currently carrying out work on templates and priorities to focus on waste prevention within contracts. All our procurement staff have also attended sustainable procurement training.

It is important that as a hospital we promote the sourcing of local and seasonal produce, not just from a carbon reduction perspective, but also to benefit the health and wellbeing of our staff and patients. For example, our Catering Department has developed a sustainable and healthy food action plan and is striving towards achieving a bronze ‘Food for Life’ award through the Soil Association.

For a number of years we have only been using free range eggs and were awarded the Good Egg Award in 2014. We have also signed up to support the Sustainable Fish City Pledge.

**Low carbon travel, transport and access**

We have been working closely with Bournemouth Borough Council on plans to ease traffic congestion around the hospital through a combination of promoting sustainable travel options and pursuing improvements to the local transport infrastructure. A new bus hub was constructed at the front of the Royal Bournemouth Hospital (RBH) site in 2014 by Bournemouth Borough Council, with land donated by us. We have been working with local bus companies to explore ways of improving modal shifts in transport usage and providing incentives for the use of public transport such as discounted bus pass prices.

Additional cycle shelters were installed at RBH in 2015 to meet the increasing demand from the large proportion of staff cycling to work.

A designated Travel Advisor was recruited during 2014 to help communicate the benefits of switching from single car occupancy to more sustainable methods of travel. Our Travel Advisor worked with staff to produce individual travel plans, providing information for all sustainable modes of travel to work, including walking, cycling, public transport and car-sharing.

We have also invested in a number of electric vehicles and electric vehicle charging stations, and our patients and visitors can use charging points within the RBH public car park.

**Waste reduction and recycling**

During 2012/13, we became ‘zero waste to landfill’, which represents a significant milestone to waste reduction and a strong commitment to protecting the environment by disposing of waste responsibly. Recycling facilities continued to be rolled out across the Trust in clinical and office areas of the hospital over the past year. We continued to send all food waste from the Catering Department to a local anaerobic digestion plant where it is used to produce energy for the national grid, and by-product liquid fertiliser to local farmers. Battery recycling facilities are also continuing to be rolled out across the Trust.

The installation of Dyson air blade hand driers in non-clinical washrooms has been carried out at the Royal Bournemouth Hospital. Great savings can be achieved through the installation of these items through the avoided cost in paper towel purchasing and disposal.

We also continued to use compostable items for all single use hot cups and lids, cold cups for drinks and desserts, napkins, cutlery, takeaway boxes and sandwich bags within the hospital restaurants. This has been estimated to save 4.4 tonnes of carbon, 5.1 tonnes of virgin materials, and diverting 11 tonnes of packaging waste from landfill every year.
Buildings and site design

In developing our services and facilities, we aim to meet the Building Research Establishment Environmental Assessment Method (BREEAM) performance benchmarks (including ‘BREEAM Very Good’ for new build developments) in respect of the specification, design, construction and use of our buildings. The BREEAM measures include aspects related to energy and water use, the internal environment (health and wellbeing), pollution, transport, materials, waste, ecology and management processes.

Green spaces

Our Estates Team has carried out a number of improvements to encourage wildlife and enhance biodiversity around the hospital sites. Around 30 bird boxes have been installed, covered duck houses situated around the lake, log piles have been formed to encourage biodiversity and a wildflower site has also been trialled to encourage nectar feeding bees and other insects. We have also been trialling green pest control in the form of a Harris Hawk. The gardening team took part in the Great Butterfly Count in 2014 - a nationwide survey aimed at helping assess the health of our environment.

In 2014, an interpretive board was erected by the lakeside at the Royal Bournemouth Hospital to communicate the wildlife present on site. This board was designed in-house and was produced by the Estates Team using recycled materials (destined for disposal). The intention of the board is to raise awareness of biodiversity and sustainable practices to help promote the link between green spaces and their positive benefits for mental health and wellbeing.

Staff engagement and communications

We are committed to ensuring staff, patients, visitors, suppliers and contractors are able to effectively engage with, and support, our carbon reduction plan.
We were the second NHS organisation to take part in the Green Impact Scheme, an environmental accreditation and awareness scheme run by the National Union of Students. During 2014, 11 teams from across our hospitals took part in the scheme, and it is estimated to have reached out to over 360 staff contacts. In addition to this, the staff behaviour change scheme saved over £23,000 in 2014 through sustainable actions implemented - this is equivalent to one band five nurse.

An awards ceremony was held in November to reward staff on their achievements and sustainable actions. Five teams successfully achieved bronze awards and one team (the Pharmacy Department) achieved a Silver Award.

Regular articles about sustainability and energy awareness are included within the staff magazines, as well as regular awareness raising events, such as the National Climate Week campaign and annual NHS Sustainability Day.

**Organisational and workforce development**

A range of initiatives associated with health improvement and promoting the health of staff, patients and the public are led and overseen by the Valuing Staff and Wellbeing Group. You can read more about its work on page 48.

**Governance**

Performance against targets is reported quarterly to the Carbon Group. A Sustainable Development Policy has also been signed off on behalf of the Trust by the Carbon Group. We routinely reports on energy consumption through the Department of Health’s ‘Estates Returns Information Collection mechanism’ (ERIC).

**IT and finance**

We introduced sustainability criteria for completion as part of all business cases. The IT Department has also recently rolled out PC power management software, aimed at reducing energy consumption through computers being left on unnecessarily.

**Future priorities and targets for 2015/16**

- Update and redraft the Trust’s Sustainable Management plan, to include realistic CO₂ targets to 2020 and inclusion of climate change adaptation aspects.
- Catering Department to achieve the Bronze Food for Life Catering Mark to showcase all work done regarding local, healthy and sustainable food.
- Waste management strategy and plan to be developed.
- Conduct annual staff and patient travel survey.
- Explore the potential to reduce congestion around sites during peak times.
- Expansion of Green Impact scheme.
- Development of an Energy and Utilities plan.
- Development of a Green ICT plan.
- Development of a Biodiversity Action Plan.
Performance data:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total gross emissions:</td>
<td>13,545</td>
<td>14,350</td>
<td>12,694</td>
<td>12,333</td>
<td>11,646</td>
<td>12,931</td>
</tr>
<tr>
<td>Gross emissions scope 1 (Gas/oil/fleet vehicles/refrigerant losses)</td>
<td>5,340</td>
<td>5,003</td>
<td>4,090</td>
<td>4,256</td>
<td>3,944</td>
<td>4,376</td>
</tr>
<tr>
<td>Gross emissions scope 2 (Electricity)</td>
<td>7,511</td>
<td>8,891</td>
<td>8,279</td>
<td>7,819</td>
<td>7,438</td>
<td>8,302</td>
</tr>
<tr>
<td>Gross emissions scope 3 (Waste/water)</td>
<td>700</td>
<td>456</td>
<td>325</td>
<td>258</td>
<td>265</td>
<td>253</td>
</tr>
<tr>
<td>Related energy consumption (MWh)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity: non-renewable</td>
<td>9,823</td>
<td>11,215</td>
<td>11,027</td>
<td>9,986</td>
<td>13,170</td>
<td>13,405</td>
</tr>
<tr>
<td>Electricity: renewable</td>
<td>4,072</td>
<td>3,738</td>
<td>3,745</td>
<td>3,713</td>
<td>114</td>
<td>87</td>
</tr>
<tr>
<td>Gas</td>
<td>28,457</td>
<td>23,566</td>
<td>19,048</td>
<td>20,250</td>
<td>18,271</td>
<td>17,853</td>
</tr>
<tr>
<td>Oil</td>
<td>0</td>
<td>164</td>
<td>227</td>
<td>278</td>
<td>118</td>
<td>118</td>
</tr>
<tr>
<td>LPHW</td>
<td>1,535</td>
<td>7,903</td>
<td>4,644</td>
<td>6,840</td>
<td>6,827</td>
<td>6,925</td>
</tr>
<tr>
<td>Financial indicators (£1,000's)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure on energy</td>
<td>1,545</td>
<td>2,035</td>
<td>2,155</td>
<td>2,325</td>
<td>2,268</td>
<td>2,514</td>
</tr>
<tr>
<td>CRC gross expenditure</td>
<td>-</td>
<td>-</td>
<td>143</td>
<td>149</td>
<td>147</td>
<td>331</td>
</tr>
<tr>
<td>Expenditure on official business travel</td>
<td>-</td>
<td>391</td>
<td>324</td>
<td>389</td>
<td>394</td>
<td>428</td>
</tr>
<tr>
<td>Energy consumption (MWh) per GIA floor area:</td>
<td>0.50</td>
<td>0.44</td>
<td>0.36</td>
<td>0.38</td>
<td>0.36</td>
<td>0.38</td>
</tr>
<tr>
<td>Carbon emissions (Kg CO₂e) per patient:</td>
<td>21.7</td>
<td>20.5</td>
<td>17.1</td>
<td>16.0</td>
<td>15.0</td>
<td>16.6</td>
</tr>
</tbody>
</table>

Performance commentary:

Energy costs increased in 2014/15, this is due to an increase in costs per unit of utilities as well as increased consumption of electricity, gas and Low Pressure Hot Water (LPHW) at the Royal Bournemouth Hospital (RBH) and increased consumption of oil at Christchurch Hospital (XCH).

Oil consumption at XCH increased by 791% in 2014/15 compared to the previous year due to the hospital site reverting from gas usage to solely oil for the month of March during the moving of the mains gas supply at the hospital, a part of the XCH redevelopment plans.

The increase in electricity base load at RBH in 2014/15 could be explained by additional equipment within the hospital and building work associated with the Jigsaw Building.

Our gross carbon emissions increased by 11% in 2014/15 compared to carbon emissions the previous year, but have reduced by 4.5% from the baseline year (2007/08).

Relative energy consumption can also be seen to have reduced by 24% since the baseline year for energy consumption per square meter of gross internal floor area, and reduced by 23.5% since the baseline year for carbon emissions per patient.

In addition, we generate roughly 15% of our energy onsite, through three solar PV installations and low pressure hot water which is produced as a by-product of onsite incineration and used to subsidise the Royal Bournemouth Hospital’s heating system.
Waste:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-financial indicators (tonnes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total waste</td>
<td>1,369</td>
<td>1,482</td>
<td>1,503</td>
<td>1,258</td>
<td>1,407</td>
<td>1,731</td>
</tr>
<tr>
<td>High temp disposal waste</td>
<td>615</td>
<td>517</td>
<td>469</td>
<td>486</td>
<td>549</td>
<td>521</td>
</tr>
<tr>
<td>Landfill</td>
<td>701</td>
<td>827</td>
<td>299</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Recycled/reused</td>
<td>123</td>
<td>181</td>
<td>444</td>
<td>247</td>
<td>269</td>
<td>450</td>
</tr>
<tr>
<td>Energy recovery</td>
<td>0</td>
<td>0</td>
<td>284</td>
<td>526</td>
<td>589</td>
<td>760</td>
</tr>
<tr>
<td>Financial indicators (£1,000's)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total waste cost</td>
<td>318</td>
<td>333</td>
<td>336</td>
<td>320</td>
<td>287</td>
<td>293</td>
</tr>
<tr>
<td>High temp disposal waste</td>
<td>256</td>
<td>258</td>
<td>221</td>
<td>237</td>
<td>200</td>
<td>194</td>
</tr>
<tr>
<td>Landfill</td>
<td>62</td>
<td>72</td>
<td>44</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Recycled/reused</td>
<td>26</td>
<td>28</td>
<td>31</td>
<td>13</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>Energy recovery</td>
<td>0</td>
<td>0</td>
<td>31</td>
<td>65</td>
<td>71</td>
<td>78</td>
</tr>
</tbody>
</table>

Performance commentary:

In 2014/15, our preferred waste contractor collected a total of 1,210 tonnes of mom-hazardous waste. Of this, zero tonnes went to landfill, 760 tonnes went to an energy recovery facility and 450 tonnes recycled, which included mixed recycling (71 tonnes); baled cardboard (102 tonnes); and separate food waste collections (111 tonnes). The Trust chose to send all waste to energy recovery as opposed to landfill as of financial year 2012/13.
Table:

<table>
<thead>
<tr>
<th>Non-financial indicators (000’s m³)</th>
<th>2007-08</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water consumption</td>
<td>130</td>
<td>142</td>
<td>140</td>
<td>141</td>
<td>142</td>
<td>124</td>
</tr>
<tr>
<td>Sewerage</td>
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<td>Water supply costs</td>
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Performance commentary:

Our water consumption has reduced by 12.5% (17,765 cubic meters) in 2014/15 compared to the previous year, and reduced by 4.6% by 2014/15 compared to the baseline year (2007/08).

The Trust’s dramatic reduction in water consumption compared to previous years is largely due to redevelopments at the Christchurch Hospital, with a number of buildings being demolished and reduced services temporarily taking place at the site.

Although water consumption can be seen to have shown an upward trend over the last couple of years (excluding 2014/15), water consumption per square meter of gross internal floor area has shown an overall reduction in water usage within the hospitals, with a reduction of 20% in 2014/15 from the baseline year (2007/08).

The Trust’s annual report and accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006. This specifies the form in which the accounts should be presented which has been set out in the NHS Foundation Trust Annual Reporting Manual for 2014/15.

Mr A Spotswood
Chief Executive
28 May 2015
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If you require any further information about the 2014/15 Quality Accounts please contact: Joanne Sims (Associate Director Quality and Risk) at Joanne.Sims@rbch.nhs.uk
2014/15 Achievements

**Patient Information Standard**
Trust achieves National Information Standard for high quality patient information

**Eye Unit**
Nominated by patients as an ‘outstanding service’ at the Macular Society’s Awards for excellence

**Falls**
50% reduction in serious falls this year

**Serious incidents**
30% reduction in serious incidents this year

**Infection control**
No MRSA bacteraemia

**CQC**
All non-compliance actions removed

**Trust shortlisted for National Patient Safety Award**

**Sign up to Safety**
Five Sign up to Safety pledges submitted

**Pathology**
Pathology services received CPA accreditation

**Wessex Quality**
Improvement Fellowships awarded to three specialist registrars

Excellent care for every patient, every day, everywhere
Part 1

Statement on quality from the Chief Executive

This Quality Report is published by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to accompany our Annual Report.

In this report we have outlined patient safety and quality improvement projects and activities which have taken place in the Trust over the last 12 months.

Our quality improvement programme has been supported by wide-ranging patient safety initiatives which cover a large range of specialties and topics.

There were a number of inspections during the year, the most important of which was a formal inspection by the Care Quality Commission (CQC) which identified that we had made significant improvement following its full inspection in 2013. We could not have made this improvement without the dedication and skill of our staff and the support from patients, carers and other public stakeholders. We also recognise that we are on a continuous journey and have further improvements to make, embed and sustain.

This year the overarching objectives agreed by the Board of Directors aim to provide a central framework and become the basis for individual objective setting across the whole organisation. It is expected that every member of staff will agree objectives which reflect the key themes of quality, improvement, personal and professional development, teamwork and performance.

There is an important balance to be struck when considering the objectives we set for the Trust. We need to consider the need for these to be clear and measurable against the importance of not over-specifying to the point they fail to be relevant to staff, or lack ownership and connectivity due to their relevance to small defined areas of the Trust.

We have sought to establish the balance necessary between the two positions. In summary our work and focus for 2015/2016 will be on:

- quality - providing safe, effective and compassionate care
- improvement - using a standard methodology to support achievement of the Trust’s quality priorities
- strategy and partnerships - to have a clear strategy for maintaining viable high-quality services
- staff - focusing on positive development and learning culture, strong leadership and teamwork
- performance - delivering the performance required to maintain access to elective diagnostic and emergency services
- value for money - staying within budget using resources wisely and cutting waste to allow the maximum funding to go to front line patient care

The views of our various stakeholders including patients, governors, staff and the wider public have been very important to the development of our specific quality objectives and priorities for 2015/16. We have engaged with staff through workshops, management briefing sessions, executive team walkabouts and informal drop in sessions. We have talked to patients and carers through our extensive programme of patient surveys and have held specific focus groups, cafes and open days. We have also invited patients and relatives to attend serious incident panel meetings to ensure we focus on everyone’s questions and issues. Improving patient safety and patient experience is a prominent agenda item for the Board of Directors and we value the opportunity to work with patients, carers, foundation trust members and the public on a wide range of patient experience and patient safety initiatives.

It has not been possible to include all of the quality and patient safety initiatives that we have been, or will be engaged in, within this report. We have considered the comments made by our external stakeholders during the consultation process and amended the
final version of the report to provide additional information where appropriate. We hope the report demonstrates our clear commitment to quality improvement and patient safety.

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in our internal audit's programme of work each year
- data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently
- national data definitions do not necessarily cover all circumstances, and local interpretations may differ
- data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data

The Trust and its Board of Directors have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate.

Tony Spotswood
Chief Executive
28 May 2015
Focus on Quality Operational Review

The key principles of our Quality Strategy are Safety, Effectiveness and Experience. We want everyone to SEE quality in everything we do.

Our ‘Quality Toolkit’ supports staff engagement in quality improvement. Our weekly ‘Focus on Quality’ bulletins are produced to inform staff about progress against our Care Quality Commission (CQC) action plans and highlight important ‘SEE Quality Strategy’ objectives. Case studies are used to promote examples of good practice, celebrate innovation and improvement and share ideas for learning.

The bulletins are also shared with members of the public via our website, on patient information screens in waiting areas at the hospital and displayed on noticeboards in the main atrium. Key quality messages are displayed on screensavers used across our hospitals, visible to both staff and patients. For each quality story, we aim to see what impact it is having on our staff and patients, so include quotes from those who are putting our quality strategy into action, and those who are seeing the benefits.

Quality is monitored in many different ways, through:
- what we see from ward and department inspections, spot checks and audits
- what we hear from staff, patients, carers, visitors and external stakeholders
- what we learn from internal and external reports, data collection and reviews

To support monitoring and learning we have implemented an internal peer review process and we were pleased the CQC commended this approach when it inspected the Trust in August 2014.

We have trained over 50 managers, matrons, consultants and allied health professionals to participate in internal peer review visits to clinical and non-clinical areas.

The internal clinical quality review process involves a small team of three reviewers visiting a ward/department for approximately two hours, following a patient journey and viewing this from a patient perspective against the CQC fundamental standards.

Observations and interviews with patients and staff are triangulated by the reviewers, with a summary sheet completed against the CQC standards.

The visits are unannounced and are a joint opportunity for learning and sharing best practice across the Trust.
The message is that we want to deliver excellent care for every patient, every day, everywhere and everyone in the organisation has an equally important role to play to support this.

**Wessex Quality Improvement Fellowships**

Health Education Wessex and the Thames Valley Wessex Leadership Academy have recruited three members of staff from RBCH to participate in a 12-month Quality Improvement Fellowship programme.

These three members of staff will be released from their current roles for two days each week to participate in the scheme.

One of the programmes participants, Ed Hewertson, a specialist registrar in geriatric medicine at RBCH said:

“I have been actively involved in quality improvement for the last two years. This fellowship is a fantastic opportunity for me to improve my skills and methodology. I hope it will allow me to make a significant contribution to RBCH during my time here. One of my aims is to disseminate my learning to staff within the organisation and throughout Wessex.”

In addition, seven members of our medical staff have been successful with their applications for the SAS (staff grade and associate specialist) doctors’ programme, which is the largest cohort across Wessex.
Part 2
Progress against quality priorities set out in last year’s quality account for 2014/15

In the 2013/14 Quality Account, we identified seven key areas for improvement in 2014/15. These were:

- harm free care
- inpatient falls
- hospital acquired pressure ulcers
- infection prevention and control
- new hospital acquired venous thromboembolism (VTE)
- privacy and dignity
- nursing risk assessments and care plans

Monitoring of progress against each of these priorities has been undertaken via the Board of Directors and specific sub groups, including the Healthcare Assurance Committee, Quality and Risk Committee and Infection Prevention and Control Committee. Where relevant, quality metrics have been incorporated into ‘ward to board’ quality dashboards and quality reporting processes.

The following pages provide details of the report provide details of our achievement against the priorities we set ourselves.

Harm free care

The 2013/14 Quality Report published in May 2014, identified ‘harm free care’ as one of the quality improvement priorities to continue to be monitored in 2014/15.

Harm free care is a national (NHS England) quality indicator and is measured monthly via a standard NHS Safety Thermometer data collection tool. The methodology requires all ward areas to record ‘harms’ for all inpatients on the ward on the monthly data collection day. The data is recorded on a standard audit sheet and results are validated prior to entry on to the national electronic standard safety thermometer data collection.

A patient is identified as having harm free care if they have not had a pressure ulcer (either before or during admission), a fall during admission, a catheter related urinary tract infection during admission, or a hospital acquired venous thromboembolism (blood clot).

A quality objective for the year 2014/15 was the completion of the NHS Safety Thermometer across all wards areas with the simple aim to be above the national average for inpatient harm free care.

In 2014/15, we achieved an average of 97.18% new harm free care (96.68% in 2013/14). Our score for 2014/15 compared to the national average of 97.59%.

Inpatient falls

Less than 0.3% of hospital inpatients surveyed in 2014/15 using the NHS Safety Thermometer tool had a fall resulting in harm after being admitted to hospital.

We had a lower number of inpatient falls (as recorded using the NHS Safety Thermometer methodology) than the national average.

Falls numbers reported 2013/14 and 2014/15

2013/14 total number of falls reported = 1,836

2014/15 total number of falls reported = 1,727

The number of falls in 2014/15 therefore fell by 6% compared to the Trust’s performance in 2013/14.

In addition to the improved Trust performance with respect to patient falls, there has been a significant reduction (50%) in the number of reported moderate and severe injuries following a fall this year.

2013/14 = 52
2014/15 = 26
Quality improvements in 2014/15:

- development of new short stay and 14 day care plans - review of falls, mobility and bed rail assessment documentation
- development of e-Nurse app for falls, mobility and bed rails risk assessments
- development of a fragility risk assessment to meet National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines
- design and implementation of eLearning programmes for staff
- local training needs identified in high risk of falls areas
- appointment of a new Trust falls lead
- Trust falls lead working with the clinical educators to provide bespoke local training
- Trust falls lead providing local training, to high risk of falls areas, on completing documentation accurately
- implementation of a new multi-disciplinary Trust falls steering group

Improvement plan priorities for 2015/6:

- implementation of the e-Nurse app for falls, frailty, mobility and bed rails risk assessments. e-Nurse assessments are due to go live in July 2015. The current falls and bedrails assessment has been completely reconfigured with relevant questions asked to ensure the new NICE guidelines on falls prevention are covered
- implementation of ‘daily’ repeat fallers list for ward leaders and matrons to assist prioritisation of care plans
- two-yearly mandatory training to include face-to-face training on falls prevention, and a practical session on safe falls management and the use of the hoverjack
- as part of the Trust’s duty of candour and our culture of being open, honest and transparent, patients and/or relatives have been invited to attend serious incident panel meetings. This has proven successful in that the relatives have had a clearer understanding of how the incident happened, what measures we put in place to prevent reoccurrence, and how we share this around the Trust. We will continue this for 2015/16
- the falls lead has been working closely with the practice educators to provide bespoke scenario based teaching/training on falls prevention and management using the ‘SIM man’ (advanced patient simulator)
- develop the role of manual handling and falls champions. They will receive specialised training on how to promote falls prevention within their areas and will be supported with cascading this information to their teams
- bay-based nursing will continue to be promoted in all clinical areas. Bay-based nursing has proven to reduce the number of falls as the patients are easily observed and they also feel safer having a nurse within the bay at all times
- the falls lead is currently liaising with falls leads from other NHS trusts to encourage shared learning and ideas
- we plan to participate in the Royal College of Physicians national audit of inpatient falls (May 2015)

Hospital acquired pressure ulcers

On average less than 2.05% of our hospital inpatients surveyed in 2014/15 using the National NHS Safety Thermometer tool had a reported hospital acquired pressure ulcer. This compared to 2.2% in 2013/14.

Although the result is better than the previous year we are disappointed that the Trust’s performance is below the national average.

Our patient profile is such that we have a high proportion of very elderly frail inpatients with often complex and long term health issues. Our patients are often admitted with existing pressure damage or at high risk of early skin deterioration. We have implemented a new prevention strategy at our front door whereby all patients are placed immediately on pressure relieving mattresses. We have also provided additional training to our Emergency Department and Acute Medical Unit staff to highlight the importance of ensuring that
patients have a full skin assessment on admission.

We know the number of patients being admitted with existing pressure damage from the community is worse than the national average and that this impacts significantly on the overall harm free care score for the Trust. We are working closely with NHS England and clinical commissioning group colleagues across Dorset and Hampshire to improve pressure ulcer prevention, care and management in the community.

All incidents of pressure damage (internally or externally acquired) are reported as adverse incidents. Each incident is formally investigated and in cases of significant pressure damage (a category three or four pressure ulcer) a formal case review meeting is held. The aim of the panel meeting is to identify any gaps in care and/or opportunities for learning. In 2013/14 we reported 31 serious incidents of avoidable category three and four hospital acquired pressure ulcers. In 2014/15 this figure reduced by 39% to only 19 cases.

**Quality improvements implemented in 2014/15:**

- implementation of new pressure relieving mattress systems. These hybrid mattresses (static foam and dynamic air cell technology) allow us to have a preventative strategy for pressure damage. Patients are automatically placed on a mattress and a pump fitted to provide pressure relieving functionally. A decision is then made to turn the pump off if the patient is assessed as low risk. Previously a patient would have been placed on a static mattress, assessed and then a specialist mattress ordered and delivered to the clinical area if required. Sometimes this meant a delay in provision could occur when areas were busy or had a high demand
- in April 2014 a study day for 60 delegates was held focusing on pressure area care prevention and management within the Trust. The programme included scenario-based workshops and sharing lessons from serious incident events
- promotion of a pressure ulcer patient information leaflet. This has been designed to explain the associated risk factors, how pressure damage can develop and what patients can expect during their hospital stay
- development of an interactive risk assessment application (eWaterlow app). The eWaterlow app will help to streamline the completion and updates of the pressure ulcer risk assessment tool. Using iPads, qualified staff can be guided through the completion risk assessment tool. Timeframes for reassessment based on the patients’ level of risk are set, highlighting to ward staff when they are due to be reviewed
- development of e-learning programmes for staff
- external review. An external review of the Trust Pressure Ulcer Strategy was undertaken by an expert from Wound UK. The external review reported that the Trust had a well-developed strategy and had invested significantly in pressure relieving equipment. The review also noted the Trust had an open and honest approach to reporting pressure damage and adverse events that was not always replicated across other healthcare organisations. The Trust was recognised as having a good learning culture and was able to demonstrate where improvements had been made following investigations

**Improvement plan priorities for 2015/16:**

- implementation of a competency framework for all clinical staff
- implementation of a new care bundle approach to pressure area care
- reducing the number of avoidable category three and four pressure ulcers acquired in our hospital in 2015/16 by 25%, measured through Adverse Incident Reports
Infection prevention and control

Reducing catheter associated urinary tract infections (CA UTI)

The mean numbers of new CA UTIs (from NHS Safety Thermometer data) for the Trust in 2014/15 was 0.39%. This is slightly above the national mean score of 0.35% but an improvement on the Trust results for 2013/14 (0.47%).

There are a number of factors that influence our results. As a Urology Centre we have a higher number of patients admitted to the Trust with urinary system related illness. There is also a higher percentage of elderly population that this Trust treats.

During the year a Trust-wide point prevalence study of urinary catheters was carried out. This included a review of catheter insertion documentation and ongoing care ensuring compliance with infection control (EPIC3) guidelines.

The study highlighted a need to update the catheter insertion stickers introduced last year to ensure that key issues are documented. This includes ‘insertion using aseptic technique’, ‘planned date for review’ and ‘number of attempts’. These are now in use within all relevant wards and departments.

Quality improvements in infection control implemented in 2014/15:

- new hand hygiene points in outpatients
- new signs at all entrances to the Trust
- carbapenemase-producing enterobacteriaceae (CPE) action plan introduced
- focused MRSA screening in line with new Department of Health guidance
- clostridium difficile cases under trajectory for 2014/15 - target was less than 25, position at end of March 2015 was 21
- there have been no MRSA health care acquired bacteraemias
- hand hygiene and ‘saving lives’ infection control audit - overall the trend in the last quarter of 2014/15 has moved up from 93.1% to 95%. Some areas still need to ensure they are submitting data on time with enough observations to ensure the results from this monthly audit are informative
- improved norovirus outbreak control. We have excellent support from ward staff and housekeeping in supporting our actions for norovirus outbreak control. Timely and informative communications between our Clinical Site Team, wards and departments as well as information from the wider community on new and ongoing community outbreaks enabled the Trust to keep ward closures to a minimum
- a successful Infection Control Resource Group 14th annual away day was held. Infection control resource leads provide a valuable link between the Infection Control

There were 79 empty bed days in 2014/15 compared to 181 in 2013/14 and 171 in 2012/13. The number of days that a ward had an area closed in 2014/15 was 88 compared to 72 in 2013/14 and 98 in 2012/13.
Team (ICT) and their own clinical area. The resource staff act as role models and are visible advocates for infection protection and control. The principle aims of their roles is to motivate and to increase awareness of infection control issues, enable individuals and their teams to learn and develop infection prevention practice while supporting local audit and surveillance.

With the date of the away day coinciding with the annual antibiotic awareness day, it was a good opportunity to focus the agenda around resistant organisms, new and emerging organisms, organisms that were in high profile at the time and management of antimicrobial therapy. The day was well attended and staff enjoyed the interactive approach to the learning.

**Improvement plan priorities for 2015/16:**

- ensuring that there are no MRSA bacteraemia cases and that the Trust achieves its target of no more than 14 clostridium difficile cases

**New hospital acquired venous thromboembolism (VTE)**

We continue to strive for excellence in the prevention of hospital acquired venous thromboembolism (VTE or a ‘blood clot’).
On average 0.12% (e.g. 12 patients per 1,000) of hospital inpatients surveyed using the NHS Safety Thermometer tool in 2014/15 had a new hospital acquired venous thromboembolism (a blood clot) during admission. This is much better (i.e. lower) than the national average value of 0.59%.

The Trust also demonstrated a much better VTE risk assessment rate of 98.77% using the NHS Safety Thermometer data collection tool compared to the national average of 90.93%.

**Electronic VTE assessments**

All patients admitted to our hospital are required to have VTE assessments due to an increased risk of blood clots, particularly after surgery, or for patients who may be less mobile than usual.

Historically, the VTE assessment data was captured on all clinical computers once a day. However in February 2014, a new system using iPads was designed which created a live data report, enabling earlier identification of any patient who required a VTE assessment.

**Mandatory training on VTE for all clinical staff**

The Trust has developed a new eLearning module which includes competency assessment and a powerful patient story to provide all clinical staff education on the risk of VTE, the signs and symptoms, how to risk assess and what measures should be taken to prevent VTE. Training is also included for all new staff as part of their corporate induction.

**Root cause analysis**

A more robust process of checking for hospital acquired VTE has also been developed which includes not only investigating any patient that presents back to the Trust within 90 days of discharge, reviewing all deaths in the community from information sent from the coroner, but also for the past year the Trust has audited the results of all investigation for VTE from a report from X-ray.

**Improvement plan priorities for 2015/16:**

- improve the consensus data capture for VTE risk assessment to consistently above 95%
- continue to complete root cause analysis on all hospital acquired venous thromboembolism analysing data for trends
- apply for national recognition of its outstanding work on VTE by applying for exemplar status

**Privacy and dignity**

One of our priority actions has been to improve standards of privacy and dignity for patient care. Action taken in 2014/15 included identification of a core set of privacy and dignity values that all staff should adopt.

**My Dignity Pledge**

I will:

1. introduce myself to patients and visitors at all time
2. acknowledge everyone who visits my clinical area
3. only hold relevant conversations in the clinical and public areas and involve patients and relatives appropriately
4. always ask and address my patients by the name they wish to be called by
5. be sensitive when discussing treatment or diagnosis:
   - use the butterfly sign so others are aware that the room is in use and not to interrupt
   - create the right environment using curtains or a quiet room
6. encourage and help my patients to wear their own clothing when it is appropriate
7. knock before entering a room or call before entering through a curtain
8. offer a chaperone to my patients for examinations and procedures
9. ensure my patients (and their carers) are involved in the decisions about their care
10. ensure my patients have the opportunity to wash their hands after using the toilet, commode, bed pan and prior to meal times
11. ensure my patients’ modesty is protected at all times:
   • provide blankets
   • patients are appropriately covered up, while in bed, at bedside, in clinics, transferring to other areas of the hospital
12. ensure curtains or screens are closed properly when my patients are expected to undress
13. ensure I have my patients’ permission to be washed or examined

We also encouraged staff to come up with their own ideas for improving privacy and dignity. Following the implementation of new wrap around hospital gowns a new poster was designed for patients. This gives patients instructions on how to put on their hospital gown to ensure their privacy and dignity is maintained at all times.

The poster was the brainchild of radiographer Holly Stevens who noticed patients struggling with putting on the new gowns. She suggested the poster as part of our Staff Leading Improvement programme. The programme encourages staff to come up with positive ways to enhance our services and suggest more efficient ways of working.

Other improvements we made included the provision of new privacy screens in the Outpatient Department and new curtains and clips for ward areas to improve privacy.

We were pleased that the Care Quality Commission (CQC) recognised the improvements that we had made when they re-inspected the Trust in August 2014.

The CQC Report October 2014 noted that “the trust has taken steps to ensure that patients received timely care and that they and their relatives were treated with dignity and respect”.

Risk assessments and care plans

A further action from the Care Quality Commission (CQC) inspection report in December 2013 was to ensure that all patients had their needs assessed and care delivered safely and in a timely manner by staff who are skilled to do so. Our focus for 2014/15 has been to improve standards of nursing documentation through education and training and also through innovation and use of information technology.

Additional ward based training sessions have been run throughout the year and updates included as part of clinical induction and essential core skills (mandatory) training. Ward sisters, directorate matrons and care group heads of nursing and quality have routinely promoted good practice and have undertaken regular spot checks of compliance. Internal peer reviews have also been used to review and share improvement stories.

Compliance is monitored monthly and results are given back to ward teams to discuss areas and actions for improvement. Spot checks are also completed by matrons and during internal peer reviews. Results for 2014/15 show improvement from 2013/14.
Electronic Nurse Assessments (eNA)

As part of our review of nursing documentation we have also involved our in house IT and information teams to work with clinical leads to design and develop Electronic Nurse Assessments (eNA).

eNA is a mobile solution for use on the ward with ‘apps’ to allow wards to complete core risk assessments for pressure damage, nutrition, mobility, falls and dementia electronically at the bedside. Wards already use iPod and iPad devices to record basic observations such as temperature and blood pressure so expanding use to nursing risk assessments seemed the next logical step.

Alongside the risk assessment tools, we have developed a ‘clinical compass’ management function that can display compliance in real time at bay, ward, directorate and care group level. The functionality will enable ward leaders and matrons to see in real time where patient assessments need to be completed or reviewed. The clinical compass will also allow clinical staff to drill down to an individual patient episode and look at trends of risk assessment data over specific time periods.

We have completed initial testing and piloting of the eNA applications and we are aiming to go live from July 2015. This will be in parallel with a roll out of a revised shorter and streamlined version of nursing care plan documentation.

The project aims to deliver the following benefits:

- improved patient safety by increasing compliance with risk assessments and appropriate clinical actions
- reduced human error and improved accuracy through automated calculations
- immediate access to patient risk assessment information
- introduction of real time monitoring of compliance
- reduction in time required to complete nursing documentation
- reduction in unnecessary duplication and double entry of patient data

### Average compliance score

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<td>Falls risk assessment</td>
<td>89%</td>
<td>90%</td>
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<tr>
<td>Waterlow (pressure ulcer risk assessment)</td>
<td>87%</td>
<td>93%</td>
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<tr>
<td>MUST (nutritional risk assessment)</td>
<td>71%</td>
<td>84%</td>
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<tr>
<td>Mobility risk assessment</td>
<td>87%</td>
<td>91%</td>
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<tr>
<td>Bedrails risk assessment</td>
<td>92%</td>
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Work commences on refurbishment Ward 26
Seven days working in CT/MRI introduced
New pharmacy tracker screen introduced
New signage in ED
Insertable cardiac monitors introduced
Internal clinical quality review programme started
Seven day working SALT service
Electronic MUST calculator implemented on wards
New acute kidney injury service introduced
Diabetes rapid access clinic
Eye Unit nominated by patients for national award
New patient tracking software in Cardiology
CQC follow-up inspection
Rapid Access Heart Failure clinic launched
Respiratory Early Discharge Service expanded
## Quality Success Stories

**2014/15**

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<tr>
<td>25th Anniversary of Cardiac Rehabilitation Service</td>
<td>CQC follow-up inspection published</td>
<td>Resuscitation team receives national prize for audit success</td>
<td>Dedicated heart failure ward opened</td>
<td>Gastroenterology service extended to seven day service</td>
<td>Sign up to safety pledge and plan submitted</td>
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<td>Seven day working in US introduced</td>
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<td>Electronic bed management system introduced</td>
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<td></td>
<td></td>
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<td>New Birth Centre opened</td>
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<td>New emergency laparotomy pathway introduced</td>
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<td></td>
<td>Trust receives Information Standard for patient information (2nd year running)</td>
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<td></td>
<td></td>
<td>Datix web roll-out started</td>
</tr>
</tbody>
</table>

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<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>25th Anniversary of Cardiac Rehabilitation Service</td>
<td>CQC follow-up inspection published</td>
<td>Resuscitation team receives national prize for audit success</td>
<td>Dedicated heart failure ward opened</td>
<td>Gastroenterology service extended to seven day service</td>
<td>Sign up to safety pledge and plan submitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Seven day working in US introduced</td>
</tr>
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<td></td>
<td>Electronic bed management system introduced</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>New Birth Centre opened</td>
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<td></td>
<td></td>
<td></td>
<td>New emergency laparotomy pathway introduced</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Trust receives Information Standard for patient information (2nd year running)</td>
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<td></td>
<td></td>
<td>Datix web roll-out started</td>
</tr>
</tbody>
</table>
Our quality priorities for 2015/16

In order to identify priorities for quality improvement in 2015/16, we have used a wide range of information sources to help determine our approach. These include:

- gathering the views of patients, public and carers using real-time feedback, surveys, focus groups and one to one meetings
- collating information from claims, complaints and adverse incidents
- using the results of clinical audits, inspections and patient surveys to tell us how we are doing in relation to patient care, experience and safety
- considering the views of our commissioners as part of our shared quality and performance meetings and their feedback following formal announced and unannounced inspections
- listening to what staff have told us during executive director patient safety walkrounds, briefing sessions and internal peer reviews
- canvassing the views of staff through our vision and values workshops

We have taken into account the comments made by the Care Quality Commission (CQC) inspection team in its follow up report and in subsequent progress meetings. We have reviewed our current CQC action plan as part of setting our principal quality priorities and improvement objectives for 2015/16.

We have also considered the results of the national staff survey to help us decide where we need to focus our quality improvement efforts and actions. We have taken on board the national picture for patient safety and collaborated with clinical commissioning groups as part of wider strategy work and clinical service reviews. We have also considered the 2015-2018 priorities of the Wessex Academic Health Science Network and our planned participation in the Wessex Patient Safety Collaborative work streams for sepsis, transfers of care, measurement and leadership.

The Trust has formally consulted with key stakeholders (general public, staff, patients, governors and commissioners) to help identify quality improvement priorities for 2015/16. Priorities have been considered with clinical staff as part of service delivery and clinical governance meetings.

We have also considered any current actions plans in place, for example those forming our response to the Francis Report, our sign up to safety plan and other national reports issued on patient safety and quality.

Our overall aim is to continue to improve the quality of care we provide to our patients ensuring that it is safe, compassionate and effective, while ensuring that it is informed by, and adheres to, best practice and national guidelines. We will drive continued improvements in patient experience, outcome and care across the whole Trust using a standard quality improvement (QI) methodology. We will continue to support and develop our staff so they are able to realise their potential and further develop a Trust culture that encourages engagement, welcomes feedback, and is open and transparent in its communication with staff, patients and the public.

Following consultation, our Board of Directors has agreed that the specific quality priorities for 2015/16 should be:

- achieving consistency in quality of care by a year on year improvement in providing harm free care, measured by a reduction in serious incidents
- ensuring patients are cared for in the correct care setting on wards by improving the flow of patients admitted non electively and reducing the average number of outlying patients and non-clinical patient moves by at least 10%
- reducing the number of avoidable category three and four pressure ulcers acquired in our hospital in 2015/16 by 25%, measured through Adverse Incident Reports
- ensuring that there are no MRSA bacteraemia cases and that the Trust achieves its target of no more than 14 clostridium difficile cases
improving the management of sepsis, ensuring we implement the six key interventions (high-flow oxygen, fluid bolus, blood cultures, IV antibiotics, monitoring urine output, and measuring lactate) within one hour of patients being identified as having sepsis or being in septic shock.

- implementing the Department of Health’s best practice guidance for effective discharge and transfer of patients from hospital and intermediate care. These include developing a clinical management plan for every patient within 24 hours of admission; ensuring all patients having an estimated date of discharge within 24-48 hours of admission; undertaking daily discharge board rounds and involving patients and carers in informed decisions about their ongoing care and discharge.

- ensuring uniform use of surgical checklists across the whole organisation with the intention that there are no ‘never events’ associated with failure to use checklist.

- implementing the National Institute for Healthcare and Care Excellence (NICE) guidelines for patients referred with suspected GI cancer ensuring patients receive an appointment within two weeks.

Sentinel Stroke Audit Programme (SSNAP)

- to improve access to the Stroke Unit within four hours.
- to increase the number of nurses who are competent to perform swallow tests.
- to improve the quality of data collection especially the clinical indicators.
- to review and improve access and treatment times for stroke patients.

To coordinate implementation of these aims and objectives, we have developed a comprehensive Sign up to Safety Plan. Progress against the plan will be monitored by the Board of Directors, Healthcare Assurance Committee, Workforce Committee and the Quality and Risk Committee.

Statements of assurance from the Board of Directors

This section contains eight statutory statements concerning the quality of services provided by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that provides a local context to the information provided in the statutory statements.

Review of services

During 2014/15 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provided and/or subcontracted eight relevant health services (in accordance with its registration with the Care Quality Commission):

- management of supply of blood and blood derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- maternity and midwifery services
- family planning
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury

The Trust has reviewed all the data available to them on the quality of care in eight of these relevant health services. This has included data available from the CQC, external reviews, participation in National Clinical Audits and National Confidential Enquiries and internal peer reviews.

The income generated by the relevant health services reviewed in 2014/15 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2014/15.
The data reviewed for the Quality Account covers the three dimensions of quality - patient safety, clinical effectiveness and patient experience. Information reviewed included directorate clinical governance reports, risk register reports, clinical audit reports, patient survey feedback, real time monitoring comments, complaints, compliments, adverse incident reports, quality dashboards and quality and risk data.

This information is discussed routinely at Trust and directorate quality, risk and clinical governance meetings. There is a clear quality reporting structure where scheduled reports are presented from directorates and specialist risk or quality sub groups to the Quality and Risk Committee, Healthcare Assurance Committee, Trust Management Board and Board of Directors each month. Many of the reports are also reported monthly and/or quarterly to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

Participation in clinical audit

During 2014/15, 31 national clinical audits and four national confidential enquiries covered relevant health services that The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust provides.

During 2014/15, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Royal Bournemouth and Christchurch Hospitals NHS Foundation was eligible to and did participate in, and for which data collection was completed during 2014/15, are listed on the next page alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.
<table>
<thead>
<tr>
<th>National Clinical Audits for Inclusion in Quality Report 2014/15</th>
<th>Eligible to Participate</th>
<th>Participated in 2014/15</th>
<th>Data Collection completed in 2014/15</th>
<th>Rate of case ascertainment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute coronary syndrome or Acute myocardial infarction (MINAP)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>98.9%</td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>■</td>
<td>■</td>
<td></td>
<td>Data collection ongoing</td>
</tr>
<tr>
<td>British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing</td>
<td>■</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>732 cases</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>Not available</td>
</tr>
<tr>
<td>Chronic Kidney Disease in Primary Care</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric Cardiac Surgery)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Coronary Angioplasty/National Audit of PCI</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>Not available</td>
</tr>
<tr>
<td>Diabetes (Adult) - National Diabetes Inpatient Audit (NADIA)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Diabetes (Paediatric)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Elective Surgery (National PROMS programme)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>Data collection ongoing</td>
</tr>
<tr>
<td>Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme Pilot Audit</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>100% (40 cases)</td>
</tr>
<tr>
<td>Fitting child (Care in Emergency Depts)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>Unable to reach minimum sample size required</td>
</tr>
<tr>
<td>Head and Neck Oncology (DAHNO)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Inflammatory Bowel Disease</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>Data collection ongoing</td>
</tr>
<tr>
<td>Lung Cancer (NLCA)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>Data collection ongoing</td>
</tr>
<tr>
<td>Major Trauma: the Trauma and Audit Research Network (TARN)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td></td>
</tr>
<tr>
<td>Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>No relevant cases to submit this year</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>100%</td>
</tr>
<tr>
<td>Audit Programme</td>
<td>Status</td>
<td>Data Collection Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health (Care in Emergency Departments)</td>
<td></td>
<td>50 cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td></td>
<td>Pilot only - Trust not selected to take part</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td></td>
<td>Trust not registered by Commissioners to participate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td></td>
<td>Data collection ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td></td>
<td>71 cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme</td>
<td></td>
<td>24 cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td></td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td></td>
<td>Data collection ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td></td>
<td>Data collection ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td></td>
<td>Data collection ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td></td>
<td>Data collection ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-invasive Ventilation - Adults</td>
<td></td>
<td>No National audit data collection in 2014/15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td></td>
<td>Data collection ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older People (Care in Emergency Departments)</td>
<td></td>
<td>100 cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric Intensive Care Audit Network (PICANet)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pleural Procedures</td>
<td></td>
<td>11 cases</td>
<td></td>
<td></td>
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<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pulmonary hypertension (Pulmonary hypertension audit)</td>
<td></td>
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</tr>
</tbody>
</table>
Rheumatoid and Early Inflammatory Arthritis | Data collection ongoing
---|---
Sentinel Stroke Audit Programme (SSNAP) Post Acute Organisational Audit | >90%
Sentinel Stroke Audit Programme (SSNAP) Clinical Audit | >90%

<table>
<thead>
<tr>
<th>National Confidential Enquiries for Inclusion in Quality Report 2014/15</th>
<th>Eligible to Participate</th>
<th>Participated in 2014/15</th>
<th>Data Collection completed in 2014/15</th>
<th>Rate of case ascertainment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Haemorrhage</td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Acute Pancreatitis</td>
<td></td>
<td></td>
<td></td>
<td>Data collection ongoing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centre for Maternal and Child Death Enquiries for Inclusion in Quality Report 2014/15</th>
<th>Eligible to Participate</th>
<th>Participated in 2014/15</th>
<th>Data Collection completed in 2014/15</th>
<th>Rate of case ascertainment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Deaths</td>
<td></td>
<td></td>
<td></td>
<td>No cases to report</td>
</tr>
<tr>
<td>Perinatal Deaths</td>
<td></td>
<td></td>
<td></td>
<td>No cases to report</td>
</tr>
</tbody>
</table>

The reports of 22 national clinical audits were reviewed by The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- the Trust participated in the national falls audit pilot. The Trust results were better than the national average across all aspects of the audit. However areas for further improvement were identified. The audit resulted in a review of the patient falls leaflet so that it can be made more available to staff, patients and carers. The Trust falls risk assessment tool has also been amended to include the measurement of lying and standing blood pressure

- the National Comparative Audit (NCA) of Blood Transfusion programme audit 2014 highlighted that patients were not always provided with a written information leaflet prior to formal consent. All staff have been reminded to provide the leaflet in addition to verbal information. An additional process step to check consent is also being considered for the electronic hand held devices used for safe blood tracking and administration. Screensavers in clinical areas have also been used to promote good consent practice

- in response to the National Emergency Laparotomy Audit report 2014, the Trust has implemented a laparotomy quality improvement programme for 2015/16

- following a review of the National Chronic Obstructive Pulmonary Disease (COPD) Audit 2014 results, new posters have been displayed at all blood gas machines to remind staff to document how much oxygen a patient receives. The DAIRS team review all COPD patients at weekends and a pharmacist joins post take ward rounds to check oxygen prescriptions. A respiratory/endocrine consultant is also now available on Sundays to facilitate discharges

- The Maternal Infant and Newborn Programme results identified the need to develop a sepsis pathway for suspected
maternal sepsis. The Trust is also working on a multi-agency evidence based guideline to standardise and improve the care of pregnant and post-partum women with epilepsy.

The Trust did not participate in three national audits this year:
- the Trust was not selected to participate in the National Audit of Dementia pilot
- the Trust was unable to reach the minimum sample required for the College of Emergency Medicine Audit on the Fitting Child
- the Trust was not registered by the Commissioners for the National Intermediate Care Audit - providers were unable to register separately for this audit

Results of local clinical audits are reviewed within the directorates and at directorate clinical governance committees. A summary of actions noted from clinical audits is reviewed quarterly by the Trust’s Quality and Risk Committee and by the Healthcare Assurance Committee. The Clinical Audit and Effectiveness Group reviews all submitted audit reports on a monthly basis.

The Trust has developed a detailed clinical audit plan for 2015/16 to include national, corporate and local clinical audit priorities. Progress is monitored via directorate clinical governance committees and the Trust Clinical Effectiveness and Audit Group. Progress is also reported quarterly to the Healthcare Assurance Committee, Audit Committee and Board of Directors.

The reports of 297 local clinical audits were reviewed by the Trust in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided:
- an audit of dementia care standards resulted in improvements to care plan documentation and a review of elderly care pathways. The review resulted in the introduction of a new Short Stay Unit, a Ambulatory Care for the Older Person Clinic and increased geriatrician presence at the front door. All inpatient therapy proformas now include the Barthel functional assessment. A structured training programme has also been developed for staff caring for people with dementia
- an audit of support following fetal loss resulted in an amendment to maternity policies to ensure there is always a visit by the named bereavement midwife
- following an audit of neutropenic sepsis in transplant patients, the Trust is to adopt protocol driven administration of antibiotics by nurses to these patients to avoid delays. Prompt reporting of temperature spikes in patients has also been enhanced
- an audit in our Ophthalmology Department has resulted in a tightening of referral criteria to the Acute Referral Clinic and implementation of a new easier referral form
- an audit of seizure management in the Emergency Department resulted in an educational session on first fit pathway being included in the junior doctors core induction

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 1,658. This compares to the 2013/14 value of 1,182 and therefore represents a significant increase in activity for the year.

In 2014/15 the Trust achieved 128% of the National Institute for Health Research (NIHR) recruitment target, testimony in part to the restructuring of research. There has been a complete reorganisation in how research staff are managed, culminating in the development of the Research and Innovation Directorate.

Our recruitment total for 2013/14 is categorised by:
- interventional
  - 50 studies, 494 participants
- observational
  - 33 studies, 967 participants
- large scale
  - 3 studies, 44 participants
- commercial studies
  - 26 studies, 153 participants

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has the third highest number of NIHR recruiting commercial studies in the Wessex Clinical Research Network (CRN). Our non-NIHR commercial research is supported by our partnership agreement with Quintiles (a clinical research organisation), which is now reaping rewards and we have been offered ‘named’ investigator studies in areas relatively new to research, e.g. gastroenterology.

We remain in a strong position to respond to Quintiles’ pipeline activity particularly in cardiovascular/diabetes and infectious diseases/hepatology.

We have supported the growth of research in orthopaedics with two chief investigators of multi-national studies. In response to the Prime Minister’s dementia challenge the lead research nurse, in consultation with the dementia matron, is appointing a dementia research nurse embedded in what will become a research-active dementia nurse team.

Our consultant podiatrist presented her research findings in an international conference on podiatry in 2014.

**Use of Commissioning for Quality and Innovation (CQUIN) payment framework**

A proportion of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.


The total income available to the Trust was £4,937,000 against which the Trust achieved income totalling £4,707,000.

Due to the nature of the contractual arrangements in place in the prior year, the Trust’s income during 2013/14 was not conditional upon achieving quality improvement and innovation goals.
Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. This means that the Trust does not have any current restrictions on its practice or services.

The CQC has not taken any enforcement action against the Trust during 2014/15.

The Trust has participated in special reviews or investigation by the CQC relating to the following areas during 2014/15:

The CQC inspected the Royal Bournemouth Hospital on the 13, 14 and 18 August 2014 as a follow up to the full inspection undertaken in October 2013.

During the inspection in October 2013 the CQC highlighted three specific compliance breaches relation to care and welfare of patients (Regulation 9), monitoring the quality of service provision (Regulation 10) and respecting the dignity of patients (Regulation 17). The CQC report highlighted four must do actions relating to where it considered that essential standards of quality and safety were not being met. At the follow up inspection in August 2014, the CQC found that “significant improvement had been made” and all the required actions had been implemented.

The CQC made particular reference to improvement in the following areas:

- greater focus on improving quality
- “We found some exceptional examples of care and attention provided by staff at all levels and disciplines across the organisation.”
- a strong emphasis on clinical leadership
- strengthened governance structures at all levels
- board members and senior management receiving more robust assurance of quality in all areas

“We found a clear commitment to quality improvement at all levels of the organisation and more robust quality assurance processes.”

- significant steps to create an open, transparent and learning culture at all levels of the organisation
- a new assessment ward and pathways that improved the care for older people and the flow of patients through the hospital
- increased staffing levels and support for junior doctors
- improved security arrangements in the Emergency Department
- improved outpatient booking processes and a reduction in unnecessary waits
- the appointment of clinical matrons and support for ward sisters to focus on leadership and supervision of staff and effective care
- improved ongoing assessment, planning and monitoring of care planning, along with support for newly qualified staff

“At follow up inspection we found that all services we visited were caring.”

- greater opportunities for staff to attend mandatory training
- privacy and dignity

“The Trust has taken steps to ensure that patients received timely care and that they and their relatives were treated with dignity and respect.”

Care Quality Commission
August 2014

The Trust has taken the following action to address the conclusions or requirements reported by the CQC. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has made the following progress by 31 March 2015 in taking such action.
<table>
<thead>
<tr>
<th>CQC Report recommendation, August 2014</th>
<th>Trust Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust should increase privacy for patients in the Emergency Department’s Majors Department by providing frosted glass or privacy film to the externally facing windows in cubicles</td>
<td>Completed</td>
</tr>
<tr>
<td>The Trust should take action to improve the service for stroke patients in line with national benchmarking for stroke patients, particularly for patients admitted at weekends or out of hours</td>
<td>Ongoing</td>
</tr>
<tr>
<td>The Trust should ensure that for patients who require their fluid intake and/or output to be monitored that this is accurately recorded</td>
<td>Complete with ongoing review</td>
</tr>
<tr>
<td>The Trust should ensure that the records of checks of essential equipment are accurately and consistently recorded on ward areas</td>
<td>Complete with ongoing review</td>
</tr>
<tr>
<td>The Alzheimer’s Society booklet ‘This is Me’ should be completed for patients living with dementia</td>
<td>Complete with ongoing review</td>
</tr>
<tr>
<td>The Trust should take action to improve the mental health care pathway in the Emergency Department which is not yet a 24-hour service</td>
<td>Additional training provided for Emergency Department (ED) staff. Additional mental health team input to ED commissioned by Dorset Clinical Commissioning Group</td>
</tr>
<tr>
<td>The Trust should work with commissioners to clarify admission criteria and suitable locations for 16-17 year olds requiring admission to hospital from the Emergency Department</td>
<td>Complete with ongoing review</td>
</tr>
<tr>
<td>The Trust Emergency Department should consider a more robust checking procedure of ensuring that transfer equipment is routinely returned to its base and left in a clean and charged condition ready for immediate use when necessary</td>
<td>Complete</td>
</tr>
<tr>
<td>The Trust should take action so that nursing staff who have the skills to provide an outreach stroke service to patients on other wards of the hospital are able to provide this service</td>
<td>Complete</td>
</tr>
<tr>
<td>The availability and visibility of hand cleansing gel in the outpatient department should be improved</td>
<td>Complete</td>
</tr>
</tbody>
</table>

A full copy of the August 2014 inspection report is available on the Trust website and also on the CQC website: [www.cqc.org.uk/sites/default/files/new_reports/AAAA1845.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/AAAA1845.pdf)
Data quality

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patients’ valid NHS number was 99.7% for admitted patient care; 99.9% for outpatient care; and 97.6% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was 99.9% for admitted patient care; 99.9% for outpatient care; and 99.8% for accident and emergency care.

Collecting the correct NHS number and supplying correct information to SUS (secondary user service) is important because it:

- is the only national unique patient identifier
- supports safer patient identification practices
- helps create a complete record, linking every episode of care across organisations

This standard covers the specific issue of capture of NHS numbers. The wider data quality measures and assurance on information governance are covered next.

The income generated by the relevant health services reviewed in 2014/15 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2014/15.

Information Governance Toolkit attainment levels

All NHS trusts are required to complete an annual information governance assessment via the Information Governance Toolkit. The self-assessment must be submitted to the Health and Social Care Information Centre, with all evidence uploaded by 31 March 2015.

The Trust’s Information Governance Assessment Report overall score for 2014/15 was 37% and was graded as not satisfactory.

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS trust and submitted to the Health and Social Care Information Centre on 31 March each year. The purpose of the IG Toolkit is to provide assurance of an organisation’s information governance practices through the provision of evidence around 45 individual requirements.

During 2014/15, the Trust has undertaken a wholly different approach to the completion of its IG Toolkit submission, removing all previous evidence and starting afresh with closer scrutiny of all of the requirements in order to give a higher quality of assurance.

This apparent decline is not indicative of a fall in information governance compliance, but rather more reflective of the approach to evidencing the specific standards within the IG Toolkit audit, some of which are highly prescriptive. In previous years, the Trust has needed to take a pragmatic approach to managing this work which was commensurate with the resource available to carry out the audit. However it is widely recognised that good information governance can be built around the tenets of this audit, and this can only be achieved through a more rigid adherence to these requirements. As such, going forward a greater focus is to be placed on attaining a robust level of compliance with each of these requirements which will in turn give a greater level of assurance of the Trust’s information governance practices.
Much of this audit is underpinned by work associated with information risk assurance. Once this work is established and firmly embedded within the Trust, this will inform compliance with many of the requirements within the IG Toolkit. In order to succeed we have identified information asset owners in all areas to ensure that the information systems under their control are compliant with the relevant IG Toolkit requirements.

There has been a reduction, and therefore improvement, in the number of reported breaches of information governance during 2014/15. In 2014/15 only 54 breaches were reported. This compared to 65 breaches in 2013/14.

Coding error rate

The Trust was subject to the Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period of diagnosis and treatment coding (clinical coding) were 9.4%.

The results should not be extrapolated further than the actual sample audited; the services that were reviewed within the sample were as follows:

- Finished Consultant Episodes (FCE’S) in 100 FCE’S randomly selected
- 100 FCE’S from Healthcare Resource Group (HRG) BZ
- 100 FCE’S from Healthcare Resource Group DZ

Clinical coding is the process by which medical terminology written by clinicians to describe a patient’s diagnosis, treatment and management is translated into standard, recognised codes in a computer system. It is important to note that the clinical coding error rate refers to the accuracy of this process of translation, and does not mean that the patient’s diagnosis or treatment was incorrect in the medical record. Furthermore, in the definition to determine the clinical coding error rate, ‘incorrect’ most commonly means that a condition or treatment was not coded as specifically as it could have been, rather than there was an error.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust will be taking the following action to improve data quality in 2014/15. The Trust will aim to make further improvement in the clarity of discharge summaries by clinicians to enable easier coding. The Trust is also in the process of implementing a new program to scan all notes and move to an electronic document management system. This will also allow access to Poole Hospital documents. This enables coders to view more clinical information when coding patient care episodes. The Trust has also reviewed and validated its coding procedures in year to ensure that the coding of diagnosis and procedures is in line with national standards.
Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report against a set of core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator the number, percentage, value, score or rate (as applicable) for the last two reporting periods (where available) are presented in the table below. In addition, where the required data has been made available by the HSCIC, a comparison with the national average and the highest and lowest national values for the same indicator has been included. The Trust considers that the data presented is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary Hospital level Mortality Indicator (SHMI)</td>
<td>Health and Social Care Information Centre (HSCIC)</td>
<td>October 13 - September 14 1.009</td>
<td>1.00</td>
<td>1.198</td>
<td>0.597</td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 12 - June 13 107.4</td>
<td>100</td>
<td>118.6</td>
<td>63.0</td>
</tr>
</tbody>
</table>

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission to HSCIC. The data has been extracted from available Department of Health information sources. The SHMI for Oct13-Sep14 are taken from [https://indicators.ic.nhs.uk/nesstar/docs/plot.HTML](https://indicators.ic.nhs.uk/nesstar/docs/plot.HTML).

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to continue to improve this rate, and so the quality of its services, by routinely monitoring mortality rates. This includes looking at mortality rates by speciality diagnosis and procedure. A systematic approach is adopted whenever an early warning of a potential problem is detected - this includes external review where appropriate. The Trust Mortality Group, chaired by the Medical Director, routinely reviews mortality data and initiates quality improvement actions where appropriate.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust</td>
<td>HSCIC</td>
<td>October 13 - September 14 44.0%</td>
<td>24.2%</td>
<td>49.4%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 12 - June 13 33.8%</td>
<td>21.3%</td>
<td>44.9%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reason. The data has been extracted from available Department of Health information sources. The figures for Oct13-Sep14 are taken from April 2015. Publication of data is found here [https://indicators.ic.nhs.uk/webview/](https://indicators.ic.nhs.uk/webview/). Figures reported are ‘diagnosis rate’ figures and the median average is used for the national value.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the routine review of mortality reports.
### Quality Indicator: % of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCIC</td>
<td>2014/15</td>
<td>2013/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(i) = 0</td>
<td>(ii) = 3670 (10.4%)</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(ii) = 3298 (9.82%)</td>
<td></td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely audited prior to submission.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by routine monitoring of performance data and root cause analysis investigations where appropriate.

### Quality Indicator: Responsiveness to the personal needs of patients

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Inpatient Survey</td>
<td>2014 - 54%</td>
<td>47%</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>2013 - 77%</td>
<td>76.9%</td>
<td>87%</td>
<td>67.1%</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reason. The data source is produced by the Care Quality Commission.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services. An action plan that addresses the issues raised in the report has been developed and will be overseen by Patient Experience and Communications Committee, which is a sub committee of the Board of Directors.

### Quality Indicator: Staff who would recommend the Trust to family or friends

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Inpatient Survey</td>
<td>2014 - 70.79%</td>
<td>67.45%</td>
<td>89.27%</td>
<td>38.17%</td>
</tr>
<tr>
<td></td>
<td>2013 - 71.37%</td>
<td>67.11%</td>
<td>93.92%</td>
<td>39.57%</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reason. The exercise is undertaken by an external organisation with adherence to strict national criteria and protocols. Data from question level data here [www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2014-Detailed-Spreadsheets/](http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2014-Detailed-Spreadsheets/).

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust intends to take the following action to improve this percentage, and so the quality of its services, by implementation of a detailed action plan. The results of the survey have been presented to the Workforce Committee (a sub committee of the Board of Directors) and key actions agreed.
### Friends and Family Test - (i) for inpatients and (ii) for patients discharged from Accident and Emergency (types 1 and 2)

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i)</td>
<td>March 2015</td>
<td>98%</td>
<td>95%</td>
<td>100%</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>Feb 2015</td>
<td>97%</td>
<td>95%</td>
<td>100%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td>Jan 2015</td>
<td>96%</td>
<td>94%</td>
<td>100%</td>
<td>51%</td>
</tr>
<tr>
<td>(ii)</td>
<td>March 2015</td>
<td>92%</td>
<td>87%</td>
<td>99%</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>Feb 2015</td>
<td>92%</td>
<td>88%</td>
<td>98%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>Jan 2015</td>
<td>94%</td>
<td>88%</td>
<td>98%</td>
<td>55%</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reason. Data is derived from validated monthly reports collated in accordance with [www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/](http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/)

### Patient Reported Outcome Measures (PROMS) - Case mix adjusted average health gains

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) groin hernia</td>
<td>April 2014 - Sep 2014 (provisional, published Feb 2015)</td>
<td>(i) Not yet available</td>
<td>(i) 0.125</td>
<td>(i) 0.139</td>
<td>(i) 0.009</td>
</tr>
<tr>
<td>ii) varicose vein</td>
<td>April 2014 - Sep 2014 (provisional, published Feb 2015)</td>
<td>(ii) NA</td>
<td>(ii) 0.142</td>
<td>(ii) 0.093</td>
<td>(ii) 0.054</td>
</tr>
<tr>
<td>iii) hip replacement</td>
<td>April 2014 - Sep 2014 (provisional, published Feb 2015)</td>
<td>(iii) 0.413</td>
<td>(iii) 0.442</td>
<td>(iii) 0.501</td>
<td>(iii) 0.350</td>
</tr>
<tr>
<td>iv) knee replacement</td>
<td>April 2014 - Sep 2014 (provisional, published Feb 2015)</td>
<td>(iv) 0.286</td>
<td>(iv) 0.328</td>
<td>(iv) 0.394</td>
<td>(iv) 0.249</td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reason. The number of patients eligible to participate in PROMs survey is monitored each month and the number of procedures undertaken by the Trust is cross tabulated with the number of patient questionnaires used.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by reviewing relevant patient pathways and undertaking a detailed quality improvement programme.

### % of patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients admitted to hospital</td>
<td>HSCIC</td>
<td>2014/15 = 95.2%</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>who were risk assessed for venous thromboembolism (VTE)</td>
<td></td>
<td>2013/14 = 93.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reason. The VTE score is based on the Department of Health definition and agreed by the local commissioners for CQUIN purposes. The source data for this indicator is routinely audited prior to submission.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the implementation of an IT application to support easier data collection and compliance.
<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rate per 100,000 bed days of cases of C difficile infection reported within the trust during the reporting period</td>
<td>HSCIC</td>
<td>2014/15 0.10 / 100000 bed days (21 confirmed)</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2013/14 0.07 / 100000 bed days (14 confirmed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2012/13 0.14 / 100000 bed days (31 confirmed)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission. All cases of clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors. Reporting is in line with the requirements of the Health Protection Agency (HPA) and Monitor.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by ensuring high standards of infection prevention and control are implemented, monitored and maintained.

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Data Source</th>
<th>Trust rate for noted reporting period</th>
<th>National average value</th>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patient safety incidents reported during the reporting period</td>
<td>National Reporting and Learning System (NRLS)</td>
<td>3623 (April 14 - Sept 14)</td>
<td>Not available</td>
<td>12,020 (NRLS Acute Trusts - non specialist)</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3239 (Oct 12 - Mar 13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of patient safety incidents reported during the reporting period</td>
<td>NRLS</td>
<td>36.76 per 1000 bed days (April 14 - Sept 14)</td>
<td>35.1</td>
<td>74.96</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td></td>
<td>39.8 per 1000 bed days (Oct 13 - March 14)</td>
<td>Not available</td>
<td>74.9</td>
<td>5.8</td>
</tr>
</tbody>
</table>

| Number of patient safety incidents reported during the reporting period that resulted in severe harm or death | NRLS | 10 (April14 - Sept 14) | Not available | 0% | 87 |
|                                                                                                               |      | 19 (Apr 13 - Sept 13)  | Not available | Not available | Not available |

| % of total number of patient safety incidents reported during the reporting period that resulted in severe harm or death | NRLS | 0.2% (April14 - Sept 14) | 0.5% | 0% | 82.8% |
|                                                                                                               |      | 0.50% (Apr 13 - Sept 13) | 0.60% | Not available | Not available |
The Trust considers that this data is as described for the following reasons. All data is validated prior to submission to the National Reporting and Learning System. The NRLS enables all patient safety incident reports, including near miss and no harm events, to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission.

The data presented is from the most recent NRLS report April 2014-September 2014.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, supporting an open culture for incident reporting and investigation and has implemented a new web based incident reporting system in 2014/15 to increase opportunities for reporting and further improve feedback and learning pathways.

Nationally under 1% of NRLS patient safety incidents were reported as severe harm or death. The Trust percentage lower than this at 0.2%.

Part 3
Review of quality performance in 2014/15

The following section provides an overview of the performance in 2014/15 against additional key quality indicators selected by the Board of Directors in consultation with stakeholders. The indicators have been selected to demonstrate our commitment to patient safety, clinical effectiveness and enhancing the patient experience. The indicators provide continuity to data presented in the 2013/4 Quality Report and have also been selected on the basis of data collection, accuracy and clarity.

Safety

Reducing adverse events

We support an open culture for reporting and learning from adverse events and near miss patient safety incidents. We promote an open reporting culture through the Adverse Incident Policy and standard Adverse Incident Report (AIR) Form.

Encouraging staff to speak out safely

The Trust supports the Nursing Times Speak Out Safely campaign and the new Freedom to Speak Up Review.

The Trust encourages any staff member with a safety concern to raise it at the earliest opportunity. We recognise that when staff raise concerns it is because they usually know things are not working well and when care could be safer. Staff feedback can help significantly in ensuring high standards of patient care. The Trust has therefore introduced a variety of ways for staff to provide feedback including:

- chatting to the Chief Executive as part of a ‘Tony on tour’ walkround
- speaking to a matron as part of our ‘talk to us’ events and communications
- via Board, staff governors or Chairman walkrounds, workshops and drop in sessions
flagging concerns to their staff side representative

- using the #thank you section on the intranet
- speaking to their line manager, occupational health, human resources or risk management departments

All reported incidents are graded in terms of the actual severity of the incident. Standard gradings set down by the National Patient Safety Agency (NPSA) are applied. All incidents are fully investigated, including near miss and no harm events, and are used as an opportunity for reflective practice, shared learning and quality improvement.

Nationally 70% of incidents reported to the National Reporting and Learning System are recorded as no harm. Nationally just under 1% are reported as severe harm or death. The Trust’s percentages for both 2012/13, 2013/14 and 2014/15 are much lower at 0.5%, 0.6% and 0.37% respectively.

### Learning from serious incidents

In 2013/14 we reported 66 serious incidents (as defined by NHS England Serious Incident Reporting Framework). In 2014/15 the number of serious incidents reported was 46 - a 30% reduction on the previous year.

Examples of changes made as a result of serious incident investigations this year have included:

- provision of additional triage training for Emergency Department staff and provision of additional middle grade cover out of hours
- revision of anticoagulation guidelines
- amendment to clinical pathway to ensure bleeding in a patient with a metal valve is automatically escalated to a cardiology consultant for review
- grand round presentation to all doctors to highlight the importance of acting on abnormal blood results
- changes to cardiac monitoring procedures in Acute Medical Unit
- improvements to decontamination procedures for theatre trays
- provision of additional pressure relieving mattresses for high risk areas

### Table: Patient safety incidents reported to NPSA via the National Reporting and Learning System - April 2014 to March 2015

<table>
<thead>
<tr>
<th>Severity of Incident Reported</th>
<th>Total Number Reported 2014/2015</th>
<th>% of Incidents Reported 2014/2015</th>
<th>Total Number Reported 2013/2014</th>
<th>% of Incidents Reported 2013/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>4,650</td>
<td>66.7%</td>
<td>4,865</td>
<td>70.69%</td>
</tr>
<tr>
<td>Minor / Low</td>
<td>2,168</td>
<td>31.0%</td>
<td>1,802</td>
<td>26.17%</td>
</tr>
<tr>
<td>Moderate</td>
<td>135</td>
<td>1.93%</td>
<td>178</td>
<td>2.59%</td>
</tr>
<tr>
<td>Major / Severe</td>
<td>26</td>
<td>0.37%</td>
<td>41</td>
<td>0.55%</td>
</tr>
<tr>
<td>Total:</td>
<td>6,979</td>
<td></td>
<td>6,886</td>
<td></td>
</tr>
</tbody>
</table>
**Never events**

The Department of Health has defined a list of specific events that are considered unacceptable and eminently preventable. These are called ‘never events’.

In 2014/15 the Trust reported four never events. All of these incidents related to surgical procedures. Although on each occasion the patient did not come to serious harm, detailed investigations concluded that routine safety checklist procedures were not followed robustly and the incident should have been avoided.

As a result of the incident reviews, a Trust-wide quality improvement programme to improve safety checklist procedures has been established. The group is chaired by the Medical Director and involves clinical champions from all areas undertaking surgical or invasive procedures.

To further improve incident reporting and support an open culture for sharing learning, the Trust is currently in the process of implementing a new web based reporting system. The system offers many benefits including cross department and directorate investigations, the opportunity for the person reporting an incident to request automatic feedback, and an end to paper forms being misplaced or lost. Training is being provided to staff on how to use the system and there has been positive feedback from areas already using the new system.

**Improving fluid and hydration**

Our Nutrition and Dietetic Department, Dr Jules Cranshaw, Dr Simon McLaughlin and the Practice Development Group led by Ellen Bull (Deputy Director of Nursing) have all worked together to make improvements in fluid and hydration during 2014/15. This has included:

- implementing a new acute fluid monitoring chart revision and a 24 hour fluid accumulative chart
- establishing a new Theory and Clinical Skills training programme for nurses in August 2014
- producing a short six minute training video on ‘how to complete’ fluid monitoring charts to support implementation of the new charts
- introducing new beverage charts with pictorial vessels and volume measurements for all clinical environments
- purchasing red cups/mugs and red lid jugs to identify patients who require help with fluids and fluid monitoring
- creating new patient information: food and drink patient leaflets have been produced by the Nutrition and Dietetic Department

In addition, in line with recent NICE guidance, the Trust has also produced an intravenous prescribing guide and intravenous fluid prescription chart. Teaching materials and presentations were used to support implementation.

Early safety audit data has shown that there has been a reduction in episodes of hypokalaemia and hyponatraemia since the new IV fluid policy was implemented. Data on fluid management comparing the use of 0.9% saline used by wards during October-December 2013 with that used during the same time period in 2014 has shown that there has been an overall reduction of 66%.

<table>
<thead>
<tr>
<th>Ward / Dept</th>
<th>Oct-Dec 2013 (Quantity in Litres)</th>
<th>Oct-Dec 2014 (Quantity in Litres)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>8,302</td>
<td>2,812</td>
</tr>
</tbody>
</table>

Further monitoring and audit will be undertaken in 2015/16 to measure additional improvements achieved.

**Reducing acute kidney injury (AKI)**

In response to a National Confidential Enquiry report on Acute Kidney Injury, we implemented a new nurse led AKI service in September 2014. The AKI nurse specialist attends all AKI stage two and three patients on medical and surgical wards to assist with their diagnosis, management and care. The Pharmacy Team is also an integral part of the service and alerts clinicians to the presence of AKI stage one in all the wards around the hospital. We have also introduced AKI alert stickers, new cumulative fluid balance charts, escalation
New Acute Fluid Management (AFM) chart - for strict input / output monitoring

**What?** The Daily Goal - should be clearly identified on the ward round.

**Nurses** - please ask for this and any special instructions, to be completed!

**Why?** All nurses caring for the patient then know what they are aiming for during their shift and can escalate quickly if their patient is becoming overloaded or fluid depleted not meeting the Daily Goal.

**What?** Each shift is responsible for completing 4 hourly totals and balance, but at midnight, 24 hour totals and balance should be completed, remembering to deduct 500mls insensible loss.

Transfer totals to separate Cumulative Balance Chart (old pink summary chart)

**What?** Base guide urine output on calculated weight based on the patient’s height.

**Why?** This is a safer way to estimate both IV fluids in and urine output and helps to avoid the risk of fluid overload.

**What?** The trigger criteria should be clearly identified on the ward round.

**Why?** All nurses caring for the patient then know what they are aiming for during their shift and can escalate quickly if their patient is becoming overloaded or fluid depleted not meeting the Daily Goal.

**What?** Using the guide on the back of the AFM chart, fill in the hourly and 8 hourly guide urine output.

**Why?** You can quickly refer to these to help assess if your patient is passing sufficient urine.

**What?** Only a small number of patients will require strict input / output monitoring - but on those it must be accurate and complete (Other patients may need a Food and Drink chart instead)

**Why?** Only enter amounts of fluid actually taken, no lines across columns to show when IVs start and are due to finish!

**What?** You need numbers to add up totals and calculate an accurate fluid balance

**What?** Complete the Running Totals (R/T) in and out for 4 hourly and calculate the balance.

**Why?** Inform the nurse in charge of any concern and document in the patient’s Health Care Record (refer to Trigger Criteria on the back of the AFM chart).

In 2015/16 we are aiming to continue with the service as well as developing additional in house training for ward staff. The AKI Team is also developing an education programme for primary care (including GPs and community pharmacists); an outreach service for primary care and telephone and follow up clinics.

A comparative audit of three months data collection has demonstrated (in a highly selective group of patients) a reduction in mortality, length of stay and re-admission rate in the AKI stages two and three seen by the AKI nurse specialist.

An initial audit of the impact of the new service (three months post implementation) suggests that there have been significant improvements in patient care.

<table>
<thead>
<tr>
<th></th>
<th>Audit results before introduction of AKI service</th>
<th>Audit results after introduction of AKI service</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of AKI patients</td>
<td>188</td>
<td>148</td>
</tr>
<tr>
<td>Mortality rate</td>
<td>23 (12%)</td>
<td>8 (5%)</td>
</tr>
<tr>
<td>Readmission rate (within 28 days)</td>
<td>45 (24%)</td>
<td>14 (9%)</td>
</tr>
<tr>
<td>Mean length of stay</td>
<td>15 days</td>
<td>9 days</td>
</tr>
<tr>
<td>No. of patients admitted to ITU</td>
<td>11 (6%)</td>
<td>9 (6%)</td>
</tr>
</tbody>
</table>
Effectiveness

Reducing hospital mortality

The Trust’s mortality rate, as expressed in both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI), continues to lie within the “as expected” category.

The Dr Foster mortality metric, known as HSMR, has become a recognised way of assessing hospital mortality. An HSMR value of 100 represents an average ‘expected’ value and therefore a score below 100 demonstrates a better than average position. The NHS, via the Health and Social Care Information Centre, has also developed a slightly different metric SHMI which additionally includes patients that have died within 30 days of being discharged from hospital. SHMI is also calculated slightly differently. Up until now the HSMR figure has been rebased (ie recalibrated against the national average) annually, whereas the SHMI figures is recalibrated each time it is produced. Dr Foster has just changed this which has altered the HSMR figures for this year.

The chart below shows the latest SHMI figures and the comparable HSMR figures. Both are annual figures produced on a quarterly basis. Both figures lie within the ‘as expected’ categories.
Midwifery and draws other programmes under its umbrella, including seven-day working, end of life care and managing the deteriorating patient.

Recent actions arising from the work of the group includes:
- the redevelopment and introduction of a fluid chart, together with associated training
- the recruitment of a consultant with an interest in Acute Kidney Injury (AKI) and the provision of a nurse specialist in this speciality and the introduction of AKI flags on the pathology system
- implementation of a Heart Failure Group and action plan, with a multi-disciplinary team (MDT) approach, the recruitment of two heart failure nurses and the cohorting of heart failure patients

**Improving heart failure services**

A new inpatient Heart Failure Service was set up in December 2013. It currently consists of one full-time heart failure nurse specialist and a heart failure consultant lead.

Ward staff are able to make referrals into the service and specific evidence-based heart failure prescribing guidelines have been produced and made available to staff via the intranet.

We have set up a small team of consultants from around the Trust with an interest in heart failure to support the identification of patients within the hospital with a primary diagnosis of heart failure. The Heart Failure Team also work closely with older people’s medicine, the Palliative Care Team, the Arrhythmia Team and cardiac rehabilitation.

There are monthly educational sessions that are very popular and weekly inpatient MDT meetings on our heart failure unit where each patient is discussed individually and a management plan is agreed.

In order to assess our service and to benchmark with other heart failure services nationally we submit data each month to the National Heart Failure Audit. We are pleased to see that there has already been an improvement in our length of stay figures.

In August 2014 we set up a very successful weekly Rapid Access Heart Function Clinic which is based on referrals from primary care for patients with a high blood-result and heart failure symptoms. All these patients are seen according to NICE guidelines and are given an echocardiogram, full assessment and management plan. We are currently auditing the first six months including a patient satisfaction survey, to assess the impact of this new service.
In November 2014, Ward 21 was re-categorised as a Heart Failure Unit with 12 beds specifically allocated for heart failure patients. This has enabled the staff to develop their skills and knowledge and is beneficial to the heart failure patients to ensure they receive consistent evidence-based care. Once a patient is discharged home they are referred to the community heart failure team for follow up.

Heart failure patients can now also attend specific heart failure cardiac rehabilitation classes to improve their exercise capacity and meet other patients with heart failure. Another recent patient improvement initiative has been to set up a pathway for patients to attend the Treatment Investigation Unit at the Royal Bournemouth Hospital for intravenous frusemide infusions which will prevent readmission into hospital.

We continue to look at additional ways to improve the heart failure service. Our intention is to ensure that all patients admitted to hospital with heart failure are seen by a heart failure specialist nurse within 24 hours of admission, with seven-day working. We also aim for all patients admitted with heart failure to be treated in the specialist Heart Failure Unit. We are developing a heart failure specialist nurse non-medical prescribing policy. This will promote timely provision of discharge treatment.

Improving care for stroke patients

Our stroke service has a combined acute and rehabilitation Stroke Unit with an established reputation of interdisciplinary working striving to provide excellent care and to achieve the best outcomes for our patients. Our purpose-built 36 bedded Stroke Unit includes hyper-acute, acute and rehabilitation beds, neurogym, patients dining and activity room and a therapeutic garden. We have very close working with our colleagues in both the emergency and radiology departments who support the provision of our 24/7 thrombolysis service and initiatives such as our direct door to CT pathway.

We are in the process of implementing our new stroke outreach service which will further streamline the patient pathway to our Stroke Unit and ensure our patients consistently receive early stroke specialist assessments, CT scans and early access to the Stroke Unit. This new team will receive a pre-alert from the ambulance for all suspected stroke patients enabling them to meet the patient in the Emergency Department, or directly at the CT scanner for appropriate patients, undertake all initial assessments and commence early treatment, such as stroke thrombolysis, and facilitate early transfer to the Stroke Unit. We anticipate providing a seven day in-hours service from the end of May 2015 and a seven day 7am-midnight service from mid/end of July 2015.
The Trust admits approximately 750 new stroke patients per annum, making it the busiest stroke service in the Wessex region. As well as our inpatient hyper-acute, acute and rehabilitation provision, we have a stroke Early Supported Discharge (ESD) Team which supports stroke patients with their discharge from hospital. It provides stroke specialist multi-disciplinary rehabilitation in the patients’ home setting enabling earlier discharges from hospital. We also provide a seven day rapid access TIA Service seeing approximately 1,000 TIA patients per annum. The TIA Service is another example of excellent collaborative working as the weekend provision is jointly provided with Poole Hospital and Salisbury Hospital. We provide consultant-led stroke follow-up clinics and have an extremely busy and proactive Stroke Research Team undertaking a wide range of stroke research studies.

There is clear national guidance to support interventions and care processes in stroke. These include for CT scanning, access and stay on a Stroke Unit, thrombolysis, therapy and multi-disciplinary working and discharge.

In 2014/15 we have seen a steady and sustained improvement with the proportion of patients having a CT brain scan within 12 hours of arrival to hospital. In April 2015 a new initiative to enable non-consultant staff to request a CT brain scan for acute stroke patients is being introduced which will further reduce delays enabling quicker access to CT brain scans. The stroke outreach service will also ensure that there is earlier identification of stroke patients, again reducing delays and enabling faster access to required interventions and treatments.

<table>
<thead>
<tr>
<th>SCANNING</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients scanned within 12 hours</td>
<td>76.6% (National Average 87.1%)</td>
<td>81.3% (National Average 87.7%)</td>
<td>82.8% (National Average 88.7%)</td>
<td>85.9% (National Average not available)</td>
</tr>
</tbody>
</table>

All people with suspected stroke should be admitted directly to a specialist acute stroke unit. Throughout 2014/15 we have again maintained our performance and continue to perform above national average. Going forward the new Stroke Outreach Service, by ensuring earlier identification and awareness of stroke patients in the Emergency Department, will enable quicker transfer to the Stroke Unit to be achieved.

<table>
<thead>
<tr>
<th>STROKE UNIT</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients directly admitted to a Stroke Unit within four hours</td>
<td>64.8% (National Average 58%)</td>
<td>66.7% (National Average 59.8%)</td>
<td>59.8% (National Average 56.9%)</td>
<td>68.2% (National Average not available)</td>
</tr>
</tbody>
</table>

Stroke services should provide early supported discharge to stroke patients who are able to transfer independently or with assistance of one person. Early supported discharge should be considered a specialist stroke service and consist of the same intensity and skill mix as available in hospital, without delay in delivery. Our highly performing stroke Early Supported Discharge (ESD) Service supported 211 patients in 2014/15 and recent patient feedback on the service demonstrated that 92.1% of patients were highly satisfied with the service they received from the stroke ESD Team.

Patient feedback:

“... member of the team came to my home on day of my discharge. The team has been so supportive and helpful in all areas - helped with my walking, making meals, handwriting, and have supported and reassured me emotionally and physically. They are very knowledgeable in all areas and able to answer my questions which helped put my mind at ease, which also helped with my recovery. The whole team were absolutely brilliant while maintaining their professionalism. Thank you so much.”
<table>
<thead>
<tr>
<th>STROKE EARLY SUPPORTED DISCHARGE</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients supported by Stroke ESD on their discharge from hospital</td>
<td>64.5% (National Average 58%)</td>
<td>68.3% (National Average 59.8%)</td>
<td>60% (National Average 56.9%)</td>
<td>68.2% (National Average not available)</td>
</tr>
</tbody>
</table>

Ensuring compliance with National Institute for Health and Care Excellence (NICE) guidance

The Trust Clinical Audit and Effectiveness Group reviews compliance with all new National Institute for Health and Care Excellence (NICE) guidance issued each month. For the period from April 2014 to March 2015 the Clinical Audit and Effectiveness Group reviewed a total of 139 newly issued guidance documents. Compliance rates are shown in the following table:

<table>
<thead>
<tr>
<th>Type of Guidance</th>
<th>Published</th>
<th>Applicable</th>
<th>Compliant</th>
<th>Partially Compliant</th>
<th>Non Compliant</th>
<th>Under Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Guidelines</td>
<td>20</td>
<td>16</td>
<td>7</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>National Guidelines</td>
<td>7</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Technology Appraisals</td>
<td>30</td>
<td>26</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Interventionsal Procedures</td>
<td>33</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Public Health Guidance</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical Technology Guidance</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Safe Staffing Guidance</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Quality Standards</td>
<td>30</td>
<td>22</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Diagnostics Guidance</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Highly Specialised Technology Guidance</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>139</strong></td>
<td><strong>82</strong></td>
<td><strong>42</strong></td>
<td><strong>14</strong></td>
<td><strong>0</strong></td>
<td><strong>26</strong></td>
</tr>
</tbody>
</table>

Where non or partial compliance has been identified an appropriate action plan agreed. The majority of guidelines noted in the above table as ‘under review’ relate to those issued during January-March 2015.
Other news

We have some outstanding services that have been recognised for their excellent clinical outcomes, innovation and patient care this year. For example:

- **Improving pre-operative care**
  Our nurse led pre-surgical assessment clinic has been recognised by the Royal College of Anaesthetists in their recent guidelines around pre-operative care for improving pre-operative care and reducing length of stay. The service aims to see people with poor diabetes control prior to surgery to ensure their diabetes is adequately managed in order to ensure that their surgery can go ahead.

- **Promoting patients with diabetes**
  We have started up a new rapid access clinic, a renal diabetes clinic, a transplant-diabetes clinic and we are in the process of setting up the Wessex Hypoglycaemia Service for people with significant difficulties with hypoglycaemia.
  A Diabetes Rapid Access Clinic has been established to facilitate appropriate discharge from hospital and prevent unplanned hospital admissions for people with diabetes. The clinic provides rapid access to specialist advice and is a multi-disciplinary clinic with both a consultant and diabetes nurse specialist present. This allows urgent clinical recommendations (for example starting insulin) to be actioned at the same appointment. The clinic has capacity to see three patients per week and at present the waiting time has not exceeded two weeks.

- **Improving pain management**
  Our Pain Management Team has been working with our Communications Team to raise the profile of pain management and support more staff via educational workshops and on the ward advice. A number of wards have subsequently implemented new ideas in best practice, such as giving patients known to be suffering with pain their medication first during rounds.

Lead nurse in acute pain management, Mandy Layzell, says:

“There are a lot of myths surrounding pain management, so staff members who are trying to help a patient may unknowingly undermine their good work. Better pain management means patients are more likely to sleep and eat well, supporting a speedier recovery.”

As a result of the campaign, the number of patients per month highlighting the need for better pain management has been halved.

**Pathology**

It has been a busy and exciting year for developments in pathology. In addition to meeting the increasing needs of our accreditation bodies, the directorate has worked tirelessly to develop and evolve services in line with the needs of our users. There have been several important improvements that have impacted our processes, informatics systems, staffing and estate with benefits in quality, turn-around time and overall productivity. A few examples of service improvements implemented last year are detailed below:

- **Accreditation - maintaining a culture of ongoing quality improvement**
  Pathology tests are among the most important aspects of modern medicine and it has recently been estimated that pathology contributes to 60-70% of clinical diagnoses. For many conditions, there is no substitute for pathology tests - for example, high blood cholesterol can be detected by testing long before any physical symptoms appear. Pathology is also relied on to help diagnose a wide range of conditions, and to help monitor the response to treatment.
  Consequently there are many processes in place to ensure that pathology does produce reliable, accurate and precise results. These have been instituted by the Government, the Department of Health, pathology professional organisations and individual laboratories themselves to ensure that quality standards are maintained.
Last year pathology at the Royal Bournemouth Hospital was inspected by the Clinical Pathology Accreditation Service when 13 assessors spent 10 days examining the quality of the service. In addition, this year three inspectors from the Human Tissue Authority spent a day reviewing procedures for bone marrow transplants. On both occasions the pathology services and associated working practices were praised and licences to practice retained.

Next year pathology will be inspected by the United Kingdom Accreditation Service (UKAS) as the next stage in evidencing the high quality and accuracy of our service.

- **Clinical haematology - improving outcomes for haematological malignancy**

The Haematological Malignancy Diagnostic Service (HMDS) division of the lab continues to work towards implementation of its bespoke ‘Haemosys’ software; configuration is being completed by lab, clinical and IT staff who are working in close partnership with the software provider. Once implemented, this will enable compliance with the NICE integrated report format which will draw together all the results from one sample to ensure that all pieces of the diagnostic puzzle are available enabling the clinician to make a robust final diagnosis.

- **Blood transfusion - reducing length of shifts increases quality and reduces errors**

Staff in blood transfusion have historically worked an extended shift. However in December, changes were made to shift patterns to reduce lone working overnight. Other changes included extending the evening shift and implementing a second specialist biomedical scientist until 8.30pm.

Audit reveals that during the last quarter the number of minor procedural errors made while lone working has decreased by over 50% - increasing quality and improving patient safety.

- **Microbiology and infection control - reducing hospital acquired infection**

In line with the recommendations from the Department of Health from February 2015, the Trust moved away from blanket screening of MRSA on all admissions. Instead we only screen those who are at clinical risk of contracting a bacteraemia during their stay. This means certain patients will continue to be screened routinely including admissions to wards 7, 11, 14 and critical care and those undergoing invasive procedures such as major arthroplasties, internal defibrillators and breast implants.

The change has enabled wide use of Octenisan wash which minimises a broad spectrum of bacteria on the skin thereby reducing the overall risk of bacteraemia and hospital acquired infections. This initiative therefore promises to improve patient outcomes and is an excellent example of joined up working, challenging the norm and diverting resources to best meet the needs of the patient.

- **Haematology laboratory - supporting front line services**

Royal College of Pathology performance indicators recommend that 90% of full blood count tests should be reported within 60 minutes of receipt by the laboratory. Biomedical staff and medical laboratory assistants have worked hard to review internal laboratory processes to ensure this target is achievable. The department is pleased to report that the target was comfortably met over the last 12 months and the department continues to improve the responsiveness of the service.
Phlebotomy - developing a community model

Last year we worked with the Dorset Clinical Commissioning Group to increase phlebotomy access in the community. Five new clinics were opened in north Bournemouth and an additional service began in Highcliffe on 1 April 2015.

This new model for phlebotomy improves patient choice, reduces waiting times at our outpatient services and moves the service closer to the patient. Feedback from patients and GPs has been extremely positive. We are now in discussion with other GP surgeries and exploring the option of opening a service in a local retail outlet.

Cellular pathology - implementation of electronic workflow management

Cellular pathology has introduced ‘Vantage’, a system which helps protect patients and staff from serious risks associated with sample misidentification. The system is the first of its kind in the industry and the Bournemouth Laboratory is the first in the country to fully install. It has a number of patient benefits and enables staff to:

- virtually eliminate errors with ‘one label, one time’ slide identification
- maintain positive sample ID with barcode scanners at each workstation
- immediately locate any patient’s slide, at any time, from any last scanned location
- easily compile quality reporting documentation
- view a comprehensive dashboard of lab performance at any time
- simplifies workflow
- presents opportunities to improve quality, staffing and efficiencies

Reception refurbishment - improving the patient experience

Works were recently completed on the refurbishment of the Pathology Reception. New lighting, flooring and furniture have improved this waiting area significantly which had not been refurbished since the original build in 1989. The redesigned reception desks is much more welcoming for patients, particularly those in wheelchairs and has allowed for several operational improvements behind the scenes.

Demand management - improving stewardship of resources

The Pathology Department has introduced software to prevent the unnecessary repetition of haematology and biochemistry requests. This software has led to a reduction in reagent spend, ensuring that only clinical relevant requests are processed by the laboratory. Since its implementation the Trust has benefited from significant savings on consumables and has reduced turn-around times for key laboratory investigations.
• **Palliative care**

Despite a significant growth in referrals and minimal increase in resources, the specialist Palliative Care Team has continued to maintain high quality, patient-centred care. The service has seen a 71% increase in referrals over the last five years and 21% increase last year alone, however the unit continues to receive excellent feedback from patients and friends and family surveys.

The Royal Bournemouth Hospital end of life steering group has proven to be dynamic and highly effective. Led by the Associate Medical Director, this group is helping to bring about improvements in end of life care throughout the Trust, especially using tools such as the AMBER care bundle, and the RBCH personalised care plan for the last days of life. A seven day hospital Palliative Care Team will launch later in 2015 which will further improve end of life care and provide additional support for patients and families.

The unit continue to return good performance in various Dorset-wide clinical audits - for example looking at time between referral and telephone contact and face to face assessment, and at concordance with patients’ preferred and actual place of death.

Last year the ‘do not attempt cardio-pulmonary resuscitation’ form was replaced by the new pan-Dorset ‘allow a natural death’ policy and form. The new form is recognised by all health and social care providers in the county, meaning that the resuscitation status of patients moving between settings is clearer for staff, and that this issue does not need to be repeatedly discussed with patients and families.

• **Haematology**

Last year there were multiple haematology consultant research publications in peer reviewed journals. This ongoing effort is testament to the team’s dedication and quality of clinical research carried out at the Trust’s Haematology Department. In addition the department was selected as one of the Myeloma UK clinical research network sites.

• **Ward 10 and 11**

JACIE (Joint Accreditation Committee ISCT EBMT) re-accreditation was achieved this year evidencing the high standard of care we deliver to our transplant patients.

The unit continues to have excellent compliance with education and training standards which supports team morale and internal peer review results. This is supported by outstanding leadership on the ward with nurse-led audit, nurse-led clinics and a multidisciplinary team approach including research.

Plans are well underway to relocate to the new Jigsaw Building. The new facility will significantly improve the patient experience in terms of privacy, dignity and patient flow, while being a more welcoming, modern and spacious environment in which to receive treatment.
Patient experience

Measuring patient experience for improvement is essential for the provision of a high quality service. It is important to ensure that patients and the public are given an opportunity to comment on the quality of the services they receive.

Patient experience work at the Trust over the last year has included:

- national annual inpatient surveys, national cancer patient surveys, national Friends and Family Test monitoring
- internal feedback via the use of: patient experience cards, real time patient feedback, the care campaign audit (undertaken in collaboration with the Patients Association) and governor audits
- monitoring for any emerging issues via: patient comment cards, formal and informal complaints, issues raised by letters and compliments from patients, carers, relatives and the public

One patient noted that when visiting the hospital the gel dispenser at a main entrance was empty at a weekend. This was highlighted due to the importance of infection control and the system amended. Housekeeping supervisors now review daily and sign to identify the check has been made and refill dispensers as appropriate.

- collating and using individual patient stories. Patient stories are shared monthly with the Trust Board, shared with staff at ward level and used for staff education. Patient diaries, experience based design interviews and one to one interviews with complainants are also used to identify opportunities for learning and improvement
- holding specific focus groups, stakeholder events and locum forums to discuss local issues for our patients. Specific project groups have included learning disabilities, Healthwatch quality audits, volunteers and patient advocates support for mealtime companions and a disability forum in partnership with Dorset Clinical Commissioning Group and Poole Hospital NHS Foundation Trust

Key improvements in patient care are centred both around direct interventions which positively impact on all aspects of quality. Actions taken in 2014/15 include:

- implementation of a carer’s audit
- protected nights scheme
- dignity pledge
- bed curtains replaced Trust-wide for improved dignity and privacy
- promotion of the #hellomynenameis campaign
- pain management education plan and analgesia proforma
- pilot site for healthcare assistant Care Certificate education programme - this has led to an established programme for all newly employed healthcare assistants to attend
- staff and volunteers training to support patients using the Hospedia system, with focus on menus and meal ordering
- Property Management Policy to reduce the number of items lost developed for launch in 2015/16
- working with local council to improve traffic flow enabling greater access for patients and visitors
- Interim Care Team supporting the provision of interim care beds for patients ready for discharge
- GP led transitional care unit to support patients fit for discharge
- expansion of volunteer roles including dementia care companions
- implementation of the Friends and Family Test into outpatient and day case areas
- stakeholder events and annual focus groups to support service reviews and changes

Care Quality Commission national inpatient survey

Improvement in overall national inpatient survey results

The 12th annual Care Quality Commission national inpatient survey includes responses from in excess of 59,000 patients from 154 acute trusts. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
had a response rate of 54% (the national response rate was 47%) with 447 responses completed from a sample of 830 eligible patients. The eligible sample (as defined by the national methodology) were all patients who had stayed in the Trust overnight during July 2014.

The national data analysis is based on an ‘expected range’ when compared to other trusts and is standardised by age, gender and method of admission to ensure the results are fair regardless of demographic. The numerical score is 0 (worst) - 10 (best).

**National comparison results**

Results are displayed when compared with other trusts as:
- better than most other trusts (coloured green)
- about the same as most other trusts (coloured amber)
- worse than most other trusts (coloured red)

Survey questions are segmented into 11 sections to reflect key aspects of the patient journey or quality of care by professional disciplines. There are a total of 60 questions in total.

**Comparison with 2013 results**

It is positive to see that the ‘overall’ score demonstrates improvement from last year. The overall score has improved from 7.9 in 2013 to 8.1 in 2014.

Comparison with 2013 performance demonstrates:
- we made improvement in 42 questions in 2014 (20 questions in 2013)
- eight questions show statistical improvement (one in 2013)
- six questions have remained the same (eight in 2013)

---

**Section scores**

<table>
<thead>
<tr>
<th>Section</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1. The Emergency/A&amp;E Department (answered by emergency patients only)</td>
<td>7.5</td>
</tr>
<tr>
<td>S2. Waiting list and planned admissions (answered by those referred to hospital)</td>
<td>7.2</td>
</tr>
<tr>
<td>S3. Waiting to get to a bed on a ward</td>
<td>7.8</td>
</tr>
<tr>
<td>S4. The hospital and ward</td>
<td>7.4</td>
</tr>
<tr>
<td>S5. Doctors</td>
<td>7.6</td>
</tr>
<tr>
<td>S6. Nurses</td>
<td>7.3</td>
</tr>
<tr>
<td>S7. Care and treatment</td>
<td>7.0</td>
</tr>
<tr>
<td>S8. Operations and procedures (answered by patients who had an operation or procedure)</td>
<td>7.1</td>
</tr>
<tr>
<td>S9. Leaving hospital</td>
<td>7.7</td>
</tr>
<tr>
<td>S10. Overall views of care and services</td>
<td>7.9</td>
</tr>
<tr>
<td>S11. Overall experience</td>
<td>7.6</td>
</tr>
</tbody>
</table>
there was a deterioration in the results of 10 questions (29 in 2013)

We improved on last year’s performance in the following categories: hospital and ward, nurses, doctors, care and treatment, operations and procedures and leaving hospital.

It was pleasing to note that we made improvement in our patients’ perception of having to share mixed-sex sleeping areas (last year the Trust was placed in the bottom 20% for mixed-sex sleeping areas, this has improved from a score of 8.2 in 2013 to 8.8 in 2014). However there is work still to do as the report highlighted that we need to make progress in our patients’ perception of not having gender specific shower or bathroom facilities (the Trust is in the bottom 20% of all acute trusts for this question). We are planning to review signage and communications during the year ahead.

National comparison

The results place the Trust in the top 20% of trusts (green) in the following four questions:

- Q8 The hospital specialist had all relevant information from referring specialist
- Q48 Anaesthetist providing information regarding induction and pain management
- Q55 Written information on discharge
- Q60 Staff telling of danger signals to be aware of after discharge

The Trust was only in the top 20% of trusts for one question in 2013.

In 2012 we had one of the lowest scores for the question relating to privacy when being examined or treated. Pleasingly the results for 2014 demonstrate further evidence of significant improvement. The Trust is now rated as amber at 9.7. The highest national score was 9.9.

The 2014 results did not indicate any areas where the Trust was significantly worse (lower) than the national average. In 2013 we had three areas where we were red, so the 2014 show positive improvement.

In summary, performance against the Trust’s 2013 demonstrates excellent improvement. We have significantly improved in four questions placing the Trust in the top 20% of the country and have also shown improvement in a further 41 questions. We aim to continue this success in 2015/15 and will introduce via the care group heads of nursing a number of new and ongoing improvement initiatives across all areas.

Trust patient experience card (PEC) results

In addition to responding to national patient surveys, the Trust has an internal patient experience card (PEC) which is available for all inpatients and outpatients to complete.

There are six questions on one side, chosen in parallel with national inpatient survey questions. The other side is a free text space for qualitative comments. The results are available to all staff and are collated and fed back quarterly to all participating areas. On review areas for improvement are themed and actioned through improvement plans.

In 2014/15, there has been a significant increase in the number of completed cards; 34,644 cards completed Trust wide (22,514 in 2013/14) by patients across our hospitals. Overall patient satisfaction was high with 96.3% recommending the Trust and only 2% not recommending.

Friends and Family Test

The national Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with other patient experience feedback, provides a tool to ensure transparency, celebrate success and stimulate improvement. The implementation of the FFT across all NHS services is an integral part of Putting Patients First, NHS England’s Business Plan for 2013/14 - 2015/16, and is designed to help service users, commissioners and practitioners.

Since April 2013, the FFT question has been asked in all NHS inpatient and emergency departments across England and, from October 2013, the Trust has included maternity services.
“How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?”
with answers on a scale of extremely likely to extremely unlikely.
(National FFT Question)

The Friends and Family Test score is calculated using ‘Net Promoter Score’ methodology. The methodology results in a FFT score of between -100 and +100. The national directive to implement the FFT question has been cascaded throughout the Trust via the use of the patient experience card (PEC).

The results are reviewed through the Patient Experience Committee and actioned where required. This data is collated and submitted to NHS England in accordance with strict guidelines. The data is also made publically available throughout the Trust for patients and the public in accordance with NHS England guidelines.

In line with the NHS England directive, the FFT has been extended to include 40 outpatient and day case areas in addition to inpatient areas.

When compared with the previous year there has been an increase (improvement) of the FFT score on aggregate from 75 to FFT Score 77.

<table>
<thead>
<tr>
<th>FFT April 13 - March 14 (all areas)</th>
<th>FFT April 14 - March 15 (all areas)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely likely responses</td>
<td>Extremely likely responses</td>
</tr>
<tr>
<td>16,626</td>
<td>25,711</td>
</tr>
<tr>
<td>Likely</td>
<td>Likely</td>
</tr>
<tr>
<td>3,466</td>
<td>5,013</td>
</tr>
<tr>
<td>Neither likely/nor unlikely</td>
<td>Neither likely/nor unlikely</td>
</tr>
<tr>
<td>437</td>
<td>569</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Unlikely</td>
</tr>
<tr>
<td>208</td>
<td>246</td>
</tr>
<tr>
<td>Extremely unlikely</td>
<td>Extremely unlikely</td>
</tr>
<tr>
<td>287</td>
<td>380</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>21,024</td>
<td>31,919</td>
</tr>
</tbody>
</table>

FFT SCORE 2013/14 75  FFT SCORE 2014/15 77

<table>
<thead>
<tr>
<th>1st April 2014 to 31st March 2015</th>
<th>Extremely likely</th>
<th>Likely</th>
<th>Neither likely nor unlikely</th>
<th>Unlikely</th>
<th>Extremely unlikely</th>
<th>Don't know</th>
<th>No answer</th>
<th>No FFT responses</th>
<th>FFT Score</th>
<th>Recommended %</th>
<th>Not Recommended %</th>
</tr>
</thead>
<tbody>
<tr>
<td>All inpatient depts.</td>
<td>8429</td>
<td>1733</td>
<td>191</td>
<td>67</td>
<td>68</td>
<td>64</td>
<td>408</td>
<td>10552</td>
<td>77</td>
<td>96.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>All ED depts.</td>
<td>4933</td>
<td>815</td>
<td>91</td>
<td>68</td>
<td>170</td>
<td>32</td>
<td>124</td>
<td>6109</td>
<td>76</td>
<td>94.1%</td>
<td>3.9%</td>
</tr>
<tr>
<td>All Maternity depts</td>
<td>681</td>
<td>191</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>18</td>
<td>889</td>
<td>75</td>
<td>98.1%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
Children’s FFT card

A new FFT card specifically for younger patients was introduced in January 2015. The cards were developed to support the NHS England directive to provide feedback opportunities for those over five years of age. Results for the first three months of data collection indicate that 98.9% of young people who completed this card would recommend the Trust.

Real Time Patient Feedback (RTPF)

Real Time Patient Feedback (RTPF) is facilitated through the Trust by trained volunteers. Patients are asked a series of standard questions through face-to-face interviews. The survey data collection and analysis process is managed by the Head of Patient Engagement.

Results are shared with clinical teams to highlight best practice and indicate areas for improvement.

One of the main RTPF audits this year has been the care campaign audit.

In partnership with the Patient Association, the care campaign audit has been designed to ensure robust feedback on a daily basis from participating older peoples’ medicine and medical wards. The audits are facilitated by trained volunteers and review five key objectives:

- communicating with care and compassion
- assistance - ensuring dignity
- relieving pain effectively
- ensuring adequate nutrition
- managing expectations

The completed audits forms are returned to the Patient Experience Team and reviewed individually on a daily basis. If issues are identified the ward is contacted immediately and informed of the area of concern and an action plan put in place for improvement. The audits have led to improvement in privacy and dignity, communication, pain control and mealtime assistance.
### Care Campaign Question

<table>
<thead>
<tr>
<th>Section</th>
<th>April 2014 Score</th>
<th>March 2015 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1 Communicate with care and compassion (total of all questions) e.g.</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Did staff ask you what name you preferred to be known by/called?</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td>Do staff use your preferred name when they speak to you?</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>Section 2 Assistance and ensuring dignity (total of all questions)</td>
<td>92%</td>
<td>94%</td>
</tr>
<tr>
<td>Section 3 Relieve pain effectively (total of all questions) e.g.</td>
<td>79%</td>
<td>84%</td>
</tr>
<tr>
<td>Do staff use other methods to relieve your pain?</td>
<td>72%</td>
<td>83%</td>
</tr>
<tr>
<td>Section 4 Ensuing adequate nutrition (total of all questions)</td>
<td>89%</td>
<td>94%</td>
</tr>
<tr>
<td>Are the meals provided enough for you?</td>
<td>80%</td>
<td>87%</td>
</tr>
<tr>
<td>If you are unable to eat a full meal were you offered regular snacks and drinks?</td>
<td>76%</td>
<td>89%</td>
</tr>
<tr>
<td>If you need assistance to eat your meal is it given?</td>
<td>61%</td>
<td>94%</td>
</tr>
<tr>
<td>Are you supported to eat your meals without interruption?</td>
<td>76%</td>
<td>93%</td>
</tr>
<tr>
<td>Section 5 - Managing expectations (total of all questions)</td>
<td>-</td>
<td>91%</td>
</tr>
<tr>
<td>Overall %</td>
<td>87%</td>
<td>91%</td>
</tr>
</tbody>
</table>

### Patient focus groups

Patient focus groups are run throughout the year. This year 11 events have taken place, including in rheumatology, orthopaedics, oncology, endoscopy and physiotherapy. The focus groups are an excellent way of using the views and recommendations of patients in the development of new or existing services.

### Working with our volunteers to support patient experience

We are extremely fortunate to receive the support of over 800 volunteers including partnership volunteer organisations. Over the last 12 months we have been reviewing and extending the number and roles of our valuable volunteers. Partnership agencies that support the Trust and in addition to the Trust Bluecoat volunteers include:

- Royal Voluntary Services
- Chaplains
- League of Friends Christchurch
- League of Friends Bournemouth
- Friends of the Bournemouth Eye Unit
- Hospital Radio Bedside
- Red Cross
- Headstrong
- Macmillan
- Healthwatch
- Patients Association

Bluecoat volunteer duties are extensive include:

- main reception meet and greet
- ward support offering tea and coffees
- patient companions, who have dementia awareness training
- administration support throughout the Trust
- driving the indoor train to help patients and visitors around the hospital
- surveying patients for real time patient feedback
- meal time companions to help support those in need of minimal support to eat
- meal time assistants to help prepare the food environment and sit and talk with patients
- gardening
- medical photography escort
- audit support
The Trust has developed a volunteers major incident policy to ensure that appropriately identified and trained volunteers would be available to offer support if required. The Lampard report recommendations following the Savile Investigation has been reviewed to provide Board and stakeholder assurance of compliance.

We continue to recruit volunteers who are happy to provide support during the day, evenings or weekends. The Board of Directors is very grateful for all the excellent work the volunteers provide and would like to publically thank them all for their continued support to our patients and the organisation.

**Learning from complaints and concerns**

A key focus for the Trust is to ensure that we have robust systems in place to enable early local resolution of concerns and clear communication with all stakeholders about the actions we have taken following complaints investigations. Our overriding objective is to learn from each complaint and resolve each complaint with the complainant through explanation and discussion.

In 2014/2015 we received 360 formal complaints from patients or their representatives. This represents a small decrease of 2.7% (10 complaints) from last year’s total of 370 complaints.

Of the 360 formal complaints received, 190 of the completed investigations were upheld or partially upheld, with the necessary changes explained and appropriate apologies offered. Where appropriate complaint resolution meetings were held with complainants and relevant staff to assist with feedback, closure and learning.

The main categories of complaint in 2014/15 were as follows:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number in 2014/15</th>
<th>Percentage in 2014/15</th>
<th>Number in 2013/14</th>
<th>Percentage in 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative systems</td>
<td>28</td>
<td>8%</td>
<td>26</td>
<td>7%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>44</td>
<td>12%</td>
<td>35</td>
<td>10%</td>
</tr>
<tr>
<td>Bed management</td>
<td>6</td>
<td>2%</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>168</td>
<td>46%</td>
<td>197</td>
<td>53%</td>
</tr>
<tr>
<td>Communication/information</td>
<td>56</td>
<td>15%</td>
<td>43</td>
<td>12%</td>
</tr>
<tr>
<td>Discharge arrangements</td>
<td>27</td>
<td>6%</td>
<td>21</td>
<td>6%</td>
</tr>
<tr>
<td>Environment</td>
<td>3</td>
<td>1%</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Equipment/facilities</td>
<td>2</td>
<td>1%</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Health and safety</td>
<td>6</td>
<td>2%</td>
<td>6</td>
<td>1.1%</td>
</tr>
<tr>
<td>Privacy and dignity</td>
<td>1</td>
<td>0.2%</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Medication</td>
<td>10</td>
<td>4%</td>
<td>15</td>
<td>4%</td>
</tr>
<tr>
<td>Availability of staff</td>
<td>6</td>
<td>1.8%</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Theatre Management</td>
<td>3</td>
<td>1%</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>360</td>
<td>1000</td>
<td>370</td>
<td>100</td>
</tr>
</tbody>
</table>
Complainants who remain dissatisfied with the response to their complaint at local resolution level were able to request an independent review to be undertaken by the Health Service Ombudsman.

After receiving a response from the Trust, seven people chose to refer their concerns to the Parliamentary and Health Service Ombudsman during 2014/15. At the time of this report, the Ombudsman partly upheld two complaints, did not uphold two with a further three complaints still under investigation.

**Changes resulting from complaints**

One of the main purposes in investigating complaints is to identify opportunities for learning and change in practice to improve services for patients. Examples of changes brought about through complaints were:

- endoscopy office telephone opening times extended, with telephone lines open until 6.30pm
- a cover-sheet/log has been introduced to patients’ notes to ensure a record is made to confirm that letters are sent to patients as appropriate to advise them when to stop taking warfarin. A communication will be sent to local GPs to remind them of the recommended timeframes for stopping warfarin prior to undergoing surgery
- training in management of suspected spinal injuries provided in the Emergency Department as direct result of a complaint
- Emergency Department now records all referrals to urology admissions so that we can ensure that they have been sent
- new ward discharge checklist implemented to ensure care home advised of discharge and patient provided with suitable clothing
- agency staff manual handling training made consistent with Trust standards
- training for reception staff updated to ensure they know to bring a patient’s notes to the attention of the medical staff if a patient contacts them to advise they are waiting for their biopsy results. Pathway mapping exercise completed to identify potential areas for delays in histology results. This has allowed us to ensure that record retrieval, results reviewing and typing of letters is streamlined and that patients receive results with a minimum of delay
- ward shift co-ordinator (nurse-in-charge) guidelines updated to incorporate continence checks and pressure relieving management in the four times a day full ward rounding. An action plan has been implemented to strengthen a drive for improvement in relation to motivational leadership, accountability for individual actions and the provision of quality care by quantifying areas for improvement and setting the expectations of staff

Details of the improvements made following comments are posted monthly on the Trust website.

[www.rbch.nhs.uk/patients_visitors/when_things_dont_go_to_plan.php](http://www.rbch.nhs.uk/patients_visitors/when_things_dont_go_to_plan.php) for further details
Other news

We have some outstanding services that have been recognised for their excellent clinical outcomes, innovation and patient care this year. For example:

- **Improving patient information**
  The Trust was awarded the Information Standard Quality Mark for Patient Information following a rigorous assessment of its patient information processes by the Royal Society for Public Health in October 2014. This is the second time the Trust has been awarded accreditation and means that all of our patient information leaflets can continue to carry the official Information Standard quality mark - a clear indication that it is accurate, evidence based, up to date and reliable.

  **Matron Jenny House:**
  “It is essential that our patients get accurate written information about their condition, operation and procedure in a format they can understand. Our leaflets are also just as important for carers and families, as the information we provide keeps them better informed helping to allay any fears or concerns they may have.”

- **Providing a better environment for maternity**
  The Royal Bournemouth Hospital celebrated the official opening of the Bournemouth Birth Centre in November 2014 - its new midwifery-led maternity unit.

  Hosting two spacious birthing suites with en-suite bathrooms, ‘quick-fill’ birthing pools and an additional overnight room, the new unit is a demonstration of our commitment to providing high quality ‘home from home’ births for new mums. The purpose-built facility boasts hidden technology, sound proofing, air conditioning and variable lighting to create a welcoming atmosphere. The more homely surroundings support our natural birth ethos, where midwives assist low risk mothers in using alternative birthing techniques to avoid unnecessary drugs during labour.

  The unit has dedicated car parking bays for parents and visitors and pull-out beds so dads and birthing partners can stay overnight. Its location next to the hospital’s road also allows for fast patient transfers by ambulance.

- **Cardiology**
  An audit of length of stay and inpatient waits for angiography for patients admitted with Acute Coronary Syndrome (ACS)/ Non ST elevation Myocardial infarction (NSTEMI) was completed in June 2014 to look at the steps in the existing pathway and where potential delays were occurring.

  NICE guidance in 2013 suggested a sign of a high quality service would be for patients to have an angiography (angio)/percutaneous coronary intervention (PCI) within 72 hours of admission if intermediate or high risk.

  The European Society of Cardiology recommends patients having an angio/PCI in less than 72 hours for low risk and less than 24 hour for high risk. The Wessex Strategic Clinical Network involving clinicians and local clinical commissioning groups have suggested a separate target of 80% of these patients having an angio/PCI within 60 hours of admission. Nationally, 53% of these patients have angio/PCI within 72 hours of admission and 67% within 96 hours.

  An internal audit undertaken in June 2014 showed a median time from presentation to angio/PCI for patients transferred to the Royal Bournemouth Hospital (RBH) for treatment of 167 hours and 135 hours for RBH patients. As a result, a working group was established to create a new pathway and process to speed up the transfer of patients and reduce time to procedure and reduce overall length of stay. The new pathway was created and commenced on 1 December 2014.

  The new pathway now involves the advanced nurse practitioner attending the Acute Admissions Unit at 8am each day and reviewing all cardiac referrals. This includes taking a clinical history and examination from patients meeting specific criteria; discussing any patient who is suitable for same day angioplasty with the consultant in the catheter lab and arranging for them to be listed for a procedure on the same day if clinically
appropriate; allocating a space on a cardiac ward or trolley in our Cardiac Intervention Unit and moving the patient promptly to the department to further reduce any delays.

A repeat audit was undertaken in February 2015 which showed improved admission to procedure times for RBH patients. Patients had only waited 90 hours in comparison to 134 hours in June 2014. This represents a 12% improvement with the 96 hour target suggested by NICE.

The directorate is planning further changes to continue this improvement progress and is looking at specific quality improvement projects for 2015/16 with regard to length of stay, timely access to the catheter labs and providing early cardiology support and intervention to patients presenting to the front door.

**Radiology**

Seven-day working in CT/MRI commenced formally in April 2014. This extended service includes:

- a radiologist on site until 9pm daily and Saturday/Sunday
- an extended scanning day 8am-8pm, Monday-Thursday CT and MRI
- Saturday/Sunday scanning 9am-5pm -inpatient/emergencies and some OPD

A seven-day ultrasound service also commenced in December 2014.

**Ambulatory Care**

Serving a population of 550,000, our Emergency Department (ED) sees on average 200 patients per day with an average take of 91 patients. The ambulatory care project has been part of a wider improvement project for unscheduled care focusing on ED, integrated care, discharge and flow.

Our aim is to prevent unnecessary hospital admissions and improve patient experience. Our initial goal was to convert 25% (excluding ED observation ward) of our take to an ambulatory care setting.

Working with the clinical teams we mapped our existing pathways of care and the network advised us to break down the pathway by length of stay (LOS) to help us understand where our target group of patients were.

Creation of flow diagram helped us to understand our flow, identify opportunities and develop a plan. We could see only 12% of patients were being treated in ambulatory care and that ED was not accessing the service. We therefore needed to develop a new model of care which put ambulatory care as the first option for patients and we quickly gained clinical consensus for a new model of care to streamline flow.

In order to make rapid progress the project teams met every week. The challenges we had along the way were swiftly resolved through weekly checkpoint meetings with a senior team. We are still facing challenges but the project has been a great success. It has helped us to manage a 13% surge in activity and unprecedented growth in demand for our emergency and urgent care services over the past year.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too many short stay patients being admitted to a bed</td>
<td>Developed a new model of care with patients treated as ambulatory until proven otherwise a key principle</td>
</tr>
<tr>
<td>Identifying and streaming patients early in the pathway</td>
<td>New model of care includes in-reach to ED from a multi-disciplinary team</td>
</tr>
</tbody>
</table>
Dr Naveed Bhatti (centre) - Consultant Physician:

“As an acute physician I am very passionate about ambulatory care - a passion to improve the quality of emergency care for patients. It is providing clinical care safely, effectively and efficiently as day-case and could be provided across the primary/secondary care interface. It is about upholding good medical practice, improving patient experience, maintaining safety and maximising efficiency. Right area, right decision, right care.”

To monitor progress we have developed a dashboard of metrics to measure and monitor improvement. We can demonstrate that the conversion rate to ambulatory care improved from 28% (160 patients per week) to 35% (215 patients per week) excluding follow ups.

Next steps

We are very excited to be working with a team of local GPs to extend our service later into the evening and weekends and also provide better integrated care. Work is also underway with our Estates Department to expand and improve the current clinical areas so that we can do even more. Our Older People Ambulatory Care Team is developing links with other innovative projects such as the virtual ward pilot to help older patients stay out of hospital. We continue to use ambulatory care to provide early supported discharge for patients. In Medicine for Older People this has contributed towards a reduction in our average length of stay from 17 to 11 days over a 12 month period.

Dr Ravin Ramtohal - GP, Highcliffe Surgery:

“As a local GP, I am delighted to be part of this innovative project to integrate primary and secondary care. A team of local GPs, alongside the Acute Admissions Team, assess a range of emergency admissions to the Trust. Together we can facilitate effective and timely investigations, outpatient treatment and follow up and community support, prioritising same day discharge.”

Sonia Mahmood - Nurse, Ambulatory Care:

“It’s so nice to spend time with patients and see them through from start to finish and I am proud of the service we offer to patients.”
Improving dementia care

Major renovation work took place on Ward 26 to improve the environment for patients who have dementia and the quality of their care.

The bays, reception area, facilities and staff offices were transformed over a period of six weeks by staff who attended specialist courses to learn what design changes would make wards safer and less confusing for those with dementia.

Performance against national priorities 2014/15

<table>
<thead>
<tr>
<th>National Priority</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15 Target</th>
<th>2014/15 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 week referral to treatment waiting times - admitted</td>
<td>17.7 weeks</td>
<td>94.5%</td>
<td>97.1%</td>
<td>90.0%</td>
<td>88.9%</td>
</tr>
<tr>
<td>18 week referral to treatment waiting times - non admitted</td>
<td>14.2 weeks</td>
<td>98.9%</td>
<td>98.4%</td>
<td>90.8%</td>
<td>95.6%</td>
</tr>
<tr>
<td>18 week referral to treatment waiting times - patients on an incomplete pathway</td>
<td>14.2 weeks</td>
<td>97.1%</td>
<td>96.2%</td>
<td>92.0%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge</td>
<td>97%</td>
<td>97.2%</td>
<td>95.5%</td>
<td>95.0%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Maximum waiting time of 62 days from urgent referral to treatment for all cancers</td>
<td>87.3%</td>
<td>88.6%</td>
<td>80.3%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service</td>
<td>94.6%</td>
<td>98.6%</td>
<td>93.4%</td>
<td>90%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Maximum cancer waiting time of 31 days from decision to treat to start of treatment</td>
<td>96.7%</td>
<td>96.4%</td>
<td>95.1%</td>
<td>96%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery</td>
<td>99.2%</td>
<td>98.8%</td>
<td>95.1%</td>
<td>100%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti cancer drug treatment</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals</td>
<td>94.2%</td>
<td>93.6%</td>
<td>93.8%</td>
<td>93%</td>
<td>100%</td>
</tr>
<tr>
<td>Two Week Wait for Breast Symptoms (where cancer was not initially suspected)</td>
<td>99.1%</td>
<td>97.0%</td>
<td>98.0%</td>
<td>93%</td>
<td>87.1%</td>
</tr>
<tr>
<td>Clostridium difficile year on year reduction</td>
<td>62</td>
<td>31</td>
<td>14</td>
<td>25</td>
<td>91.1%</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>Compliance certified</td>
<td>Compliance certified</td>
<td>Compliance certified</td>
<td>Compliance certified</td>
<td>Compliance certified</td>
</tr>
</tbody>
</table>
Annex A

Statements from commissioners, local Healthwatch organisations and scrutiny committees

The following groups have had sight of the Quality Report and have been offered the opportunity to comment:

- NHS Dorset Clinical Commissioning Group
- NHS West Hampshire Clinical Commissioning Group
- Borough of Poole’s Health and Social Care Overview and Scrutiny Committee
- Bournemouth Borough Council Health and Adult Social Care Overview and Scrutiny Panel
- Healthwatch Dorset
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Council of Governors

Comments received were as follows:

**Dorset Clinical Commissioning Group**

**Statement from the Dorset Clinical Commissioning Group**
7 May 2015

In 2014/15 The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust pursued achievement of the key quality priorities identified in the 2013/14 Quality Account. We can confirm that we have no reason to believe this Quality Account is not an accurate representation of the performance of the organisation during 2014/15. The CCG recognises the areas of strength described in the Quality Account which were also identified by the Care Quality Commission who undertook a further inspection this year. The CCG monitor quality and performance at the Trust throughout the year. There are monthly quality meetings and there is frequent ongoing dialogue as issues arise. The information contained within this Quality Account is consistent with information supplied to commissioners throughout the year.

Over the year the Trust has shown consistent use of the Patient Safety Thermometer to collate safety information. Whilst it is pleasing to note the reducing levels of harm in relation to patient falls, catheter associated infections and compliance with Venous Thromboembolism risk assessments, there are clearly further improvements required in relation to hospital acquired pressure ulcers. It is also evident that compliance with Information Governance requirements is an area of priority for improvement.

The CCG were asked to comment on the quality priorities for 2015/16 at an early stage and is supportive of the areas identified particularly in relation to the reduction of avoidable pressure ulcers. The CCG will continue to work with Royal Bournemouth Hospital NHS Foundation Trust over the coming year to ensure all quality standards are monitored as set out in the reporting requirements of the NHS Contract and local quality schedules.
West Hampshire Clinical Commissioning Group

Statement from the West Hampshire Clinical Commissioning Group
14 May 2015

West Hampshire Clinical Commissioning Group (CCG) would like to thank The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) for the opportunity to review and provide a statement response to their 2014/15 Quality Account.

It is clear that the Trust puts quality care high on its agenda with the various quality improvement initiatives implemented throughout the year, in particular the internal peer review process combined with the analysis of other information such as complaints and incident data, allows staff and managers to scrutinise all aspects of care and provide constructive feedback to staff. It is pleasing to note that this was also acknowledged by the Care Quality Commission during their last visit in August 2015 who also gave a more positive report than the previous one in 2013.

The Trust should be congratulated on the efforts made on improving outcomes for patients with the reduction in number and severity of inpatient falls. In addition, the Trust has worked to reduce hospital acquired infections, particularly those associated with urinary catheters, which is also a key quality indicator in the 2015/16 contract with West Hampshire CCG.

However, we are concerned that there has not been any significant improvement in the number of hospital acquired pressure ulcers during the past year and are pleased to see this as a key priority in 2015/16 with an internal reduction target of 25%.

The Trust failed to achieve the targets for management of patients being admitted with a stroke, and this was also identified by the CQC in their report; however West Hampshire CCG acknowledges that there has been an improvement in the proportion of patients scanned within 12 hours, over the year and we are keen to see the impact of the stroke outreach team once this fully implemented in 2015. The Stroke Unit has been a subject of concern for the CCG and, in particular, our GPs, throughout the year. Whilst we have had assurances from the Trust in the form of a performance and development plan, clinical presentations to the Clinical Quality Review Meetings and clinical visits to the unit including discussions with staff and patients, this still remains a concern. We are pleased that you have assured us that significant improvements will be made during 2015/16 and we will be monitoring this closely over the coming months.

The Trust has not met the Commissioning for Quality and Innovation (CQUIN) targets for the identification of patients over the age of 75 years with dementia and their subsequent assessment and referral and it is disappointing to find little reference to this in the Quality Account; however it is recognised that the Trust has undertaken actions to enhance the environment and improvements to care plan documentation, improved staff training and a review of the elderly care pathways. We look forward to seeing how the implementation of the e-NURSE app will impact on patient care and experience during 2015/16.The CCG has seen at first hand the implementation of bay-based nursing which staff have, positively, commented on.

In accordance with national requirements, the Trust has included monthly reports on their planned versus actual nursing/midwifery hours and have had a challenging year in terms of recruitment; however, they have undertaken many initiatives to improve recruitment in order to ensure their patients are looked after safely.

The CCG supports the priorities identified for 2015/16 and confirms that as far as it can be ascertained the quality account complies with the national requirements for such a report and the following are of specific note:

- The report provides information across the three domains of quality - patient safety, clinical effectiveness and patient experience
- The mandated elements are incorporated into the report
There is evidence within the report that the Trust has used both internal and external assurance mechanisms.

Commissioners are satisfied, as far as we can be, with the accuracy of the quality account, based on the information available to us.

Overall West Hampshire Clinical Commissioning Group is satisfied that the plans outlined in the Trust’s quality account will maintain and further improve the quality of services delivered to patients and the CCG looks forward to working closely with the Trust over the coming year to further improve the quality of local health services.

Heather Hauschild (Mrs)
Chief Officer

Statement from the Poole Health and Social Care Overview and Scrutiny Committee

Members of Poole’s Health and Social Care Overview and Scrutiny Committee would like to thank The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for the opportunity to comment on an early draft of the Quality Account for 2014/15. This response is based on a PowerPoint presentation delivered to Members on 9th March 2015; we had also received a very helpful update during a visit in November. Comments from the interim visit have already been shared with the Trust; comments in this document refer to information presented in the latest meeting.

Members particularly wanted to reflect that the regular meetings with Trust staff over the past year had been very useful in building a good working relationship and also felt that the careful and reflective preparation Trust staff had put into the summaries as well as the opportunities to explore the issues in greater detail face to face were particularly valued.

These visits have already led to the opportunity for additional shared working between the council, RBCH and other NHS Trusts on falls prevention and greater awareness of the key issues facing the Trust in all of the quality priority areas.

Members were very pleased to note that feedback they had given regarding last year’s Quality Account has resulted in a number of changes to the way evidence is presented eg a glossary page, comparative national data, actual numbers as well as percentages where possible etc. This was evidenced in both the interim and end of year presentations making the information presented clearer and more meaningful. We would encourage the Trust to further develop this good practice to make your Quality Account increasingly intelligible to the wider public.

The end of year presentation clearly set out progress against the Quality Priorities for 2014/15, namely harm free care which reduces the harm from inpatient falls, hospital acquired pressure ulcers and catheter caused urinary tract infections as well as ensuring privacy and dignity and ensuring completion of nursing risk assessments and care plans. As stated above, Members appreciated the trend data, national comparators and clear actions and look forward to this being incorporated increasingly in future published Quality Accounts.

In terms of Harm Free Care, the safety thermometer metric shows that although performance improved from October to December, at 90.4% it still lags behind the national average of 94% for acutes, although there is a small improvement on the 89% outturn for 2013/14. Various reasons for this were discussed at the meeting as well as the actions being taken to improve it. It is good to see that the metric for new harms only is in line with the national average at December.

Members would encourage the Trust to work with staff, patients and other stakeholders to continue to improve performance and would ask for a progress update at the half year meeting in the autumn.

Patient falls - Members were pleased to note that at December 14 falls with harm were significantly lower than the national average although performance has declined since the
interim visit (5 falls with major severe harm compared to 0 in the previous quarter). We were reassured that whilst this is unfortunate on an individual basis, the Trust have a robust process in place to ascertain whether more could have been done to prevent the incident, including root cause analysis, discussions with relatives etc. It is also reassuring to note that the vast majority of falls have no harm or only minor harm (445/454). The Trust have appointed a Falls Lead who has been invited to be part of a working group comprising health and social care partners across Dorset led by Borough of Poole - the first meeting is due to take place in April. Members would be interested to receive an update at the interim meeting on any resulting developments.

Pressure ulcers - Members remain extremely concerned about the high incidence of pressure ulcers within the Trust compared to the national average (8.35 compared with 4.31 respectively as at December 14). Whilst we note that the number of patients admitted with existing pressure damage continues to increase and that a number of the Category 3 and 4 ulcers were subsequently deemed to be unavoidable, we would urge the Trust to implement all the identified measures (eg the SSKIN bundle, e-Nurse, additional staff, staff learning and additional Hybrid mattresses) swiftly and comprehensively. Members would expect to see the anticipated 25% reduction in avoidable ulcers achieved in 2014/15 and would request a comprehensive update as to how the above measures have worked to improve performance at the mid year meeting.

Catheter-related Urinary Tract Infections - members would wish to commend the Trust on their performance as at December regarding catheters and new UTIs (0.0 compared to the national average of 0.30) and note the actions taken to achieve the good performance. We look forward to seeing this good performance maintained over the year.

Privacy and Dignity - Members would like to praise the Trust for your approach to improving the patient experience in this vital area as noted by CQC in their October report. We particularly liked the very tangible, pragmatic steps taken to help with issues such as putting on a hospital gown and were even more impressed that the RBCH culture had enabled a member of staff in the radiography department to design a “Putting on your hospital gown” poster as part of a Staff Leading Improvement event. We commend and encourage you to continue to develop this approach in staff across the Trust.

Nursing risk assessments - Members noted the risk assessment compliance metrics and were interested to hear how the introduction of an electronic MUST calculator tool (to measure nutrition and weight) in June was helping to improve compliance in an effective manner. It would be helpful on this chart to know whether 100% was the expected standard of compliance and also how RBCH performance compared with other acute Trusts and last year’s performance.

Looking ahead to 2015/16, Members noted plans for the implementation of e-Nurse risk assessments and the implementation of a new 14 day care plan. We also noted statements of assurance and the Clinical Audit details.

In terms of the Care Quality Commission (CQC) follow up inspection in August 2014, Members had been given an early sight of the findings and their comments are recorded in the notes of the interim meeting in November. In summary, both Cllrs. Wilson and Matthews stated that the Trust and its staff were to be commended for the excellent performance recognised by Inspectors including: “exceptional examples of care and attention provided by staff at all levels and disciplines,” a “clear commitment to dignity improvement at all levels” and patients receiving “timely care” and being treated with “dignity and respect”. Members were also pleased to learn that all compliance actions from the CQC inspection in October 2013 had been met.

The presentation in March provided other useful information including an update on efforts to reduce mortality, and how the Trust was working hard to develop its culture and encourage staff to incorporate its values (including an open and honest reporting culture) into everything they did. Other developments such as the award of the Information Standard quality mark and the use of an internal peer review process to look at services against CQC fundamental standards
and then triangulate findings with staff and patient interviews were also commended by Members for “making improvement real” for staff.

In terms of patient experience, Members were impressed with work to renovate Ward 26 for dementia patients and also with the Trust’s commitment to encouraging inpatient participation, for example through the use of a new patient safety film.

Members noted the statistics regarding learning from complaints and were pleased to hear the example of “Lily” where learning from a complaint resulted in a clear presentation of the changes made and their impact on a new member of staff. This style of reporting complaints is particularly powerful and Members would be interested to learn of more examples of how complaints have tangibly changed practice.

In terms of priorities for 2015/16, Members agreed that the “Sign up to Safety” diagram gave a clear representation of what the Trust wanted to achieve. They also welcomed early sight of the draft Quality Priorities (ie Sepsis, Surgical Safety checklists, simple discharge planning/transitions, reducing hospital acquired pressure ulcers and implementing various IT systems in support of patient safety), and appreciated the opportunity to comment and give feedback on them. They felt that the above list reflected the Trust’s ambitions and ongoing commitment to focus on the patient’s experience / feedback and the need for culture change.

In summary, therefore, we would wish to state that Members are extremely pleased to learn of the Trust’s many successes and developments; whilst there are still some areas of performance which require further improvement, it is clear that over the past year the Trust has put significant effort and thought into making improvements that bring real change to the quality of patients’ experiences as well as clinical outcomes. This has been recognised both by CQC and by individual staff and patients as part of the overall drive to embed culture change in the organisation.

Thank you for the opportunity to comment on performance - we look forward to reading the published version of your Quality Account but please take this letter as Borough of Poole’s response to that document based on performance reported to Members in early March 2015. We are particularly grateful to Paula Shobbrook (Director of Nursing), Jo Sims (Assistant Director of Governance) and Nikki Greenall (Project Manager) for going out of your way to help us understand key issues and successes.

We would welcome the opportunity for a follow up visit in the autumn. I am sure Gabrielle Longdin will let you know the name of the ‘new’ Chairman of HASCOSC.

Councillor the Rev. Charles Meachin
Chairman Health and Social Care Overview and Scrutiny Committee
Borough of Poole

Bournemouth Borough Council Health and Adult Social Care Overview and Scrutiny Panel

I am able to confirm that in respect of the Quality Account for 2014/15, representatives from the Bournemouth Health and Adult Social Care Overview and Scrutiny Panel met with the Trust and colleagues from the Borough of Poole on two occasions to study the Quality Account and provide feedback.

Please accept the written feedback submitted by the Borough of Poole Council as a joint response, formulated from the discussions at the above mentioned meetings. I understand that a number of verbal comments made by Members were also acknowledged by the Trust.

Matthew Wisdom
Democratic and Overview and Scrutiny Officer
In the past year Healthwatch Dorset has received feedback about the Trust’s services from patients, relatives, carers and professionals. We’ve worked with the Trust throughout the year, holding Healthwatch information stands in Bournemouth Hospital, making our leaflets available to patients, visitors and staff and working with the hospital’s public governors to gather feedback from inpatients for the Healthwatch England special inquiry project.

Our 2014 report “Every One Matters” highlighted the wide variation in the standard of care received at hospitals in Dorset. We will be monitoring the outcomes from the Trust’s response to our report in 2015/16.

The positive feedback we gather often relates to staff attitudes and the high quality of care and compassion patients receive.

However, we are still receiving concerns about lack of communication especially regarding discharge (unsure of times, waiting for paperwork and medication, not being kept informed of what’s happening, feelings of being discharged too early and discharged without appropriate support in place) so we are pleased to note that this area is being recognised as a priority for 2015/16.

The 2014 Emergency Department National Patient Survey highlighted 12 areas for improvement. The Trust has stated that an action plan is in place to address the key findings. It would be useful to have sight of the plan and details of the actions and timescales. Feedback received by Healthwatch Dorset relating to the Emergency Department has improved over the past year but we still receive comments about long waiting times and poor communication.

We are pleased to note that the Trust continues to prioritise issues regarding dementia and dementia awareness/staff training. We have received feedback from carers and relatives highlighting concerns about perceived staff lack of awareness of the needs of someone with dementia and their unwillingness to listen to the carer who knows them best. This is an issue especially when dementia patients are brought in as an emergency.

Our Community Investment Projects have gathered feedback from people and communities whose views might otherwise be under-represented when it comes to matters of health and social care. We’ll be producing a report of these projects in 2015 and there will be opportunities for the Trust to respond to issues raised.

We note that issues about infection control are being picked up with daily checks on hand gel dispensers. We welcome this initiative as a number of patients have informed us of empty dispensers around the hospital.

We would like to acknowledge the work being undertaken to encourage patient feedback through a variety of methods but it would be useful to have further information about how patient feedback contributes to affecting change. The “My Dignity Pledge” is also an area where information about how it has worked and how it is monitored would be appreciated.

We acknowledge and welcome the Trust’s openness in discussing with us our findings - both from our report “Every One Matters” and from the feedback patients and visitors shared with us at our information stands in the hospital - and the very full responses they have given, together with their action plans to address areas of concern. We look forward to continuing to work with the Trust to ensure that people’s feedback on the Trust’s services, both good and bad, is welcomed, listened to, learned from and drives forward improvements.
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Council of Governors

The Council of Governors welcomes the opportunity to make a meaningful contribution through the consultation process on the quality priorities for the Trust in 2015/16 and to express its views on the Quality Report for 2014/15.

This process has been supported by a consultation seeking the Governors’ views on the 2014/15 quality priorities for the Trust and on the way the Trust has performed and reported against these.

The Council of Governors supports the quality priorities which have been set for 2015/16 and the continuing focus on these key benchmarks of good quality nursing care in order to improve the Trust’s performance and meet the objectives which the Trust has set for itself.

The Council of Governors is concerned at the ongoing under-performance in the treatment of stroke and has asked the external auditors to review the data in relation to stroke as part of their assurance on the Trust’s quality indicators. The external auditors will carry out sample testing of the 2014/15 stroke data to provide additional assurance on the data and report to the Council of Governors.

The Council of Governors continues to monitor and provide challenge to the Board of Directors on the delivery of care in line with the targets set by Monitor, particularly around four hour waits in the Emergency Department and the completion of treatment within 18 weeks of referral.

The Council of Governors continues to improve the way we communicate and engage with members, patients and the wider community about important issues around the care and services which the Trust provides and we have committed to a comprehensive programme of engagement including the involvement of local Healthwatch.
Annex B

Statement of directors’ responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including -
  - board minutes and papers for the period April 2014 to May 2015
  - papers relating to quality reported to the Board over the period April 2014 to May 2015
  - feedback from commissioners dated 7 May 2015 and 14 May 2015
  - feedback from governors dated 6 May 2015
  - feedback from Local Healthwatch organisations dated 7 May 2015
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2014
  - the latest national in patient survey dated May 2015
  - the latest national staff survey dated February 2015
  - the Head of Internal Audit annual opinion over the Trusts control environment dated April 2015
  - Care Quality Commission Intelligent Monitoring Report dated July 2014 and December 2014
  - the Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered
  - the performance information reported in the quality report is reliable and accurate
  - there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
  - the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
  - the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Account regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Jane Stichbury  
Chairman  
28 May 2015

Mr A Spotswood  
Chief Executive  
28 May 2015
Annex C

Independent Auditor’s Report to the Council of Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the council of governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust’s Quality Report for the year ended 31 March 2015 (the ‘Quality Report’) and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as a body, to assist the council of governors in reporting The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week referral to treatment waiting times - patients on an incomplete pathway
- maximum waiting time of 62 days from urgent referral to treatment for all cancers

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- the quality report is not consistent in all material respects with the detailed guidance provided by Monitor
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and the six dimensions of data quality set out in the ‘Detailed guidance for external assurance on quality reports’

We read the Quality Report and consider whether it addresses the content requirements
of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period 1 April 2014 to the date of signing the limited assurance opinion
- papers relating to quality reported to the board over the period 1 April 2014 to the date of signing the limited assurance opinion
- feedback from commissioners
- feedback from governors
- feedback from local Healthwatch organisations dated 7 May 2015
- the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015
- the 2014 National Patient Survey
- the 2014 National Staff Survey
- Care Quality Commission Intelligent Monitoring Report dated December 2014
- the Head of Internal Audit’s annual opinion over the Trust’s control environment dated April 2015
- any other information included in our review

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report
- reading the documents

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.
Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- the Quality Report is not consistent in all material respects with the sources specified in the detailed guidance for external assurance on quality reports 2014/15
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual

Deloitte LLP
Chartered Accountants
Reading
28 May 2015
Glossary of Terms

CA UTI
Catheter Associated Urinary Tract Infections

CPA
Clinical Pathology Accreditation

CPE
Carbapenemase-producing Enterobacteriaceae

eNA
Electronic nurse assessments

EPIC3 Guidelines
National Evidence Based Guidelines for preventing healthcare associated infections in NHS Hospitals in England. These Department of Health guidelines provide comprehensive recommendations for preventing healthcare infections in hospital and other acute care settings based on best available evidence.

ESD
Early supported Discharge

Harm Free Care
Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a ‘temperature check’ on harm that can be used alongside other measures of harm to measure local and system improvement. The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are ‘harm free’ on the day of data collection. Further details are available at http://harmfreecare.org/measurement/nhs-safety-thermometer/

Healthcare Resource Group (HRG)
A HRG is a coding grouping consisting of patient events that have been judged to consume a similar level of NHS resource. For example, there are different knee related procedures that all require a similar level of resource; they are therefore assigned to one HRG. HRG codes are set out by the National Case Mix Office which is part of the NHS Health and Social Care Information Centre.

Healthcare Quality Improvement Partnership (HQIP)
was established in April 2008 to promote quality in UK health services, by increasing the impact that clinical audit has on healthcare quality in England and Wales.

Finished Consultant Episode (FCE)
An NHS Term used for a consultant episode (period of care) that has ended e.g. patient has been discharged or transferred from the consultants care.

Dr Foster Intelligence
Dr Foster is an organisation founded as a joint venture with the Department of Health to collect and publish healthcare information to support patient care. The Dr Foster Unit at Imperial College London collates and produces reports on hospital mortality rates. Dr Foster is a leading provider of comparative information on health and social care services. Its online tools and consumer guides are used by both health and social care organisations to inform the operation of their services.

JACIE
Joint Accreditation Committee ISCT EBMT (haematopoietic stem cell transplant assessor)

MRSA
meticillin-resistant staphylococcus aureusis. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

MUST
Malnutritional Universal Screening Tool

National Institute for Health and Care Excellence (NICE)
NICE is sponsored by the Department of Health to provide national guidance and advice to improve health and social care. NICE produce evidence based guidance and advice and develop quality standards and performance metrics for organisations providing and commissioning health, public health and social care services.
**NHS Safety Thermometer**
The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and ‘harm free’ care.

**Never Event**
Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. Never Events include incidents such as wrong site surgery, retained instrument post operation and wrong route administration of chemotherapy. The full list of Never Events is available on the NHS England website.

**NCEPOD**
National Confidential Enquiry into Patient Outcome and Death

**NICE**
National Institute for Health and Care Excellence

**Patient Reported Outcome Measure Scores**
Patient reported outcome measures (PROMS) are recorded for groin hernia, varicose vein, hip replacement and knee replacement surgery.

National data (HSCIS) compares the post-operative (Q2) values, data collected from the patients at 6 months post-operatively by an external company. The data is not case mix adjusted and includes all NHS Trusts, Foundation Trusts, PCT and NHS Treatment Centre data. Private hospital data is omitted.

EQ-VAS is a 0-100 scale measuring patients’ pain, with scores closest to 0 representing least pain experienced by the patient.

EQ-5D is a scale of 0-1 measuring a patient’s general health level and takes into account anxiety/depression, pain/discomfort, mobility, self-care and usual activities. The closer the score is to 1.0 the healthier the patient believes themselves to be.

The Oxford Hip and Oxford Knee Score measures of a patient’s experience of their functional ability specific to patients who experience osteoarthritis. The measure is a scale of 0-48 and records the patient ability to perform tasks such as kneeling, limping, shopping and stair climbing. The closer the score is to 48 the more functionally able the patient perceives themselves to be.

**Point Prevalence**
A point prevalence survey or audit gives a figure for a factor at a single point in time only.

**SALT**
Speech and Language Therapy

**SAS**
Staff Grade and Associate Specialist
**Serious Incident**
In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. In general terms, a serious incident must be declared for where acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) result in:

- Unexpected or avoidable death of one or more people.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- A Never Event

Full details of the NHS England Serious Incident Reporting Framework can be found on the NHS England website.

**Sign up to Safety campaign**
The NHS England Sign up to Safety campaign was launched in June 2014. It is designed to help realise the aim of making the NHS the safest healthcare system in the world by creating a system devoted to continuous improvement. The NHS England campaign has a 3 year objective to reduce avoidable harm by 50% and save 6000 lives. Healthcare organisations have been encouraged to sign up to five pledges and create a three-five year plan for safety. To find out more about the Trust’s pledge go to: [www.rbch.nhs.uk](http://www.rbch.nhs.uk)

**US**
Ultrasound

**Venous Thromboembolism (VTE)**
VTE is the collective name for:

- deep vein thrombosis (DVT) - a blood clot in one of the deep veins in the body, usually in one of the legs
- pulmonary embolism - a blood clot in the blood vessel that carries blood from the heart to the lungs

**Waterlow Score**
The Waterlow pressure ulcer risk assessment/prevention policy tool is the most frequently used system in the UK for estimating the risk for the development of a pressure sore in a given patient. The tool was developed in 1985 by Judy Waterlow.
Annual Governance Statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I have ultimate responsibility for ensuring that there is an effective risk management system in place within the Foundation Trust and for meeting all statutory responsibilities and adhering to guidance issued by the independent regulator in respect of governance. The executive with specific responsibility for risk is the Director of Nursing and Midwifery. However, the requirement to manage risk more effectively is a responsibility affecting all staff in every part of the Foundation Trust; from the control of finance, through all the disciplines supporting and delivering the environment of care, to the direct delivery of clinical care itself, risk management is everyone’s responsibility. The Foundation Trust’s Risk Management Strategy clearly defines these responsibilities and provides guidance for the fulfilment of these roles.

The Trust has a structured risk management training course in place and it is mandatory for all managers and staff in a managerial role, to attend. The training provides staff with the skills required to recognise, manage and monitor risk within their areas of responsibility. Risk management and health and safety training is included on induction and mandatory training programmes for all staff. Formal training is then supported by a variety of other resources that seek to promote and facilitate individual, departmental, directorate and organisational learning. As an example, the Quality and Risk Committee produces a quarterly Quality and Risk report which highlights patient safety, patient experience and patient outcome trends for the period. The report includes the results of complaints, claims and adverse incident investigations and notes examples of and recommendations for, quality improvement and safe practice. Recommendations and learning from complaints and adverse incidents are discussed at directorate clinical governance groups, senior nurses and ward sister meetings, Medical Grand Round meetings and
team briefings. Actions and learning points are also shared with other stakeholders through Clinical Commissioning Group (CCG) meetings and clinical network groups.

The risk and control framework

In compliance with statutory controls, the Foundation Trust has developed a standard matrix for measuring risk and determining the level of risk that can be accepted at the key management levels within the organisation. Detailed guidance and advice on assessing, quantifying and managing risk is contained within the Foundation Trust’s Risk Management Strategy (and associated Risk Assessment Policy and Procedures). Under the Strategy, directorate managers and clinical directors are responsible for maintaining directorate Risk Registers and for bringing significant risks to the attention of the Quality and Risk Committee and/or appropriate sub-committees of the Foundation Trust’s Board of Directors. In turn the sub-committees will bring important matters to the attention of the Board of Directors. The Foundation Trust continuously monitors risk control systems in place and utilise the assurance framework process to monitor, develop, implement, demonstrate and promote continuous improvement and learning. The effectiveness of the assurance framework and its application has been reviewed by the Healthcare Assurance Committee and verified by the internal auditors and the Audit Committee.

There is a strategic co-ordinated approach to the Trust’s Clinical Audit activities to ensure that the Clinical Audit cycle is complete and therefore leads to improvement in patient care. There is a consultant lead for Clinical Audit, a Clinical Effectiveness Manager who is part of the Clinical Governance Team, and consultant leads for Clinical Audit in each directorate. An annual audit plan is developed within each directorate with audits prioritised in relation to national requirements, Trust objectives, contractual and statutory duties and local requirements. To provide focus on the audit priorities and completion of the plan the directorates have identified a clinical audit lead consultant, which has a role profile. This approach has been approved by the

Trust Management Board. The committee for coordinating the Trust strategy for clinical effectiveness and clinical audit is the Quality and Risk Committee, which provides oversight that systems are in place and used to support, monitor and disseminate audit within the Trust. The Quality and Risk Committee submits the clinical audit plan to the Trust Management Board and the Board of Directors for approval. Directorates review their progress against the audit plan on a quarterly basis and provide a report for the Clinical Audit and Effectiveness Group. Progress against the annual audit plan is reviewed quarterly and a clinical audit report presented to the Healthcare Assurance Committee, and Trust Board as part of the Quality and Risk quarterly report. A quarterly report is also provided to the Audit Committee. The Clinical Audit and Effectiveness Group is chaired by the consultant lead for clinical audit and membership includes the directorate clinical audit leads. The group collectively reviews the results of national and Trust clinical audits and will consider any Trust-wide actions required for quality improvement. The group also monitors implementation of the action plans and re-audit as required to ensure required improvements have been achieved consistently across all relevant areas.

In line with statutory requirements, the Board of Directors has reviewed the Foundation Trust’s principal corporate and strategic objectives and identified mitigating strategies for any risks to the delivery of those objectives using the Assurance Framework process. The development of the Assurance Framework has involved consideration of all objectives (strategic, quality, financial, corporate, business, clinical, human resources etc.) and all risks. In addition, a comprehensive review has taken place of the Trust’s committee structure and its ability to provide the necessary assurance to the Board in support of the Assurance Framework. The framework is specifically linked to the Foundation Trust’s strategic objectives and to the regulatory requirements of the independent regulator and the Care Quality Commission (CQC). Within the Assurance Framework, principal risks are identified and key risk controls in place to provide necessary assurances on identified gaps in control systems and action
plans to further reduce risk are mapped out against identified objectives. The Assurance Framework is populated from the Foundation Trust Risk Register with risk reduction being achieved through a continuous cycle of the identification, assessment, control, and review of risk.

Risks may be entered onto the Foundation Trust Risk Register as a result of risk issues being raised or identified by: employees, directorates, external or internal reviews, internal or external audits, incident investigations, complaints reviews and comments from public stakeholders and/or service developments. Risks may also be raised by the Board’s sub-committees and/or by specialist sub-committees of these. These include the Healthcare Assurance Committee, Finance Committee, Information Governance Committee, Infection Prevention and Control Committee, Quality and Risk Committee and Health and Safety Committee. All risks entered onto the risk register are categorised according to the Trust risk management strategy using a standard risk matrix. The risk rating value is a combination of likelihood and consequence. All risks are assigned a current risk score and a target risk score following implementation of action plans and mitigation. All action plans have a responsible lead and timeframe noted. All significant and corporate level risks are also assigned an executive director lead.

Significant risks on the Foundation Trust Risk Register and Assurance Framework are reviewed by the Healthcare Assurance Committee monthly. Membership of the Healthcare Assurance Committee includes representation from the Board of Directors and the Council of Governors. The Quality and Risk Committee also reviews all significant clinical risks monthly providing feedback to directorates as appropriate. The Assurance Framework dashboard “Heat Map” is reviewed monthly by the Healthcare Assurance Committee and Board of Directors. The full Assurance Framework is reviewed at least annually. An annual review is also incorporated within the Internal Audit programme and approved by the Audit Committee. The current significant risks are reported to the Board of Directors each month, identifying changes to those risks.

The organisation’s major risks are categorised below in terms of current and future risks:

Current risks

- Risk and potential for care to be compromised due to delays in the emergency care pathway. The Trust has agreed specific actions internally and with local partners to increase capacity and improve flow. New pathways have been introduced to strengthen ambulatory care, seven day working and improve responsiveness.
- 18 weeks referral to treatment times (RTT) performance including non admitted patients. Action plans to bring the Trust back into line with the target include implementation of increased theatre capacity, combined with other additional capacity and improved Patient Treatment Lists (PTL).
- Risk of not maintaining above threshold performance of the two week, 31 and 62 day from referral to treatment targets as required by Monitor. The Trust continues to undertake a full review of the service with production of action plans to bring the position back into line with the target.
- Risk of poor patient care due to reliance on locum consultant cover in elderly care and stroke. Actions continue to mitigate the risk including advertising nationally, use of general medical consultant cover, covering on-call internally and the redistribution of workload across the current consultant base.

Future risks

- Risk of not delivering the requirements of the Dorset Clinical Commissioning Group’s Clinical Services Review (CSR) impacting on longer term sustainability of RBCH current model. The CCG is leading the work across Dorset and the Trust is actively contributing to the clinical working groups.
- The financial stability of the Trust is reliant on delivering cost improvement each year. The Trust has appointed an advisor to support the Trust during 2015/16 to deliver the required level of cost improvement.
The Trust has experienced difficulty in recruiting and retaining trained staff to fulfil templates and agreed levels of staffing posing a risk to patient care. The Trust has developed initiatives and plans that will help to attract new staff and supporting actions to help retain staff and encourage talent management.

The principal risks to compliance with the Condition 4 of the NHS Foundation Trust condition set out in the Trust’s provider licence are:

- compliance with the two week, 31 and 62-day wait for treatment from urgent GP referral for suspected cancer access target, due to ongoing risks
- the maximum waiting time of four hours from admission to Accident and Emergency due to the continued high level of ambulance conveyances, attendances and admissions, though noting a strong performance in March above 95%
- 18 weeks referral to treatment times (RTT) performance and risk of breaching the relevant thresholds. Current risk areas also include non admitted patients. Action plans to bring the Trust back into line with the target include implementation of increased theatre capacity, combined with other additional capacity and enhanced PTL management

These risks have been notified to the Board and also to Monitor as part of the annual planning and regular reporting processes. The statements made to Monitor are reviewed by the Board in advance of submission and have been highlighted to the Board in advance of this through the regular performance reporting to the Board at its monthly meetings. The Trust has submitted its action plan to return to compliance.

More generally the Board conducts its own reviews of its governance structures including reviews of performance by its sub-committees to ensure that information provided to the Board identifies the key performance risks and the risk to compliance with the Trust’s provider licence, other local and national performance targets, including its own performance objectives. These include indicators and measures relating to quality, performance, clinical outcomes, productivity, workforce, activity and finance. Appraisals of both non-executive directors and executive directors take place annually with objectives and development plans identified. This is supported by the work of the internal auditors which have conducted a review of Board reporting during the current year which included reporting to the Board sub-committees and reviews were also conducted as part of the preparation for merger and are also part of the Trust’s response to the CQC compliance actions with recommendations from all of these being taken forward.

The Trust is required to register with the CQC and its current registration status is unconditional. The CQC has not taken any enforcement action against the Trust during 2014/15. The CQC inspected the Royal Bournemouth Hospital on 13, 14 and 18 August 2014 as a follow up to the full inspection undertaken in October 2013. During the inspection in October 2013 the CQC highlighted three specific compliance breaches in relation to care and welfare of patients (Regulation 9), monitoring the quality of service provision (Regulation 10) and respecting the dignity of patients (Regulation 17). The CQC report highlighted four must-do actions relating to where they considered that essential standards of quality and safety were not being met.

At the follow up inspection in August 2014, the CQC found that “significant improvement had been made” and all the required actions had been implemented. The Foundation Trust is fully compliant with registration requirements of the CQC.

There is a monitoring framework in place to review implementation of the CQC action plan and implementation of the CQC fundamental standards of care. The Healthcare Assurance Committee and Board of Directors have reviewed progress against the CQC report requirements and CQC action plan monthly. An external review of implementation processes has been incorporated within the Internal Audit programme and approved by the Audit Committee. The Trust governance framework sets out roles and responsibilities for monitoring compliance with CQC outcomes.
This is currently being reviewed to ensure that the framework supports assurance against the new CQC inspection model and proposed new regulatory framework. The terms of reference for relevant Board sub-committees will be reviewed to ensure that they continue to monitor and review relevant CQC fundamental standards. The Trust has established a programme of internal quality inspections to ensure compliance. One of the key actions resulting from the CQC visit involved the consistent levels of nursing staff across all areas. The Trust has been successful in recruiting to establishment for the healthcare assistants and has actively recruited significant numbers of qualified nurses from overseas and more locally.

The Trust is in dialogue to actively manage risks with public stakeholders. Example of this dialogue include the Chief Operating Officer attending the local health economy urgent care board to ensure stakeholders are involved in managing the risks of rising emergency activity at the Trust. The Director of Nursing and Midwifery also presents to the Council of Governors the quarterly significant risks and discusses mitigating actions. The Trust also undertakes monthly contract monitoring meetings with the clinical commissioning groups where quality, activity, performance, finance and risk management reports are presented and discussed.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments in to the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with. Equality Impact Assessments (EIAs) are carried out on all Trust policies and service developments. A toolkit has been developed and is available on the Trust intranet and results of EIAs are also shown on the Trust website. The Foundation Trust has an Equality and Diversity Committee which is chaired by a Board Director and has wide representation from across the Trust. Sub-groups report into the Equality and Diversity Committee and have an agreed work plan which ensures that we meet our obligations.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

### Review of economy, efficiency and effectiveness of the use of resources

The Foundation Trust employs a number of internal mechanisms and external agencies to ensure the best use of resources.

Executive and senior managers in the organisation have responsibility for the effective management and deployment of their staff and other resources to maximise the efficiency of their directorates or departments.

The Board of Directors considers the Trust to be fully compliant with the principles of The NHS Foundation Trust Code of Governance as well as with the provisions of the Code in all respects, save as to paragraphs A.4.2, B.1.2, B.7.1 and E.1.3 where there are other arrangements in place.

The Foundation Trust monitoring mechanism for finance using the Continuity of Services risk (with a range from one (high risk) to four (low risk)) recorded a rating of three demonstrating a lower level of financial risk. The Trust however, recorded a deficit for the first time in its history. The Trust had set a budgeted deficit of £1.9m, however due to a continuing increase in emergency pressures of 15% experienced during the year, combined with the requirement to cover vacant posts with high cost agency staff the deficit increased...
to £5.2m. The Trust will need to manage the cash balance over the next two years to ensure the rating is maintained. In terms of longer-term financial planning, the Trust is working in partnership with other trusts in Dorset with the Dorset Clinical Commissioning Group as part of the Clinical Services Review.

Information governance

In line with Monitor’s guidance, risks to data security are being managed and controlled through the Information Governance infrastructure established by the Foundation Trust’s Information Governance Strategy. The Information Governance (IG) Toolkit is used to assess how well the Foundation Trust complies with the relevant legal and regulatory requirements and guidance. The Trust has assessed itself as level one for 10 of the 45 standards on the IG Toolkit, which means that the Trust failed the toolkit as level two must be obtained for each standard. This is because the Trust is aiming for best practice evidence rather than sufficient evidence of compliance and for the five standards reviewed in detail there were cases where the evidence was over and above the toolkit requirement. Further improvement is planned for 2015/16. There were no Serious Incident Requiring Investigation (SIRI) in 2014/15.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The production of the Quality Report is overseen by the Director of Nursing and Midwifery and co-ordinated by the Associate Director of Clinical Governance. This team leads on all regulatory quality assessments for the Trust and is experienced in this type of work. To ensure a balanced approach, input to the report is obtained from a wide range of sources within the organisation through the governance infrastructure and staff engagement forums. External opinion has been sought from the Trust’s lead commissioners, local health scrutiny panels, Healthwatch and the Foundation Trust’s Council of Governors. The production processes have mirrored those used for all quality assessments and aspects of these have been regularly audited. External audit only perform limited assurance and only publically on two indicators, one of which relates to elective waiting data. The internal audit programme has provided assurance to the Board that the controls and procedures upon which the organisation relies to manage these areas are effective. Data to support the Quality Report is largely handled by the Trust’s Information Department, Risk Management Department and the Clinical Effectiveness Department, all of which are subject to internal and external quality checking and control.

Review of effectiveness of the system of internal control

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Healthcare Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

A non-executive director chairs the Audit Committee. It met five times during the year. Representatives of external audit and internal audit attended. The committee reviewed and accepted the audit plans of both internal and external audit. The plans specifically include economy, efficiency and effectiveness reviews.
The committee received regular updates on counter fraud matters from representatives from the Local Counter Fraud Service. The Audit Committee also met separately with representatives of external audit and internal audit without any executive management present.

A non-executive director chairs the Healthcare Assurance Committee. The committee met 13 times during the year and received reports related to internal control, risk management and assurance and ensured that action plans, where remedial action was required, were implemented including the action plan relating to the compliance actions identified by the CQC.

A non-executive director chairs the Finance Committee. The committee met 14 times during the year and reviewed the Trust’s business plans, budgets, cash flow, treasury management, reporting arrangements and efficiency savings programme.

The Board of Directors received performance and financial reports during the year at its meetings and received the minutes of the following sub committees to which it has delegated powers and responsibilities:
- Audit Committee
- Trust Management Board
- Healthcare Assurance Committee
- Infection Prevention and Control Committee
- Finance Committee
- Patient Experience and Communications Committee
- Workforce Strategy and Development Committee

The effectiveness of the system of the internal control has been reviewed by the Audit Committee and further work to refine and develop our assurance processes is in progress and will be reviewed and evaluated on an ongoing basis.

The Head of Internal Audit (HOIA) provides an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control. This is achieved through a risk-based plan of work, agreed with the management and approved by the Audit Committee which should provide a reasonable level of assurance. The Head of Internal Audit opinion indicates that improvement is required. The opinion is based on all audits undertaken during the year including key themes arising from the value enhancement reviews that are not risk rated. Overall there were four high risk findings from the seventy three audits undertaken. The first three high risk findings relate to clinical data quality within the Stroke Unit. The unit has since appointed an administrative post to avoid future concerns. The final high risk is within the information governance area and is described under the section above. The Trust is aiming for best practice evidence rather than sufficient evidence of compliance will improve compliance during 2015/16.

**Conclusion**

The Head of Internal Audit has rated the Trust as ‘Improvement Required’ which is the second rating of four ranging from ‘Adequate and Effective’ to ‘Unsatisfactory’. The basis of this opinion is formed from 73 findings from 13 audits during the year. Within these audits there were four high risk findings and these are detailed above. Actions have been implemented to reduce or avoid the risk in 2015/16. Although the Trust’s Continuity of Services risk rating remains at three, the Trust did deliver a deficit during 2014/15 and will need to manage its cash over the next two years in the lead up to the Clinical Services Review implementation.

Mr A Spotswood  
Chief Executive  
28 May 2015
Directors' Report

Annual Report and Accounts 2014/15

Board of Directors

The Board of Directors is made up of seven executive directors and seven non-executive directors, including the Chairman. 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. The Board of Directors is responsible for the day-to-day running of the Trust and the delivery of the Trust’s objectives and wider strategy. Its role is to determine the overall corporate goals for the Trust and it is responsible for ensuring they are delivered. Much of this work is done by the executive directors, who work closely with the clinical directors, senior nurses, ward sisters/charge nurses and managers throughout the organisation.

The Board of Directors and its committees receive sufficient information to gain understanding of the issue and take decisions on an informed basis. Where required the Board of Directors and individual members can access independent advice as necessary to discharge their responsibilities as directors. The Board of Directors also works closely with the Council of Governors to ensure that the public interests of patients and the local community are represented. Both the Council of Governors and the Board of Directors have duties defined within the Trust’s constitution.

During 2014/15, the Trust’s Board of Directors was made up of the following members:

Non-Executive Directors

Jane Stichbury, Chairman
Jane has a long career in public service with 32 years spent in policing. She held a number of high profile positions including Deputy Assistant Commissioner of the Metropolitan Police and Chief Constable of Dorset. Jane spent five years as Her Majesty’s Inspector of Constabulary for the south of England before her appointment as Chairman at the Foundation Trust from 1 April, 2010.

Alexandra Pike, Non-Executive Director
Alex is Executive Chairman of Neom Organic, London and a Non-Executive Director of Simply Health. She was formally Global Vice President of Unilever and former Marketing Director of Fitness First. Alex joined the Trust as a non-executive director in June 2006 and has a wide range of experience in marketing and communication. She was appointed Senior Independent Director in 2009 and chairs the Patient Experience and Communications Committee.

David Bennett, Non-Executive Director
Dave has extensive experience in strategy and operational consulting and has held senior commercial roles in the logistics, telecoms and technology sectors. Dave joined the Board of Directors in October 2009 and chairs the Healthcare Assurance Committee.

Steven Peacock, Non-Executive Director
Steve was appointed as a non-executive director in October 2009. He is a Chartered Accountant and has worked in retail and fast-moving consumer goods for the last 16 years - most recently as Financial Services Group Director for The Estee Lauder Companies. Steve has a wide range of financial and commercial experience. Steve is chairman of the Audit Committee.

Ian Metcalfe, Non-Executive Director
Ian joined the Trust as non-executive director on an interim basis on 2 May 2013 to fill a vacancy on the Board. He was substantively appointed as a non-executive director following an open recruitment process with effect from 1 April 2014.
Ian has a regulatory background working in a number of different sectors including financial services, social housing and as an interim senior finance professional. Ian was a non-executive director of the Trust previously from 2006 until 2010 when he left to work in London at the Financial Services Authority. Ian holds the Chartered Institute of Management Accountants qualification and chairs the Finance Committee.

Bill Yardley, Non-Executive Director
Bill was appointed a non-executive director of the Trust in April 2014. He started his career as a Chartered Surveyor in the property and construction industry and has led major business change and operational delivery programmes and projects. More recently he has held a number of high profile positions in Whitehall, including membership of the government’s Construction Board and as a crown representative.

He has extensive non-executive experience in the education and housing sectors and is a public member of Network Rail. Bill is Chairman of the Charitable Funds Committee and the Christchurch Fairmile Village LLP.

Derek Dundas, Non-Executive Director
Derek was a Consultant Radiologist in a London teaching hospital for 25 years. Alongside his clinical responsibilities, he was Consultant in Charge of Radiology, Clinical Director for Diagnostic Services and then a Medical Director. He was a governor for five years at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and has now taken on the role of clinical non-executive director. Derek is the Chairman of the Workforce Strategy and Development Committee.

Executive Directors

Tony Spotswood, Chief Executive
Tony has been Chief Executive of the Trust since 2000. He was previously Chief Executive of Leicester General Hospital between 1998 and 2000 and a director for over 20 years. Tony has extensive experience of leading organisations through strategic change including service reconfiguration and merger.

Helen Lingham, Chief Operating Officer (until September 2014)
Helen joined the Trust in April 2008 as Director of Operations, prior to that she was Director of Operations at NHS Lothian. Helen is responsible for strategic leadership, delivery of performance related targets and the development of clinical services across the acute hospital. Her background is in radiography prior to moving into NHS management in 2003. Helen was appointed Deputy Chief Executive in 2010.

Richard Renaut, Director of Service Development (until September 2014), Chief Operating Officer (from September 2014)
Richard joined the NHS 17 years ago through the NHS management training scheme. He has worked in both primary care and tertiary hospital settings. Prior to his appointment as Director of Service Development in April 2006, Richard was General Manager of the Orthopaedic Directorate.

As the Chief Operating Officer, Richard is responsible for the three clinical care groups who in turn provide the clinical services within the Trust. He also has estates, facilities, emergency and business planning within his portfolio.
Karen Allman, Director of Human Resources
Karen was appointed Director of Human Resources in 2007. She joined the NHS in 2003 from the Audit Commission where she was HR Director for District Audit. Her early career was spent in the private sector in retail with Marks & Spencer plc and Fenwick Limited before working in the city at the London Stock Exchange plc. Karen is also responsible for communications.

Stuart Hunter, Director of Finance
Appointed in February 2007, Stuart has over 30 years of NHS experience, combined with being a qualified member of the Chartered Institute of Management Accountants. Stuart brings a commercial outlook to the Trust while understanding the fundamental complexities of the health service. Stuart is responsible for Commercial Services and Business Intelligence.

Basil Fozard, Medical Director
Basil Fozard was appointed as Medical Director in September 2013. Basil is a Consultant Colorectal Surgeon and has worked for the Trust since 1992. He was the Clinical Director for Surgery and a member of the Trust Management Board from 2000 to 2010. He was also a member of the Charitable Funds Committee between 2001 and 2009.

Basil has been a member of a number of local and regional networks relating to cancer services and was appointed Medical Director for the Dorset Cancer Network in January 2012 and held that position until 2013. He also was Chair of the Clinical Services Committee and member of the Executive and Council of the Association of Coloproctology of Great Britain and Ireland between 2007 and 2010.

Paula Shobbrook, Director of Nursing and Midwifery
Paula joined the Trust as Director of Nursing and Midwifery in September 2011. Previously Director of Nursing at Winchester Hospital where she worked for 10 years, Paula’s NHS career includes working as a ward sister in acute medicine, cardiac and respiratory specialties. She also spent some time working in primary care before moving back in to a hospital setting.

Peter Gill, Interim Director of Informatics (from February 2015)
Peter has been Director of Informatics since 2012 and is responsible for the shared informatics service which also serves Poole Hospital NHS Foundation Trust. He has held two previous Informatics Director roles for a total of eight years in London and Head of Informatics at Salisbury NHS Foundation Trust for two years. He has been working in the NHS continuously from 1991, where he joined as a general management trainee. Peter is responsible for delivering the Informatics strategy which aims to improve patient safety by implementing paperless healthcare.
Paragraph B.1.2 of the Code of Governance provides that at least half the board of directors, excluding the chairperson, should comprise non-executive directors determined by the board to be independent. The Trust is non-compliant with this paragraph and its constitution provides for equal numbers between the executive and non-executive directors. The quorum for meetings of the Board of Directors requires that six directors are present including not less than two executive directors and two non-executive directors, one of whom must be the Chairman or the Vice-Chairman/Senior Independent Director of the Board. In addition, the Chairman has a second or casting vote in the case of an equality of votes and no resolution of the Board of Directors may be passed if it is opposed by all of the non-executive directors present at the meeting.

The Chairman was determined to be independent upon appointment and all of the other non-executive directors are considered to be independent. This included Alex Pike who has served on the Board of Directors for more than six years from the date of her first appointment and was reappointed by the Council of Governors for a further period of one year, which commenced during 2014, to provide stability and continuity to the Board of Directors following the failed merger proposal and the appointment of two new non-executive directors.

All of the directors of the Trust meet the “fit and proper” persons test described in the Trust’s provider licence issued by Monitor, the terms of which are reflected in the eligibility requirements for directors in the Trust’s constitution. In addition, all directors meet the requirements of the Care Quality Commission’s Fit and Proper Person Requirement which came into force in November 2014.

Board’s responsibility for Annual Report and Accounts

The directors are required by the National Health Service Act 2006 (as amended):

- to prepare, in respect of each financial year, annual accounts in such form as Monitor may, with the approval of the Secretary of State, direct
- to comply with any directions given by Monitor with the approval of the Secretary of State as to the methods and principles according to which the accounts are prepared and the content and form to be given in the accounts

The accounts must provide a true and fair view and comply with International Financial Reporting Standards and the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15. In preparing the Annual Report and Accounts, the directors are required to:

- select suitable accounting policies and apply them consistently
- make judgements and estimates that are reasonable and prudent
- prepare the annual report and accounts on the going concern basis, unless it is inappropriate to do so

The Board has reviewed the Annual Report and Accounts, having taken into account all the matters considered by the Board and brought to the attention of the Board during the financial year. The Board consider that taken as a whole the Annual Report and Accounts, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust’s performance, business model and strategy.

In the case of persons who are directors as at the date when this report is approved:

- so far as each of the directors is aware, there is no relevant audit information of which the Trust’s auditors are unaware
- each of the directors has taken all steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the Trust’s auditors are aware of that information
This confirmation is given and should be interpreted in accordance with section 418 of the Companies Act 2006.

### Board meetings

The Board of Directors meets on the last Friday of every month, except August, and at other times as necessary. The first part of the meeting is open to the public. Against each name in the table [below] is shown the number of meetings at which the director was present and in brackets the number of meetings that the director was eligible to attend. The number of meetings includes both scheduled and special/extraordinary meetings. The discussions and decisions relating to all items on the agenda of the Board of Directors meetings are recorded in the minutes of the meeting.

Where appropriate, and as required, the Chairman and the non-executive directors meet without the executive directors present. Paragraph B.7.1 of the Foundation Trust Code of Governance specifies that any term of appointment beyond six years (e.g. two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the Board of Directors. It also sets out that non-executive directors may serve longer than six years (e.g. two three-year terms following authorisation of the NHS Foundation Trust) but subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive director’s independence.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen Allman</td>
<td>Director of Human Resources</td>
<td>12 (12)</td>
</tr>
<tr>
<td>David Bennett</td>
<td>Non-Executive Director</td>
<td>7 (12)</td>
</tr>
<tr>
<td>Derek Dundas</td>
<td>Non-Executive Director</td>
<td>11 (12)</td>
</tr>
<tr>
<td>Basil Fozard</td>
<td>Medical Director</td>
<td>9 (12)</td>
</tr>
<tr>
<td>Peter Gill</td>
<td>Interim Director of Informatics (from February 2015)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Stuart Hunter</td>
<td>Director of Finance</td>
<td>12 (12)</td>
</tr>
<tr>
<td>Helen Lingham</td>
<td>Chief Operating Officer (until September 2014)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Ian Metcalfe</td>
<td>Non-Executive Director</td>
<td>12 (12)</td>
</tr>
<tr>
<td>Steven Peacock</td>
<td>Non-Executive Director</td>
<td>11 (12)</td>
</tr>
<tr>
<td>Alexandra Pike</td>
<td>Non-Executive Director (Deputy Chairman and Senior Independent Director)</td>
<td>11 (12)</td>
</tr>
<tr>
<td>Richard Renaut</td>
<td>Director of Service Development (until September 2014)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Richard Renaut</td>
<td>Chief Operating Officer (from September 2014)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Paula Shobbrook</td>
<td>Director of Nursing and Midwifery</td>
<td>12 (12)</td>
</tr>
<tr>
<td>Anthony Spotswood</td>
<td>Chief Executive</td>
<td>12 (12)</td>
</tr>
<tr>
<td>Jane Stichbury</td>
<td>Chairman</td>
<td>12 (12)</td>
</tr>
<tr>
<td>Bill Yardley</td>
<td>Non-Executive Director</td>
<td>10 (12)</td>
</tr>
</tbody>
</table>
Non-executive directors are appointed by the Council of Governors following a selection process through its Non-Executive Director Nomination Committee for specified terms. Historically within the Trust, the initial term of appointment has been four years and the original letter of appointment for some serving non-executive directors created an expectation that any re-appointment following the initial term would be for a term of three years. With the approval of the Council of Governors, and following particularly rigorous review, these commitments have been honoured with the result that some non-executive directors will serve two terms totalling seven years. Dave Bennett, Steven Peacock and Jane Stichbury will all serve over six years.

In determining their independence, the Board of Directors considered whether their previous tenure as non-executive directors of the Trust might affect their independence. The Board concluded based on a number of factors, including their experience and knowledge from other senior executive and non-executive roles and the fact that they have always exercised a strongly independent judgment during the preceding period of tenure as non-executive directors, that the independence of their character and judgement was not compromised.

All new appointments of non-executive directors provide for an initial term of three years and any subsequent re-appointment, subject to approval by the Council of Governors, for a maximum term of three years.

The terms of office and the period of appointment of the non-executive directors is set out in the table (on the next page). These appointments and reappointments were approved by the Council of Governors. Should any non-executive appointment need to be terminated this will be subject to scrutiny and approval by the Council of Governors.

The Board of Directors has given careful consideration to the range of skills, expertise and experience required for the running of a foundation trust and it confirms that the Board has the necessary balance and the required range of skills, expertise and experience has been in place during the year under report.

The performance of the non-executive directors and the Chairman was evaluated during the year. The Chairman led the process of evaluation of the non-executive directors and the Senior Independent Director undertook the evaluation of the performance of the Chairman. In line with the Trust’s appraisal policy agreed by the Council of Governors, the Chairman’s appraisal incorporated the views of the non-executive directors and the governors. No meeting was held as part of this process as specified in paragraph A.4.2 of the Code of Governance. A meeting of non-executive directors without the Chairman present will be incorporated into this process as part of the current year’s appraisal of the Chairman.

<table>
<thead>
<tr>
<th>Non-Executive Director</th>
<th>When appointed</th>
<th>Term of office</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Bennett</td>
<td>1 October 2009 (reappointed on 1 October 2013)</td>
<td>3 years</td>
</tr>
<tr>
<td>Derek Dundas</td>
<td>1 April 2014</td>
<td>3 years</td>
</tr>
<tr>
<td>Ian Metcalfe</td>
<td>2 May 2013 (reappointed on 1 November 2013 and 1 April 2014)</td>
<td>2 years, 1 month</td>
</tr>
<tr>
<td>Steven Peacock</td>
<td>1 October 2009 (reappointed on 1 October 2013)</td>
<td>3 years</td>
</tr>
<tr>
<td>Alexandra Pike</td>
<td>22 June 2006 (reappointed as a Non-Executive Director on 21 June 2014 and as Senior Independent Director on 10 October 2014)</td>
<td>1 year as non-executive director 8 months as senior independent director</td>
</tr>
<tr>
<td>Jane Stichbury</td>
<td>1 April 2010 (reappointed on 1 April 2014)</td>
<td>3 years</td>
</tr>
<tr>
<td>Bill Yardley</td>
<td>1 April 2014</td>
<td>3 years</td>
</tr>
</tbody>
</table>
Governors agreed the evaluation processes for appraising the Chairman and non-executive directors and the outcome of both processes was shared with the Council of Governors.

The Chief Executive undertook performance appraisals of the executive directors and the chief executive’s performance was appraised by the Chairman.

The performance evaluations were used as a basis to determine individual and collective professional development programmes for board members, which will enable them to discharge their duties more effectively.

The Board of Directors, and each of its committees, evaluate its own performance annually and undertake a more formal evaluation every three years. The process includes a review against the committee’s terms of reference. A full evaluation of the Board of Directors was undertaken in 2013/14 as part of the action plan in relation to the Care Quality Commission’s report. No external evaluation has been undertaken and none is planned in 2015/16.

Each director has declared their interests at public meetings. The register of interests is held by the Trust Secretary and is available for inspection by arrangement by contacting the Trust Secretary on 01202 704777. This includes the other significant commitments of the Chairman.

The Board of Directors has worked with Monitor, its regulator, and the Council of Governors to draw attention to the specific challenges around finance and performance faced by the Trust during the year under report.

The Chairman acts as the link between the Board of Directors and the Council of Governors and ensures that the views of the governors and members are communicated to the Board of Directors as a whole.

Governance requirements

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Board of Directors considers the Trust to be fully compliant with the principles of the NHS Foundation Trust Code of Governance as well as with the provisions of the Code in all respects, save as to paragraphs B.1.2 and B.7.1, A.4.2, and E.1.3 where there are other arrangements in place. Details of compliance or an explanation are provided in this report.

The Scheme of Delegation and Reservation of Powers was reviewed in the year under report and will be reviewed at the commencement of each financial year.

Audit Committee

The Trust’s Audit Committee meets at least quarterly and representatives of external audit, internal audit and the counter fraud service attend these meetings. The Director of Finance, Director of Nursing and Midwifery, Chief Operating Officer and representatives from the risk management and clinical audit teams also regularly attend meetings at the request of the chairman. The Audit Committee met five times during the year. The committee members are all independent non-executive directors and during 2014/15 were:

<table>
<thead>
<tr>
<th>Meetings of the Audit Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Steven Peacock (Chairman)</td>
</tr>
<tr>
<td>David Bennett</td>
</tr>
<tr>
<td>Ian Metcalfe</td>
</tr>
</tbody>
</table>

The Audit Committee’s duties cover the following areas:
Internal control, risk management and corporate governance

The committee reviews the establishment and maintenance of an effective system of internal control, risk management and corporate governance, with particular reference to the Trust’s Assurance Framework.

In particular, the committee reviews the adequacy of:

- all risks and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board
- the structure, processes and responsibilities for identifying and managing key risks facing the organisation
- the operational effectiveness of relevant policies and procedures including those related to fraud and corruption and economy, efficiency and effectiveness in the use of resources
- the scope, maintenance and use of the Assurance Framework
- the Trust’s clinical audit programme

Internal audit

The committee:

- appoints the internal auditors, sets the audit fee and resolves any questions of resignation and dismissal
- ensures that the internal audit function is adequately resourced and has appropriate standing within the organisation
- reviews the internal audit programme, considers major findings of internal audit investigations (and management’s response), and ensures co-ordination between the internal and external auditors
- reports non-compliance with, or inadequate responses to, internal audit reports to the Board of Directors
- utilises internal audit reports to provide assurance to the Board of Directors on the governance of the Trust’s Healthcare Assurance Committee. The Healthcare Assurance Committee provides assurance to the Board of Directors on the quality and safety of services which the Trust provides

The Trust does not have an internal audit function but these services are provided by a third party provider of internal audit services which reports to the Audit Committee. The internal auditors, working with staff at the Trust and the Audit Committee, develop an audit plan each year based on the level of inherent risk and the strength of the control environment across the Trust. Depending on changes in the risk profile of certain areas, all areas of the Trust should be covered during the internal audit cycle of three years. The Audit Committee approves the final plan ensuring that the budget is available to meet the costs of delivering the plan. Internal audit is performed in accordance with NHS Internal Audit Standards which must be followed for the NHS.

External audit

The committee:

- considers the appointment of the external auditors, the audit fee and any questions of resignation and dismissal before making a recommendation to the Council of Governors
- discusses with the external auditors, before the audit commences, the nature and scope of the audit, and ensures co-ordination, as appropriate, with internal audit and the representative from the counter fraud service
- reviews external audit reports, together with the management response
- reports non-compliance with, or inadequate responses to, external audit reports to the Board of Directors
- determines the policy on which the external auditors may provide non-audit services to the Trust

The Audit Committee formally reviews the work of the external auditor each year and communicates this to the Council of Governors to ensure that it is aware of the Trust’s satisfaction with its auditors. In addition, the Audit Committee reviews the auditors’ work plan for each year in advance. Deloitte LLP are the appointed auditors and the committee approved their remuneration and terms of
engagement and considered in detail the results of the audit, Deloitte LLP’s performance and independence and the effectiveness of the overall audit process. Deloitte LLP was appointed by the Council of Governors for a term of three years in 2012 with the option to offer up to two extensions each of 12 months’ duration. This was the first time Deloitte LLP was appointed as external auditor to the Trust and the appointment was made following a joint tender process with Poole Hospital NHS Foundation Trust, involving the Chairman of the Audit Committee and Governors of the Trust, and a recommendation from the Audit Committee to the Council of Governors. The Council of Governors determined not to extend Deloitte LLP’s appointment and initiated a tender for external audit services in January 2015. A new auditor will be appointed for 2015/16.

**Counter fraud service**

The committee:
- appoints the counter fraud service, sets the fee and resolves any questions of resignation and dismissal
- ensures that the counter fraud function has appropriate standing within the organisation
- reviews the counter fraud programme, considers major findings of investigations (and management’s response) and ensures co-ordination between the internal auditors and counter fraud
- reports non-compliance with, or inadequate responses to, counter fraud reports to the Board of Directors

**Financial reporting**

The committee reviews the annual financial statements before recommendation to the Board of Directors, focusing particularly on:
- changes in, and compliance with, accounting policies and practices
- major judgemental areas
- significant adjustments resulting from the audit
- the impact of the Trust’s cost improvement programme on clinical risk

**Whistleblowing**

The committee will review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action

In carrying out its duties, the committee is authorised by the Board to:
- recommend actions to the Board
- oversee the investigation of any activities within its terms of reference
- seek any information it requires from any employee of the Trust which may include requiring attendance at its committee meetings and all employees have been directed to cooperate with any requests
- obtain outside legal or other professional advice on any matter within its terms of reference
Significant issues

During the year under report the significant issues that the committee considered were:

- progress of the clinical audit plan to ensure that the Trust was provided with a comprehensive plan across the organisation focused on national and local priorities, compliance with relevant NICE guidance and areas of potential risk or importance based on complaints, incidents or other measures. While there are issues which remain to be resolved to ensure full clinical engagement and the balancing of clinical activity and clinical audit activity, this is being supported through the Trust Management Board (which includes executive directors and clinical directors within its membership) with the assistance of the Medical Director.

- the delivery of the Trust’s transformation savings programme and the management and control of these plans by individual directorates and care groups which is being monitored by the Finance Committee of the Board of Directors. Management teams from individual directorates and care groups attend meetings of the Finance Committee to update on progress where any slippage is identified.

- the monitoring of clinical governance and performance by the Healthcare Assurance Committee.

The Audit Committee reviews the Annual Report and Accounts prior to their approval by the Board. It reviewed and challenged relevant accounting policies and significant financial judgements including the recoverability of receivables, the valuation of land and buildings and provisioning for redundancies. In order to address these issues, the committee sought and received detailed briefings and explanations from the Director of Finance and the Director of Nursing and Midwifery. The chairmen of the Healthcare Assurance Committee and the Finance Committee are members of the Audit Committee and are able to provide details of scrutiny undertaken in these committees where it is appropriate. In carrying out its review of the Annual Report and Accounts, the Audit Committee provides assurance to the Board of Directors, which supports the statement made by the Board that, taken as a whole the annual report and accounts, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust’s performance, business model and strategy.

Non-audit services

The Audit Committee has approved a policy which governs the provision of non-audit services by the external auditors. The policy sets out limits on the services which may be provided by the external auditors so as not to impair their objectivity or independence when reviewing the Trust’s financial statements but does not restrict the Trust from purchasing other services from the external auditors where this is in the best interest of the Trust. Any non-audit services provided by the external auditors are reported to the Audit Committee which is responsible for reviewing the objectivity and independence of the external auditors.

Nomination committees

Non-Executive Director Nomination Committee

The Non-Executive Director Nomination Committee is a committee of the Council of Governors with responsibility for:

- reviewing the number of and skills required for the non-executive directors in the context of the overall Board composition and making recommendations to the Council of Governors on any changes.

- developing succession plans for non-executive directors, taking into account the challenges and opportunities facing the Trust.

- selecting candidates to fill vacancies among the non-executive directors and recommending them to the Council of Governors for appointment.

- making recommendations to the Council of Governors concerning the re-appointment of any non-executive director at the conclusion of their specified term of appointment.
The Non-Executive Director Nomination Committee met twice in 2014/15: once to consider the re-appointment of one non-executive director. The second time was to consider the recruitment of a new non-executive director. The appointment process followed the policy agreed with the Council of Governors. This considered the Board of Directors’ view of the skills, qualifications and experience of its members and any gaps required to be filled. Candidates were identified using an external search agency. The shortlisted candidates will meet with stakeholder groups, undertake psychometric testing and attend a formal interview panel, which will include an independent adviser, before the appointment is made in early 2015/16.

The following table shows who attended the meeting of the committee during 2014/15. Against each name is shown the number of meetings of the committee at which the governor was present and in brackets the number of meetings that the governor was eligible to attend.

<table>
<thead>
<tr>
<th>Name</th>
<th>Meetings attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Stichbury (Chairman)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Judith Adda (until September 2014)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Sue Bungey (until September 2014)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Glenys Brown (from January 2015)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Alf Hall (until September 2014)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>Graham Swetman (from January 2015)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>David Triplow (from January 2015)</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

Executive Director Nomination Committee

The Board of Directors takes on the role of a Nomination Committee as the need arises. In 2014/15 the Board of Directors agreed to expand its Remuneration Committee to become a Nomination and Remuneration Committee in 2015/16. The Chairman will be the chairman of this committee, which will enable a more impartial review of the structure, size and composition of the Board of Directors to be considered.

Two executive appointments were made in the year under report. The role of Chief Operating Officer was filled under open competition and with the help of a recruitment search. An interim appointment was made to the temporary role of Executive Director of Informatics. The requirement for this post will be reviewed in 2015/16. This role or any other substantive appointment will be filled following an open competition process.
Remuneration Report

Remuneration committees

The Trust operates two separate committees to make decisions or recommendations relating to the remuneration of executive and non-executive directors. Each committee is advised by the Director of Human Resources.

The remuneration of executive directors is considered by a committee consisting of all seven non-executive directors. The Remuneration Committee determines the final salaries of the executive directors and makes recommendations to the Board of Directors on annual pay awards and remuneration policies for other staff who are not on Agenda for Change contracts. Details of the membership, number of meetings and attendance at meetings of the Remuneration Committee are shown in the table on page 157.

The remuneration of non-executive directors is considered by a committee comprised of four governors who have been elected by their fellow governors. The Non-Executive Director Remuneration Committee monitors the performance of the non-executive directors, including the Chairman, and makes recommendations to the Council of Governors on the total level of remuneration to be paid to non-executive directors. Details of the membership, number of meetings and attendance at meetings of the Non-Executive Director Remuneration Committee are shown in the table on page 157.

The remuneration of executive and non-executive directors is not included within Agenda for Change. When reviewing the remuneration of executive and non-executive directors, the remuneration committees review pay awards and increases made to staff within the Trust and nationally alongside information on remuneration for directors at other trusts of a similar size and nature, taking account of overall and individual performance, with the aim of ensuring that directors’ remuneration is fair and appropriate. Once every three years external consultants undertake a benchmarking exercise and, in the intervening years, less formal reviews are conducted using data collated by NHS Providers (formerly the Foundation Trust Network).

The Non-Executive Director Remuneration Committee is advised by the Director of Human Resources on market rates and relativities (based on research commissioned by the Trust and carried out and reported upon by NHS partners). The Remuneration Committee is advised by the Chief Executive on performance aspects, by the Director of Finance on the financial implications of remuneration or other proposals and by the Director of Human Resources on personnel and remuneration policy. No independent consultants, who materially assisted the committees in their consideration of any matter, were engaged to provide advice or services to the Remuneration Committee or the Non-Executive Director Remuneration Committee during the year under report. The Trust Secretary attends meetings of both committees to record the proceedings.

Directors’ and governors’ expenses

The expenses of directors and staff governors are reimbursed in accordance with the Trust’s policy on expenses applicable to all staff. Travel and other costs and expenses for all other governors are reimbursed in accordance with a separate policy approved by the Remuneration Committee, which is comprised of non-executive directors. Governors are volunteers and do not receive any remuneration for their role.
Attendance at meetings
Against each name is shown the number of meetings of the committees at which the non-executive director or governor was present and in brackets the number of meetings that the non-executive director or governor was eligible to attend as a member of the committee during 2014/15.

Meetings of the Remuneration Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Meetings attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Stichbury (Chair)</td>
<td>7 (7)</td>
</tr>
<tr>
<td>David Bennett</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Derek Dundas</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Ian Metcalfe</td>
<td>5 (7)</td>
</tr>
<tr>
<td>Steven Peacock</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Alexandra Pike</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Bill Yardley</td>
<td>6 (7)</td>
</tr>
</tbody>
</table>

Meetings of the Non-Executive Director Remuneration Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Meetings attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eric Fisher (Chair)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Judith Adda (until September 2014)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Glenys Brown (from January 2015)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Sue Bungey (until September 2014)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Alf Hall (until September 2014)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Graham Swetman (from January 2015)</td>
<td>0 (1)</td>
</tr>
<tr>
<td>David Triplow (from January 2015)</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

Summary and explanation of policy on duration of contracts, notice periods and termination payments

Executive directors
All executive directors are required to give/receive six months’ notice of termination. In appropriate cases this can be varied by mutual agreement. All contracts are permanent (i.e. not fixed term). All senior managers who are appointed on permanent contracts are required to give/receive three months’ notice of termination.

There are no provisions in place for termination payments, other than through legal compromise agreements.

Non-executive directors
Arrangements for the termination of the appointment of a non-executive director are set out in the Trust’s constitution and a period of one month’s notice is required.

Mr A Spotswood
Chief Executive
28 May 2015
## Senior manager remuneration

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Members</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr A Spotswood</td>
<td>Chief Executive</td>
<td>190-195</td>
<td>190-195</td>
</tr>
<tr>
<td>Mrs M Armitage</td>
<td>Medical Director (see note 1)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mr B Fozard</td>
<td>Medical Director (see note 2)</td>
<td>130-135</td>
<td>130-135</td>
</tr>
<tr>
<td>Mrs H Lingham</td>
<td>Chief Operating Officer (see note 3)</td>
<td>60-65</td>
<td>60-65</td>
</tr>
<tr>
<td>Mr R Renaut</td>
<td>Chief Operating Officer (see note 4)</td>
<td>120-125</td>
<td>120-125</td>
</tr>
<tr>
<td>Mr S Hunter</td>
<td>Director of Finance</td>
<td>130-135</td>
<td>130-135</td>
</tr>
<tr>
<td>Mrs P Shobbrook</td>
<td>Director of Nursing and Midwery</td>
<td>110-115</td>
<td>110-115</td>
</tr>
<tr>
<td>Mrs K Allman</td>
<td>Director of Human Resources</td>
<td>110-115</td>
<td>110-115</td>
</tr>
<tr>
<td>Mr P Gill</td>
<td>Director of Informatics (see note 5)</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td><strong>Board Member</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr P Gill</td>
<td>Director of Informatics (see note 5)</td>
<td>40-45</td>
<td>40-45</td>
</tr>
<tr>
<td><strong>Non-Executive Members</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs J Stichbury</td>
<td>Chairman</td>
<td>50-55</td>
<td>50-55</td>
</tr>
<tr>
<td>Mrs A Pike</td>
<td>Non-Executive Director</td>
<td>15-20</td>
<td>15-20</td>
</tr>
<tr>
<td>Mr D Bennett</td>
<td>Non-Executive Director</td>
<td>15-20</td>
<td>15-20</td>
</tr>
<tr>
<td>Mr S Peacock</td>
<td>Non-Executive Director</td>
<td>10-15</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr I Metcalfe</td>
<td>Non Executive Director (see note 6)</td>
<td>15-20</td>
<td>15-20</td>
</tr>
<tr>
<td>Mr W Yardley</td>
<td>Non Executive Director (see note 7)</td>
<td>10-15</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr D Dundas</td>
<td>Non Executive Director (see note 7)</td>
<td>10-15</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr B Ford</td>
<td>Non Executive Director (see note 8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mr K Tullett</td>
<td>Non Executive Director (see note 8)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Notes:

1. Mrs M Armitage retired from her post as Medical Director on 6 September 2013. The salary shown for 2013/14 represents her Medical Director post for the Trust; the ‘Other Remuneration’ represents her post as a medical consultant.
2. The salary shown against Mr B Fozard represents his Medical Director post for the Trust; the ‘Other Remuneration’ represents his post as a medical consultant. He commenced his post as Medical Director on 7 September 2013.
3. Mrs H Lingham resigned from her post as Chief Operating Officer with effect from 30 September 2014.
4. Mr R Renaut commenced his role as Chief Operating Officer on 15 September 2014. Previously he was Director of Service Development.
5. Mr P Gill holds a joint Director of Informatics post with Poole Hospital NHS Foundation Trust and was recharged on a half-time basis. He became an interim Executive Director 1 February 2015.
6. Mr I Metcalfe commenced his post as non executive director on 2 May 2013.
7. Mr W Yardley and Mr D Dundas commenced in their non executive director posts on 1 April 2014.
8. Mr B Ford and Mr K Tullett retired from their posts as non executive directors on 31 March 2014.
9. Senior manager remuneration does not include any ‘annual performance-related bonuses’ or ‘long-term performance-related bonuses’.
10. No individual named above received any benefit in kind during the financial year ended 31 March 2014 or financial year ended 31 March 2013.
11. No other categories in the proforma single figure table disclosure are relevant to the Trust.

12. Of the 15 executive/non executive directors employed during 2014/15, 10 received expenses during the year amounting to a total of £7,573.

13. There are 23 governors (excluding staff governors), of which nine received expenses during the year amounting to a total of £4,000.

14. Mr B Fozard will retire in June 2015 and will draw his pension. He will rejoin the Trust as Medical Director and will be paid a salary for this role.

**Median Total Remuneration:**
The HM Treasury FReM requires disclosure of the median remuneration of the reporting entity’s staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director. The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis.

The median total remuneration was calculated by annualising the March salary payments, and adjusting this for outliers that would adversely distort the results. Agency costs have been excluded from this calculation.

### Senior manager pension entitlements

<table>
<thead>
<tr>
<th>Name</th>
<th>Title (as at 31 March 2015)</th>
<th>Real Increase in Pension and Related Lump Sum at age 60 (Bands of £2500)</th>
<th>Total accrued Pension and Related Lump Sum at age 60 at 31 March 2014 (Bands of £5000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2014 £’000</th>
<th>Cash Equivalent Transfer Value at 31 March 2013 (Inflated) £’000</th>
<th>Real Increase in Cash Equivalent Transfer Value £’000</th>
<th>Employer-Funded contribution to growth in CETV for the year £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr A Spotswood</td>
<td>Chief Executive</td>
<td>0-2.5</td>
<td>310-315</td>
<td>1,536</td>
<td>1,491</td>
<td>45</td>
<td>23</td>
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<tr>
<td>Mrs P Shobbrook</td>
<td>Director of Nursing and Midwifery</td>
<td>0</td>
<td>140-145</td>
<td>560</td>
<td>582</td>
<td>(22)</td>
<td>(11)</td>
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<tr>
<td>Mr S Hunter</td>
<td>Director of Finance</td>
<td>0-2.5</td>
<td>210-215</td>
<td>1,056</td>
<td>1,021</td>
<td>35</td>
<td>18</td>
</tr>
<tr>
<td>Mr R Renaut</td>
<td>Chief Operating Officer</td>
<td>10-12.5</td>
<td>105-110</td>
<td>371</td>
<td>324</td>
<td>47</td>
<td>24</td>
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<tr>
<td>Mrs K Allman</td>
<td>Director of Human Resources</td>
<td>2.5-5</td>
<td>60-65</td>
<td>321</td>
<td>292</td>
<td>29</td>
<td>15</td>
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<tr>
<td>Mr B Fozard</td>
<td>Medical Director</td>
<td>12.5-15</td>
<td>320-325</td>
<td>1,866</td>
<td>1,679</td>
<td>187</td>
<td>96</td>
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<tr>
<td>Mr P Gill</td>
<td>Director of Informatics</td>
<td>Not applicable</td>
<td>100-105</td>
<td>420</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Notes:**

1. Non executive directors do not receive pensionable remuneration, and as such, there are no entries in respect of pensions for non executive directors.

2. Mr P Gill holds a joint Director of Informatics post with Poole Hospital NHS Foundation Trust. He was employed by Poole Hospital NHS Foundation Trust during 2013/14 meaning that only limited pensions information is available.

**Cash Equivalent Transfer Values**

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated as prescribed by the Institute and Faculty of Actuaries.

**Real Increase in CETV**

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Mr A Spotswood, Chief Executive, 28 May 2015
Council of Governors

There are 29 members of the Council of Governors. The Council of Governors’ principal duties are:

- to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors
- to represent the interests of the members of the Trust as a whole and the interests of the public

The role and responsibilities of the Council of Governors are set out in the NHS Act 2006 and were extended under the Health and Social Care Act 2012.

During 2014/15, the Trust worked with the Council of Governors to consult with the Trust’s membership and the public specifically on its forward plans. The forward plan included its financial, quality and operating objectives and a review of outcomes to evaluate its performance.

In 2014/15, the Council of Governors was made up as follows:

### Public governors - Bournemouth and Poole constituency (elected)

- Judith Adda (until September 2014)
- Jayne Baker (until September 2014)
- David Bellamy (re-elected from September 2014)
- Glenys Brown
- Sharon Carr-Brown (until September 2014)
- Carole Deas (re-elected from September 2014)
- Paul Higgs (from September 2014)
- Keith Mitchell (re-elected from September 2014)
- Roger Parsons (from September 2014)
- Colin Pipe (from September 2014)

### Public governors - Christchurch and Dorset County constituency (elected)

- Eric Fisher (Deputy Chairman of the Council of Governors and Lead Governor until 28 April 2015)
- Alf Hall (until September 2014)
- Doreen Holford (re-elected from September 2014)
- Brian Young (from September 2014)
- Paul McMillan (from September 2014)

### Public governors - New Forest, Hampshire and Salisbury constituency (elected)

- Mike Allen (re-elected from September 2014)
- Bob Gee (re-elected from September 2014)
- Graham Swetman (re-elected from September 2014)

### Staff governors (elected)

- Dean Feegrade
- Ian Knox (re-elected from September 2014)
- Richard Owen (re-elected from September 2014)
- Dexter Perry (until January 2015)
- Emma Willett (until September 2014)
Appointed governors (appointed by their respective organisation)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Adams</td>
<td>Bournemouth Borough Council</td>
</tr>
<tr>
<td>Phil Goodall</td>
<td>Poole Borough Council</td>
</tr>
<tr>
<td>Colin Jamieson</td>
<td>Dorset Borough Council</td>
</tr>
<tr>
<td>Tom Knight</td>
<td>Dorset Clinical Commissioning Group</td>
</tr>
<tr>
<td>Gail Thomas</td>
<td>Bournemouth University</td>
</tr>
<tr>
<td>Vacant</td>
<td>The Royal Bournemouth and Christchurch Hospitals Volunteers Group</td>
</tr>
</tbody>
</table>

All of the governors meet the “fit and proper” persons test described in the Trust’s provider licence issued by Monitor, the terms of which are reflected in the eligibility requirements for governors in the Trust’s Constitution.

Each governor has declared their interests at public meetings. The register of interests is held by the Trust Secretary and is available for inspection by arrangement by contacting the Trust Secretary on 01202 704777.

There are the following vacancies on the Council of Governors at the end of the year under report:

- Staff Governor Medical and Dentistry (filled from April 2015)
- Staff Governor Nursing, Midwifery and Healthcare Assistants (filled from April 2015)
- Appointed Governor Internal Hospital Volunteers (filled from April 2015)

Public and staff governors are elected by secret ballot of the relevant public constituency or staff class using the first past the post system. Each governor is elected for a term of three years.

At each meeting of the Council of Governors, a declaration of any interests held which may conflict with the role of any governor is recorded. A copy of the declaration of interest is included in the papers for each meeting of the Council of Governors which are available on the Trust’s website and can be inspected by arrangement with the Trust Secretary.

The nominated Lead Governor for the Trust is Eric Fisher.

Executive and non-executive directors attend the public meetings of the Council of Governors both to report on matters and take questions from the governors and in order to develop a deeper understanding of the views of governors and members. Governors also attend the public meetings of the Board of Directors and have the opportunity to ask questions of the Board of Directors at the end of these meetings. The Council of Governors and Board of Directors also have joint seminars to consider and discuss issues of concern to the directors and governors.

In order to discharge its duties, the Council of Governors met five times in 2014/15. It received and considered all appropriate information required to discharge its duties. The Council of Governors periodically assesses its performance. In addition, individual and collective development needs are considered and included in a training programme.

Attendance at Council of Governor meetings is set out in the table (on the next page). Against each name is shown the number of meetings of the Council of Governors at which the governor or director was present and in brackets the number of meetings that the governor or director was eligible to attend during 2014/15. The number of meetings includes both scheduled and special/extraordinary meetings.
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Constituency/class/appointing organisation</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Stichbury</td>
<td>Chairman</td>
<td>Bournemouth Borough Council</td>
<td>5 (5)</td>
</tr>
<tr>
<td>John Adams</td>
<td>Appointed Governor</td>
<td>Bournemouth Borough Council</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Judith Adda (until September 2014)</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Mike Allen (re-elected from September 2014)</td>
<td>Public Governor</td>
<td>New Forest, Hampshire and Salisbury</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Chris Archibold</td>
<td>Public Governor</td>
<td>Christchurch and Dorset County</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Jayne Baker (until September 2014)</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>2 (2)</td>
</tr>
<tr>
<td>David Bellamy (re-elected from September 2014)</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Glenys Brown</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Sue Bungey (until September 2014)</td>
<td>Public Governor</td>
<td>Christchurch and Dorset County</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Sharon Carr-Brown (until September 2014)</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Derek Chaffey (re-elected from September 2014)</td>
<td>Public Governor</td>
<td>Christchurch and Dorset County</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Carole Deas (re-elected from September 2014)</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Dean Feegrade</td>
<td>Staff Governor</td>
<td>Administrative and Clerical/Management</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Eric Fisher (re-elected from September 2014)</td>
<td>Public Governor</td>
<td>Christchurch and Dorset County</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Bob Gee (re-elected from September 2014)</td>
<td>Public Governor</td>
<td>New Forest, Hampshire and Salisbury</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Phil Goodall</td>
<td>Appointed Governor</td>
<td>Poole Borough Council</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Alf Hall (until September 2014)</td>
<td>Public Governor</td>
<td>Christchurch and Dorset County</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Paul Higgs (from September 2014)</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Board Role</td>
<td>Terms of Office</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Doreen Holford</td>
<td>Public Governor</td>
<td>Christchurch and Dorset County</td>
<td>4 (5)</td>
</tr>
<tr>
<td>(re-elected from September</td>
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<td></td>
</tr>
<tr>
<td>2014)</td>
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<tr>
<td>Colin Jamieson</td>
<td>Appointed Governor</td>
<td>Dorset County Council</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Tom Knight</td>
<td>Appointed Governor</td>
<td>Dorset Clinical Commissioning Group</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Ian Knox</td>
<td>Staff Governor</td>
<td>Allied Health Professionals, Scientific and</td>
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</tr>
<tr>
<td>(re-elected from September</td>
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<td>Technical</td>
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<tr>
<td>2014)</td>
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</tr>
<tr>
<td>Paul McMillan (from</td>
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<td>Christchurch and Dorset County</td>
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</tr>
<tr>
<td>September 2014)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Keith Mitchell</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>4 (5)</td>
</tr>
<tr>
<td>(re-elected from September</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Richard Owen</td>
<td>Staff Governor</td>
<td>Estates and Ancillary Services</td>
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<tr>
<td>(re-elected from September</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roger Parsons</td>
<td>Public Governor</td>
<td>Bournemouth and Poole</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Graham Swetman (from</td>
<td>Public Governor</td>
<td>New Forest, Hampshire and Salisbury</td>
<td>4 (5)</td>
</tr>
<tr>
<td>September 2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gail Thomas</td>
<td>Appointed Governor</td>
<td>Bournemouth University</td>
<td>4 (5)</td>
</tr>
<tr>
<td>David Triplow</td>
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<td>Bournemouth and Poole</td>
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<tr>
<td>(re-elected from September</td>
<td></td>
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</tr>
<tr>
<td>2014)</td>
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<tr>
<td>Monika Whitmarsh</td>
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<td>Bournemouth and Poole</td>
<td>0 (3)</td>
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<tr>
<td>(from September 2014)</td>
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<td></td>
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</tr>
<tr>
<td>Emma Willett (until</td>
<td>Staff Governor</td>
<td>Nursing, Midwifery and Healthcare Assistants</td>
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</tr>
<tr>
<td>September 2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brian Young</td>
<td>Public Governor</td>
<td>Christchurch and Dorset County</td>
<td>3 (3)</td>
</tr>
</tbody>
</table>
The Council of Governors has a policy for addressing any consistent and unjustifiable failures to attend its meetings. This policy covers the actions required to address any actual or potential conflict of interest which may prevent a governor exercising their duties properly.

The Council of Governors engages with the Board of Directors through the Chairman and Senior Independent Director. Any concerns would be raised with them.

Paragraph E.1.3 of the Code of Governance specifies that the Senior Independent Director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.

The Senior Independent Director has not attended any of the five formal meetings of the Council of Governors during 2014/15. However, the Senior Independent Director is a member of a number of committees where the attendees also includes governors and governors also attend meetings of the Board of Directors with an opportunity to comment and ask questions of the Board of Directors at the end of the meeting. There are also joint seminars of the directors and governors and less formal meetings between the non-executive directors and governors, which provide opportunities for governors to express their views and highlight any issues or concerns.

<table>
<thead>
<tr>
<th>Directors:</th>
<th>Director of Human Resources</th>
<th>Non-Executive Directors</th>
<th>Non-Executive Director</th>
<th>Medical Director</th>
<th>Director of Finance</th>
<th>Chief Operating Officer</th>
<th>Non-Executive Director</th>
<th>Non-Executive Director/Deputy Chairman/Senior Independent Director</th>
<th>Director of Service Development</th>
<th>Chief Operating Officer</th>
<th>Director of Nursing and Midwifery</th>
<th>Chief Executive</th>
<th>Non-Executive Director</th>
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</thead>
<tbody>
<tr>
<td>Karen Allman</td>
<td>4</td>
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<td>David Bennett</td>
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<td>Derek Dundas</td>
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<tr>
<td>Basil Fozard</td>
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<tr>
<td>Stuart Hunter</td>
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<tr>
<td>Ian Metcalfe</td>
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<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Steven Peacock</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Alexandra Pike</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Richard Renaut</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Richard Renaut</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Paula Shobbrook</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Tony Spotswood</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Bill Yardley</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>


Elections

Elections were held in three public constituencies and four staff classes during the year. Efforts to maximise nominations included contacting members and articles in staff publications and on the Trust’s intranet and meetings prior to nomination. Two of the public constituency elections were contested. All staff class elections were uncontested. The elections to the Council of Governors were held in accordance with the Constitution. Nursing, Midwifery and Healthcare Assistants and Medical and Dentistry staff governors will take up post in April 2015.

<table>
<thead>
<tr>
<th>Date of election</th>
<th>Constituency / Staff Class</th>
<th>Number of members in constituency</th>
<th>Number of seats contested</th>
<th>Number of contestants</th>
<th>Election turnout (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2014</td>
<td>Bournemouth and Poole Constituency</td>
<td>8,782</td>
<td>8</td>
<td>12</td>
<td>27.6%</td>
</tr>
<tr>
<td>June 2014</td>
<td>Christchurch and Dorset County Constituency</td>
<td>1,877</td>
<td>5</td>
<td>6</td>
<td>32.7%</td>
</tr>
<tr>
<td>June 2014</td>
<td>New Forest, Hampshire and Salisbury Constituency</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td>Allied Health Professional, Scientific and Technical</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td>Estates and Ancillary Services</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td>Nursing, Midwifery and Healthcare Assistants</td>
<td>No election</td>
<td>No election</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2014</td>
<td>Nursing, Midwifery and Healthcare Assistants</td>
<td>No election</td>
<td>No election</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2015</td>
<td>Nursing, Midwifery and Healthcare Assistants</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td></td>
</tr>
<tr>
<td>March 2015</td>
<td>Medical and Dentistry</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td>Uncontested</td>
<td></td>
</tr>
</tbody>
</table>

Membership

During 2014/15, the Council of Governors has continued to develop on its existing membership strategy using health talks, constituency events, monthly emails and the quarterly membership newsletter to engage with existing members and recruit new members. The strategy has also been developed to focus on recruitment of members from groups which have historically been under-represented in the Trust membership: younger people and minority ethnic groups. Through presentations and attendance at careers events at local schools the Trust has begun to recruit younger members and is seeking to engage with local authorities in its public constituencies and local Healthwatch to reach minority ethnic groups. The membership strategy set a recruitment target of 350 new public members for 2014/15 and the performance against that target is shown in the table on page 166.

Over the next 12 months the governors will:

- continue local constituency meetings whether these are educational or for consultation
- continue the work with local schools including holding ‘Careers in the NHS’ events for students in Year 12 at local schools
- provide more information in the FT Focus member magazine and in regular emails to members who have provided their email address about governors’ activities
• develop the governor and member pages on the Trust’s website to provide more information to members and the public

• try to increase the awareness and understanding of members and the local community of the NHS and foundation trusts and the benefits of foundation trust membership

As at 31 March 2015, there were 14,964 members in the following constituencies:

<table>
<thead>
<tr>
<th>Public constituency</th>
<th>Last year (2014/15)</th>
<th>Next year (2015/16) (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At year start (1 April)</td>
<td>11,295</td>
<td>11,284</td>
</tr>
<tr>
<td>New members</td>
<td>544</td>
<td>350</td>
</tr>
<tr>
<td>Members leaving</td>
<td>555</td>
<td>500</td>
</tr>
<tr>
<td>At year end (31 March)</td>
<td>11,284</td>
<td>11,134</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff constituency</th>
<th>Last year (2014/15)</th>
<th>Next year (2015/16) (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At year start (1 April)</td>
<td>1,345</td>
<td>3,680</td>
</tr>
<tr>
<td>New members</td>
<td>3,003</td>
<td>500</td>
</tr>
<tr>
<td>Members leaving</td>
<td>668</td>
<td>500</td>
</tr>
<tr>
<td>At year end (31 March)</td>
<td>3,680</td>
<td>3,680</td>
</tr>
</tbody>
</table>

**Analysis of membership in constituencies (as at 31 March 2015)**

<table>
<thead>
<tr>
<th>Public</th>
<th>Staff</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bournemouth and Poole</td>
<td>Medical and Dentistry</td>
<td>320</td>
</tr>
<tr>
<td>Christchurch and Dorset County</td>
<td>Allied Healthcare Professionals, Scientific and Technical</td>
<td>654</td>
</tr>
<tr>
<td>New Forest, Hampshire and Salisbury</td>
<td>Nursing Midwifery and Healthcare Assistants</td>
<td>1,534</td>
</tr>
<tr>
<td></td>
<td>Administrative and Clerical Management</td>
<td>850</td>
</tr>
<tr>
<td></td>
<td>Estates and Ancillary Services</td>
<td>322</td>
</tr>
</tbody>
</table>

**Notes**

• The constitution was amended to include all staff unless they opt out, as members during 2014/15.

• In addition to staff on permanent contacts members of staff on fixed term or temporary contracts who have been continuously employed by the Trust for at least 12 months are eligible to become members of the staff constituency although this does not include bank staff.
Analysis of current public membership (as at 31 March 2015)

As at 31 March 2015, there were 11,284 public members in the following demographic groups:

<table>
<thead>
<tr>
<th>Public constituency</th>
<th>Number of members</th>
<th>Eligible membership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-16</td>
<td>195</td>
<td>254,651</td>
</tr>
<tr>
<td>17-21</td>
<td>624</td>
<td>90,702</td>
</tr>
<tr>
<td>22+</td>
<td>9,018</td>
<td>1,065,042</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>10,660</td>
<td>1,304,608</td>
</tr>
<tr>
<td>Mixed</td>
<td>73</td>
<td>19,674</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>122</td>
<td>41,943</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>29</td>
<td>9,842</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>6,561</td>
</tr>
<tr>
<td><strong>Socio-economic groupings</strong>:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AB</td>
<td>3,635</td>
<td>95,655</td>
</tr>
<tr>
<td>C1</td>
<td>3,343</td>
<td>131,260</td>
</tr>
<tr>
<td>C2</td>
<td>2,162</td>
<td>92,209</td>
</tr>
<tr>
<td>DE</td>
<td>2,100</td>
<td>92,037</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4,605</td>
<td>694,597</td>
</tr>
<tr>
<td>Female</td>
<td>6,679</td>
<td>715,797</td>
</tr>
</tbody>
</table>

Notes

- The analysis above excludes 1,447 public members with no stated date of birth, 379 members with no stated ethnicity and zero members with no stated gender.
- Socio-economic data should be completed using profiling techniques (e.g. postcode) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this information.
- The population data used to calculate “Eligible membership” in the table above may differ as a result of using the most reliable source for this data. This may lead to variations in the total of eligible members provided under each section of the table, primarily due to the currency of the data.

Members who wish to communicate with their governors should contact:

Governor Co-ordinator (B28)
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Castle Lane East
Bournemouth
BH7 7DW

or email: ftmembers@rbch.nhs.uk
Consolidated Financial Statements
For the year ended 31 March 2015
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The Foundation Trust

NHS Foundation Trust Code: RDZ

Registered Office: The Royal Bournemouth Hospital
Castle Lane East
Bournemouth
BH7 7DW

Executive Directors:
Mr A Spotswood Chief Executive
Mrs P Shobbrook Director of Nursing and Midwifery
Mr S Hunter Director of Finance
Mr R Renaut Chief Operating Officer
Mrs K Allman Director of Human Resources
Mr B Fozard Medical Director
Mr Peter Gill Director of Informatics (Interim Executive)

Non-Executive Directors:
Mrs J Stichbury Chairman
Mr I Metcalfe Non Executive Director
Mrs A Pike Non Executive Director
Mr B Yardley Non Executive Director
Mr S Peacock Non Executive Director
Mr D Bennett Non Executive Director
Mr D Dundas Non Executive Director

Trust Secretary: Mrs S Anderson Trust Secretary

Bankers: Barclays PLC
London

Solicitors: DAC Beachcroft LLP
Winchester

Internal Auditors: PricewaterhouseCoopers LLP
Southampton

External Auditors: Deloitte LLP
Reading
Foreword to the accounts

These accounts for the year ended 31 March 2015 for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the “Foundation Trust”) have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, and comply with the annual reporting guidance for NHS Foundation Trusts within the NHS Foundation Trust Financial Reporting Manual (FT FReM) for the financial year.

Mr A Spotswood  
Chief Executive  
28 May 2015
Accounting Officer’s statement

Statement of the Chief Executive’s responsibilities as the accounting officer of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the National Health Service Act 2006, Monitor has directed The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgments and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him to ensure that the accounts comply with the requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor’s NHS Foundation Trust Accounting Officer Memorandum.

Mr A Spotswood
Chief Executive
28 May 2015
Auditors’ Report

Independent Auditor’s Report to the Council of Governors and Board of Directors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Opinion on the financial statements of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust’s affairs as at 31 March 2015 and of the Group’s and Trust’s income and expenditure for the year then ended
- have been properly prepared in accordance with the accounting policies directed by Monitor
- have been prepared in accordance with the requirements of the National Health Service Act 2006

The financial statements comprise the Consolidated and Trust Statements of Comprehensive Income, the Group and Trust Statements of Financial Position, the Group and Trust Statements of Changes in Taxpayers Equity and the Group and Trust Statements of Cashflows and the related notes 1 to 33. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Going concern

We have reviewed the Accounting Officer’s statement on page 5 that the Group is a going concern. We confirm that:

- we have concluded that the Accounting Officer’s use of the going concern basis of accounting in the preparation of the financial statements is appropriate
- we have not identified any material uncertainties that may cast significant doubt on the Group’s ability to continue as a going concern

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group’s ability to continue as a going concern.
Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

<table>
<thead>
<tr>
<th>Risk</th>
<th>How the scope of our audit responded to the risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS revenue</td>
<td>We evaluated the design and implementation of controls over recognition of Payment by Results income.</td>
</tr>
<tr>
<td></td>
<td>We performed detailed substantive testing of the recoverability of over performance income and the adequacy of</td>
</tr>
<tr>
<td></td>
<td>the provision for underperformance through the year, and evaluated the results of the agreement of balances</td>
</tr>
<tr>
<td></td>
<td>exercise.</td>
</tr>
<tr>
<td></td>
<td>We tested the historical accuracy of provisions made for disputes with commissioners, and considered this in</td>
</tr>
<tr>
<td></td>
<td>evaluating bad debt provisions and other provisions in respect of NHS income at 31 March 2015.</td>
</tr>
<tr>
<td></td>
<td>We challenged key judgements around specific areas of dispute and actual or potential challenge from</td>
</tr>
<tr>
<td></td>
<td>commissioners and the rationale for the accounting treatments adopted.</td>
</tr>
<tr>
<td>Property valuations</td>
<td>We evaluated the design and implementation of controls over property valuations, and tested the accuracy and</td>
</tr>
<tr>
<td></td>
<td>completeness of data provided by the Trust to the valuer.</td>
</tr>
<tr>
<td></td>
<td>We used internal valuation specialists to review and challenge the appropriateness of the key assumptions used</td>
</tr>
<tr>
<td></td>
<td>in the valuation of the Trust’s properties through discussion with the district valuer.</td>
</tr>
<tr>
<td></td>
<td>We assessed whether the valuation and its accounting treatment were compliant with the relevant accounting</td>
</tr>
<tr>
<td></td>
<td>standards and in particular whether impairments should be recognised within the deficit for the year or in</td>
</tr>
<tr>
<td></td>
<td>Other Comprehensive Income.</td>
</tr>
</tbody>
</table>

Revenue for the year was £267m (2013: £260m). There are significant judgments in recognition of revenue from contracts for delivering care to NHS patients and service users and in provisioning for disputes with commissioners due to:

- the complexity of the Payment by Results regime, in particular in determining the level of over performance and Commissioning for Quality and Innovation (CQUIN) revenue to recognise
- the judgemental nature of provisions for disputes, including in respect of performance income. There is minimal risk of overperformance on the basis that the majority contracts are managed contracts.

The Trust holds property assets within Property, Plant and Equipment that are initially measured at cost and subsequently measured at fair value. This has resulted in an increase of £3.9m to the fair value of the property held by the Trust.

The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value.
**Accounting for Capital Expenditure**

The Trust has an extensive capital programme and additions in 2014/15 amounted to more than £17m.

Determining whether expenditure should be capitalised can involve significant judgement as to whether the costs meet the accounting standards criteria for capitalisation.

In addition, accounting adjustments may be required to the carrying values of assets that are being replaced or refurbished.

We tested the design and implementation of controls around the capitalisation of costs and tested individual transactions on a sample basis to assess compliance with relevant accounting requirements. We have also considered whether any impairment arises in respect of newly capitalised expenditure.

We obtained an understanding of key projects and challenged the appropriateness of accounting for significant transactions in connection with the project. We have also considered the increase in value of adjustments of old assets were dealt with as part of the revaluation process.

**Going Concern Assessment**

The Directors’ Going Concern statement is set out on page 38 of the Annual Report, and the Trust’s principal risks and uncertainties on page 138 of the Annual Governance Statement.

The going concern assessment became an area of significant audit focus because the final deficit of £5.2m for the year ended 31 March 2015 was higher than had been previously forecast by the Trust and the uncertainties detailed in the Directors’ statement.

We evaluated management's going concern assessment by challenging the key judgements within the Trust's forecasts through to the end of 2016/17 financial year, including assumptions over activity levels, cost improvement programme savings, and cost of agency staff requirements.

We examined the Trust's funding agreements that are in place, reviewed the operational plan and considered how projections compare with other trusts and the headroom available.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page 151 of the Directors Report.

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

We determined materiality for the Group to be £2.6m, which is below 1% of Operating Income and below 2% of Total Taxpayers Equity.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £129,000, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including internal controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust’s head offices in Bournemouth directly by the audit engagement team, led by the audit partner. We also performed substantive analytical procedures on The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust’s Charitable Funds trial balance based on component materiality for the purposes of consolidation.

At the Group level, we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and information technology systems.

All testing was performed by the main audit engagement team, led by the audit partner.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors’ Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006
- the information given in the Strategic Report and the Directors’ Report for the financial year for which the financial statements are prepared is consistent with the financial statements
Matters on which we are required to report by exception

Under the Audit Code for NHS Foundation Trusts, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit

- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

- proper practices have not been observed in the compilation of the financial statements

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Opinion on other matters prescribed by the National Health Service Act 2006

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements

- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit

- otherwise misleading

In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors’ statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.
Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Accounting Officer’s Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team and independent partner reviews.

This report is made solely to the Council of Governors and Board of Directors (“the Boards”) of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group’s and the Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Susan Barratt, BA, ACA
(Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Reading
28 May 2015
# Statement of Comprehensive Income

<table>
<thead>
<tr>
<th>Notes</th>
<th>Group 2014/15</th>
<th>Group 2013/14</th>
<th>Trust 2014/15</th>
<th>Trust 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating income from continuing operations</td>
<td>4</td>
<td>266,539</td>
<td>260,323</td>
<td>266,232</td>
</tr>
<tr>
<td>Operating expenses of continuing operations</td>
<td>7</td>
<td>(267,555)</td>
<td>(255,856)</td>
<td>(266,870)</td>
</tr>
<tr>
<td>OPERATING (DEFICIT)/SURPLUS</td>
<td></td>
<td>(1,016)</td>
<td>4,467</td>
<td>(638)</td>
</tr>
<tr>
<td>FINANCE COSTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance income: interest receivable</td>
<td>12</td>
<td>154</td>
<td>169</td>
<td>149</td>
</tr>
<tr>
<td>Finance expense: Finance lease/loan interest</td>
<td>13</td>
<td>(247)</td>
<td>(48)</td>
<td>(247)</td>
</tr>
<tr>
<td>Finance expense: Unwinding of discount on provisions</td>
<td>23</td>
<td>(12)</td>
<td>(11)</td>
<td>(12)</td>
</tr>
<tr>
<td>Movement in fair value of investment property and other investments</td>
<td></td>
<td>286</td>
<td>210</td>
<td>0</td>
</tr>
<tr>
<td>(DEFICIT)/SURPLUS FOR THE YEAR</td>
<td></td>
<td>(5,320)</td>
<td>463</td>
<td>(5,233)</td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairment (chargeable to revaluation reserve)</td>
<td></td>
<td>(3,197)</td>
<td>(238)</td>
<td>(3,197)</td>
</tr>
<tr>
<td>Revaluation (credited to revaluation reserve)</td>
<td></td>
<td>7,219</td>
<td>11,296</td>
<td>7,219</td>
</tr>
<tr>
<td>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</td>
<td></td>
<td>(1,298)</td>
<td>11,521</td>
<td>(1,211)</td>
</tr>
</tbody>
</table>

The notes on pages 16 to 49 form part of these accounts.
Statement of Financial Position

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Non-current assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>14</td>
<td>2,007</td>
<td>1,133</td>
<td>2,007</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>14</td>
<td>171,018</td>
<td>158,242</td>
<td>171,018</td>
</tr>
<tr>
<td>Other investments</td>
<td>12.1</td>
<td>3,453</td>
<td>3,167</td>
<td>0</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>176,478</td>
<td>162,542</td>
<td>173,025</td>
<td>159,375</td>
<td></td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>17</td>
<td>6,615</td>
<td>5,120</td>
<td>6,615</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>18</td>
<td>10,182</td>
<td>12,182</td>
<td>10,279</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>12.2</td>
<td>73</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>19</td>
<td>50,774</td>
<td>54,899</td>
<td>48,316</td>
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<tr>
<td>Total current assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>67,644</td>
<td>72,278</td>
<td>65,210</td>
<td>69,332</td>
<td></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>20</td>
<td>(27,233)</td>
<td>(29,322)</td>
<td>(26,853)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>21</td>
<td>(746)</td>
<td>(389)</td>
<td>(746)</td>
</tr>
<tr>
<td>Provisions</td>
<td>23</td>
<td>(229)</td>
<td>(1,356)</td>
<td>(229)</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(28,208)</td>
<td>(31,067)</td>
<td>(27,828)</td>
<td>(30,548)</td>
<td></td>
</tr>
<tr>
<td>Total assets less current liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>215,914</td>
<td>203,753</td>
<td>210,407</td>
<td>198,159</td>
<td></td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>20</td>
<td>(1,048)</td>
<td>(1,062)</td>
<td>(1,048)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>21</td>
<td>(13,883)</td>
<td>(1,409)</td>
<td>(13,883)</td>
</tr>
<tr>
<td>Provisions</td>
<td>23</td>
<td>(519)</td>
<td>(511)</td>
<td>(519)</td>
</tr>
<tr>
<td>Total non-current liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15,450)</td>
<td>(2,982)</td>
<td>(15,450)</td>
<td>(2,982)</td>
<td></td>
</tr>
<tr>
<td>Total Assets Employed:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>200,464</td>
<td>200,771</td>
<td>194,957</td>
<td>195,177</td>
<td></td>
</tr>
<tr>
<td>Taxpayers’ Equity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Dividend Capital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79,665</td>
<td>78,674</td>
<td>79,665</td>
<td>78,674</td>
<td></td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74,612</td>
<td>73,002</td>
<td>74,612</td>
<td>73,002</td>
<td></td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40,680</td>
<td>43,501</td>
<td>40,680</td>
<td>43,501</td>
<td></td>
</tr>
<tr>
<td>Charitable Fund Reserve</td>
<td>33</td>
<td>5,507</td>
<td>5,594</td>
<td>0</td>
</tr>
<tr>
<td>Total Taxpayers’ Equity:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>200,464</td>
<td>200,771</td>
<td>194,957</td>
<td>195,177</td>
<td></td>
</tr>
</tbody>
</table>

The notes on pages 16 to 49 form part of these accounts.

The financial statements comprising the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers’ Equity, and Statement of Cash Flows were approved by the Foundation Trust Board on 28 May 2015 and signed on its behalf by:

Mr A Spotswood, Chief Executive 28 May 2015
Statement of Changes in Taxpayers’ Equity

<table>
<thead>
<tr>
<th></th>
<th>Trust</th>
<th>Charity</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public Dividend Capital</td>
<td>Revaluation Reserve</td>
<td>Income and Expenditure Reserve</td>
</tr>
<tr>
<td>Current Year</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Taxpayers’ Equity at 1 April 2014</td>
<td>78,674</td>
<td>73,002</td>
<td>43,501</td>
</tr>
<tr>
<td>Surplus/(Deficit) for the year</td>
<td>0</td>
<td>0</td>
<td>(5,233)</td>
</tr>
<tr>
<td>Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve</td>
<td>0</td>
<td>(2,412)</td>
<td>2,412</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>(3,197)</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations</td>
<td>0</td>
<td>7,219</td>
<td>0</td>
</tr>
<tr>
<td>Public Dividend Capital received</td>
<td>602</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Public Dividend Capital received</td>
<td>389</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Taxpayers’ Equity at 31 March 2015</td>
<td>79,665</td>
<td>74,612</td>
<td>40,680</td>
</tr>
<tr>
<td>Prior Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxpayers’ Equity at 1 April 2013</td>
<td>78,674</td>
<td>64,488</td>
<td>40,399</td>
</tr>
<tr>
<td>Surplus/(Deficit) for the year</td>
<td>0</td>
<td>0</td>
<td>558</td>
</tr>
<tr>
<td>Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve</td>
<td>0</td>
<td>(2,544)</td>
<td>2,544</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>(238)</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations</td>
<td>0</td>
<td>11,296</td>
<td>0</td>
</tr>
<tr>
<td>Taxpayers’ Equity at 31 March 2014</td>
<td>78,674</td>
<td>73,002</td>
<td>43,501</td>
</tr>
</tbody>
</table>

The notes on pages 16 to 49 form part of these accounts.
## Statement of Cash Flows

<table>
<thead>
<tr>
<th>Notes</th>
<th>Group 2014/15</th>
<th>Trust 2014/15</th>
<th>Group 2013/14</th>
<th>Trust 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating (Deficit)/Surplus</td>
<td>(1,016)</td>
<td>4,467</td>
<td>(638)</td>
<td>4,793</td>
</tr>
<tr>
<td><strong>Non-cash income and expense</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>8,067</td>
<td>7,458</td>
<td>8,067</td>
<td>7,458</td>
</tr>
<tr>
<td>Impairments/Reversal of Impairments</td>
<td>121</td>
<td>(290)</td>
<td>121</td>
<td>(290)</td>
</tr>
<tr>
<td>Loss on disposal</td>
<td>0</td>
<td>258</td>
<td>0</td>
<td>258</td>
</tr>
<tr>
<td>Non-cash donations/grants credited to income</td>
<td>0</td>
<td>(332)</td>
<td>0</td>
<td>(332)</td>
</tr>
<tr>
<td>(Increase)/Decrease in Trade and Other Receivables</td>
<td>1,849</td>
<td>(1,170)</td>
<td>1,849</td>
<td>(1,170)</td>
</tr>
<tr>
<td>Increase in Inventories</td>
<td>(1,495)</td>
<td>(1,014)</td>
<td>(1,495)</td>
<td>(1,014)</td>
</tr>
<tr>
<td>Increase/(Decrease) in Trade and Other Payables</td>
<td>(2,994)</td>
<td>3,746</td>
<td>(2,994)</td>
<td>3,746</td>
</tr>
<tr>
<td>Decrease in provisions</td>
<td>(1,131)</td>
<td>(858)</td>
<td>(1,131)</td>
<td>(858)</td>
</tr>
<tr>
<td>NHS Charitable funds - net adjustments for working capital movements and non-cash transactions</td>
<td>30</td>
<td>(81)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other movements in operating cash flows - PDC Adjustment</td>
<td>389</td>
<td>0</td>
<td>389</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net cash generated from operations</strong></td>
<td>3,820</td>
<td>12,184</td>
<td>4,168</td>
<td>12,591</td>
</tr>
<tr>
<td><strong>Cash flow from investing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>149</td>
<td>148</td>
<td>149</td>
<td>148</td>
</tr>
<tr>
<td>Purchase of intangible assets</td>
<td>(1,189)</td>
<td>(851)</td>
<td>(1,189)</td>
<td>(851)</td>
</tr>
<tr>
<td>Purchase of Property, Plant and Equipment</td>
<td>(15,601)</td>
<td>(9,087)</td>
<td>(15,601)</td>
<td>(9,087)</td>
</tr>
<tr>
<td>NHS Charitable funds - net cash flow from investing activities</td>
<td>5</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net cash flow from investing activities</strong></td>
<td>(16,636)</td>
<td>(9,778)</td>
<td>(16,641)</td>
<td>(9,790)</td>
</tr>
<tr>
<td><strong>Cash flow from financing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>602</td>
<td>0</td>
<td>602</td>
<td>0</td>
</tr>
<tr>
<td>Loans received</td>
<td>13,221</td>
<td>0</td>
<td>13,221</td>
<td>0</td>
</tr>
<tr>
<td>Capital element of finance lease rental payments</td>
<td>(391)</td>
<td>(418)</td>
<td>(391)</td>
<td>(418)</td>
</tr>
<tr>
<td>Loans interest</td>
<td>(181)</td>
<td>0</td>
<td>(181)</td>
<td>0</td>
</tr>
<tr>
<td>Interest element of finance lease</td>
<td>13</td>
<td>(51)</td>
<td>(51)</td>
<td>(48)</td>
</tr>
<tr>
<td>PDC Dividend paid</td>
<td>(4,561)</td>
<td>(4,437)</td>
<td>(4,561)</td>
<td>(4,437)</td>
</tr>
<tr>
<td>Cash flows from (used in) other financing activities</td>
<td>52</td>
<td>0</td>
<td>52</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net cash flow used in financing activities</strong></td>
<td>8,691</td>
<td>(4,903)</td>
<td>8,691</td>
<td>(4,903)</td>
</tr>
<tr>
<td><strong>Net increase in cash and cash equivalents</strong></td>
<td>(4,125)</td>
<td>(2,497)</td>
<td>(3,782)</td>
<td>(2,102)</td>
</tr>
<tr>
<td>Cash and cash equivalents at beginning of year</td>
<td>54,899</td>
<td>57,396</td>
<td>52,098</td>
<td>54,200</td>
</tr>
<tr>
<td>Cash and cash equivalents at end of year</td>
<td>50,774</td>
<td>54,899</td>
<td>48,316</td>
<td>52,098</td>
</tr>
</tbody>
</table>

The notes on pages 16 to 49 form part of these accounts.
1 Accounting policies

1.1 Accounting policies and other information

Monitor has directed that the financial statements of the NHS Foundation Trust shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2014/15 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury’s Financial Reporting Manual to the extent that they are meaningful and appropriate to the Foundation Trust. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These financial statements have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken from outside the public sector. Activities are considered ‘discontinued’ if they transfer from one public body to another. The Foundation Trust has no acquisitions or discontinued operations to report within these accounts.

Notes to the accounts

Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation Trust’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually revised if the revision affects only one period, or in the period of the revision and future periods, if the revision affects both current and future periods.

Details of key accounting judgements and estimations are contained within Note 30 to these accounts.

Operating segments

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Finance Committee that makes strategic decisions.

Recently issued IFRS Accounting Standards

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but have not yet been adopted in the Annual Reporting Manual. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.
1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Foundation Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity, which is to be delivered in the following financial year, that income is deferred.

Charitable funds

Income is received from donations, legacies, fundraising events and from other charitable bodies.

Patient related revenue

Revenue is recognised when the service has been delivered, that is, in the period when the services were provided. At the end of the financial year, a revenue estimate is recognised for patients who are in hospital and have not completed their period of treatment (an incomplete patient spell). This revenue estimate is based on the level of treatment provided to date.

Education and training

Revenue is recognised when the conditions of education and training contracts have been met.

Non patient care services

This is the income in relation to the education and training of specific staff groups. Income is recognised when the Foundation Trust has achieved its objectives as set out in the annual contract.

Interest

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.
Catering services
The Foundation Trust operates canteen services for employees and patients. Revenue is recognised when the Foundation Trust sells to the employees and the public. Canteen sales are usually by cash or by debit card.

Rental income
The Foundation Trust owns some residential properties which are let out to members of staff and related parties. Rental income is recognised on a straight-line basis over the term of the lease. Car park fees are recognised when the public have used the Foundation Trust’s facilities and are usually received in cash.

Income from the sale of non-current assets
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability, as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.
The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

**Scheme provisions**

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

- the scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable services
- with effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”
- annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the 12 months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI)
- early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable
- for early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer
- members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers

**National Employment Savings Trust (NEST)**

The National Employment Savings Trust (NEST) is a defined contribution scheme that was created as part of the Government’s workplace pensions reforms under the Pensions Act 2008. With effect from 1 May 2013, the Foundation Trust auto-enrols employees into this scheme in line with the national eligibility criteria.

**1.4 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.
1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item individually has a cost of at least £5,000; or
- collectively, a group of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates, and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, refurbishment of a ward or unit irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. They are subsequently measured at fair value.

Non-current assets are stated at the lower of replacement cost and recoverable amount. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from the financing of the construction of fixed assets are not capitalised but are charged to the Statement of Comprehensive Income in the year to which they relate.

All land and buildings are revalued using professional valuations in accordance with International Accounting Standard 16 every five years. A three yearly interim valuation is also carried out.

Professional valuations are carried out by the District Valuer of the Valuation Office Agency. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A full asset valuation (excluding Assets Under Construction/Work In Progress) was undertaken as at 31 March 2015; and this value has been included in the closing Statement of Financial Position.

The valuations are carried out primarily on the basis of Modern Equivalent for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Assets in the course of construction are valued at current cost. Larger schemes are valued by the district valuer on completion or when brought into use, and all schemes are valued as part of the three/five yearly revaluation.

Operational equipment is valued at net current replacement cost.
**Subsequent expenditure**

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is derecognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Depreciation**

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. The estimated useful lives of assets are summarised below:

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>Minimum Life (years)</th>
<th>Maximum Life (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings and dwellings</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Furniture / fittings</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Set-up costs</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Medical and other equipment</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Vehicles</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Radiology equipment</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>IT equipment</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Property, plant and equipment which has been reclassified as ‘Held for Sale’ ceases to be depreciated upon this reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

**Revaluation gains and losses**

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

**Impairments**

In accordance with the Foundation Trust Annual Reporting Manual, impairments that arise from a clear consumption of economic benefits or service potential in the assets are charged to operating expenses. A compensating transfer is made from...
Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**Donated, government grant and other grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

### 1.6 Intangible assets

**Recognition**

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust’s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and where the cost of the asset can be measured reliably.
Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the product is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Foundation Trust intends to complete the asset and sell or use it
- the Foundation Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits
- adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset
- the Foundation Trust can measure reliably the expenditures attributable to the asset during development

Software
Software which is integral to the operation of hardware (for example, an operating system) is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware (for example, application software) is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or ‘fair value less costs to sell’.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of assets are summarised below:

<table>
<thead>
<tr>
<th></th>
<th>Minimum Life (years)</th>
<th>Maximum Life (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Software</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

1.7 Revenue government and other grants
Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. Due to the high turnover of stocks within the Foundation Trust, current cost is used as a fair estimate of current value.

1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust’s normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Foundation Trust becomes a party to the contractual provisions of the instrument.
De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as ‘loans and receivables’. Financial liabilities are classified as ‘other financial liabilities’.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Foundation Trust’s loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and are measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the Statement of Comprehensive Income. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Foundation Trust assesses whether any financial assets, other than those held at ‘fair value through income and expenditure’ are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cashflows discounted at the asset’s original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.
The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

**1.11 Provisions**

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

**Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Foundation Trust is disclosed at Note 23 but is not recognised in the Foundation Trust’s accounts.

**Non-clinical risk pooling**

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any ‘excesses’ payable in respect of particular claims are charged to operating expenses when the liability arises.

**1.12 Contingencies**

Contingent assets (that is assets, arising from past events whose existence will only be confirmed by one or more future events not wholly within the Foundation Trust’s control) are not recognised as assets, but are disclosed by note where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed by note unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Foundation Trust’s control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.
1.13 Public Dividend Capital (PDC) and PDC Dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard 32.

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loan Fund (NFL) deposits, excluding cash balances held in GBS accounts that relate to short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the ‘pre-audit’ version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 Value added tax

Most of the activities of the Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation tax

Under current legislation, foundation trusts are not liable for corporation tax.

1.16 Foreign exchange

The functional and presentation currency of the Foundation Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

1.17 Third party assets

Assets belonging to third parties, such as money held on behalf of patients, are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. However, they are disclosed within Note 19 to the accounts in accordance with the requirements of HM Treasury’s FRaM.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Foundation Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.19 Going concern

After making enquiries, the directors have a reasonable expectation that the Foundation Trust has adequate resources to continue in operational existence for at least the next 12 months. For this reason, they continue to adopt the going concern basis in preparing the accounts.
1.20 Investments
The Foundation Trust does not have any investments and cash is held primarily with the Government Banking Service.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund does hold investments, both Fixed Asset Investments and Short Term Investments:

Charitable Fund Fixed Asset Investments
Investment Fixed Assets are shown at Market Value, as detailed in the Statement of Financial Position.

The Trustee policy is to invest charitable funds with investments that maximise capital and are the most suitable investment type. The long-term objective is to invest capital that will give the maximum growth on income with minimal risk. The investment held as at the Statement of Financial Position date are units within a Restricted Investment Portfolio and are included in the Statement of Financial Position at the closing price at 31 March 2015. Investments comprise equities, gilts, other fixed interest investments and pooled funds, the majority of which are quoted investments.

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

Charitable Fund Short Term Investments
Short Term Investments include Stocks and Equities that have been received as part of Legacy distributions given to the Charitable Funds. These are revalued at the year-end and any gain or loss on revaluation of the investment asset is shown in the Statement of Comprehensive Income.

1.21 Joint venture
The Foundation Trust is a voting member of the joint venture, Christchurch Fairmile Village LLP, which was incorporated on 19 September 2014. The joint venture has not been consolidated in these accounts on the grounds that it is not material to the Foundation Trust in this financial year.
2 Operating segments

The Foundation Trust has determined the operating segments based on the reports reviewed by the Finance Committee that are used to make strategic decisions. The Finance Committee considers the Foundation Trust’s business from a services perspective as “Healthcare” and only one segment is therefore reported.

The segment information provided to the Finance Committee for the reportable segments for the year ended 31 March 2015 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment revenue</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td></td>
<td>266,539</td>
<td>260,323</td>
</tr>
<tr>
<td>Patient and other income</td>
<td>266,539</td>
<td>260,323</td>
</tr>
</tbody>
</table>

It is appropriate to aggregate the Trust’s activities as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- the nature of the products and services
- the nature of the production processes
- the type of class of customer for their products and services
- the methods used to distribute their products or provide their services
- the nature of the regulatory environment

3 Income generation activities

The Foundation Trust does not undertake any other income generation activities with an aim of achieving profit.
### 4 Operating income

#### 4.1 Income from patient related activities

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>Continuing Operations 2014/15</th>
<th>Continuing Operations 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Foundation Trusts</td>
<td>3,056</td>
<td>4,845</td>
</tr>
<tr>
<td>CCGs and NHS England</td>
<td>234,725</td>
<td>227,802</td>
</tr>
<tr>
<td>Local authorities</td>
<td>2,558</td>
<td>2,365</td>
</tr>
<tr>
<td>Non NHS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- private patients</td>
<td>3,591</td>
<td>3,284</td>
</tr>
<tr>
<td>- overseas patients (non-reciprocal)</td>
<td>78</td>
<td>54</td>
</tr>
<tr>
<td>- NHS Injury Scheme income</td>
<td>487</td>
<td>467</td>
</tr>
<tr>
<td>- other</td>
<td>242</td>
<td>157</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>244,737</td>
<td>238,974</td>
</tr>
</tbody>
</table>

The NHS Injury Scheme Income above is reported net of an 18.9% impairment of receivables (2013/14 12.6%).
4.2 Other operating income

<table>
<thead>
<tr>
<th>Group</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuing Operations 2014/15</strong></td>
<td><strong>Continuing Operations 2013/14</strong></td>
</tr>
<tr>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Research and development</td>
<td>1,861</td>
</tr>
<tr>
<td>Education and training</td>
<td>5,675</td>
</tr>
<tr>
<td>NHS Charities - capital acquisitions (donated assets)</td>
<td>0</td>
</tr>
<tr>
<td>NHS Charities - other contributions to expenditure</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS Charities - capital acquisitions (donated assets)</td>
<td>0</td>
</tr>
<tr>
<td>Received from other bodies: Other charitable and other contributions to expenditure</td>
<td>1,572</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>7,130</td>
</tr>
<tr>
<td>NHS Charitable Funds: incoming resources excluding investment income</td>
<td>1,232</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>- NHS drug sales</td>
<td>214</td>
</tr>
<tr>
<td>- car parking</td>
<td>1,305</td>
</tr>
<tr>
<td>- catering services</td>
<td>1,055</td>
</tr>
<tr>
<td>- miscellaneous other</td>
<td>802</td>
</tr>
<tr>
<td>Income from operating leases</td>
<td>956</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21,802</td>
</tr>
<tr>
<td>Total</td>
<td>266,539</td>
</tr>
</tbody>
</table>

5 Private patient monitoring

The Foundation Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purpose of the health service in England must be greater than its income from the provision of goods and services for any other purposes.
6 Mandatory and non-mandatory income from activities

<table>
<thead>
<tr>
<th></th>
<th>Group 2014/15</th>
<th>Group 2013/14</th>
<th>Trust 2014/15</th>
<th>Trust 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Commissioner requested services</td>
<td>250,412</td>
<td>244,405</td>
<td>250,412</td>
<td>244,405</td>
</tr>
<tr>
<td>Non Commissioner requested services</td>
<td>16,127</td>
<td>15,918</td>
<td>15,820</td>
<td>15,249</td>
</tr>
<tr>
<td></td>
<td>266,539</td>
<td>260,323</td>
<td>266,232</td>
<td>259,654</td>
</tr>
</tbody>
</table>

7 Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>Group 2014/15</th>
<th>Group 2013/14</th>
<th>Trust 2014/15</th>
<th>Trust 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Services from NHS foundation trusts</td>
<td>2,922</td>
<td>3,199</td>
<td>2,922</td>
<td>3,199</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>1,337</td>
<td>1,405</td>
<td>1,337</td>
<td>1,405</td>
</tr>
<tr>
<td>Purchase of healthcare from non NHS bodies</td>
<td>2,555</td>
<td>267</td>
<td>2,555</td>
<td>267</td>
</tr>
<tr>
<td>Employee expenses - Executive directors</td>
<td>1,114</td>
<td>1,181</td>
<td>1,114</td>
<td>1,181</td>
</tr>
<tr>
<td>Employee expenses - non-executive directors</td>
<td>157</td>
<td>157</td>
<td>157</td>
<td>157</td>
</tr>
<tr>
<td>Employee expenses - staff</td>
<td>162,406</td>
<td>153,485</td>
<td>162,406</td>
<td>153,485</td>
</tr>
<tr>
<td>Employee expenses - redundancy</td>
<td>646</td>
<td>98</td>
<td>646</td>
<td>98</td>
</tr>
<tr>
<td>Employee expenses - research and development</td>
<td>1,611</td>
<td>1,735</td>
<td>1,611</td>
<td>1,735</td>
</tr>
<tr>
<td>Supplies and services - clinical (excluding drug costs)</td>
<td>32,535</td>
<td>33,617</td>
<td>32,381</td>
<td>33,260</td>
</tr>
<tr>
<td>Supplies and services - general</td>
<td>3,708</td>
<td>3,608</td>
<td>3,708</td>
<td>3,608</td>
</tr>
<tr>
<td>Establishment</td>
<td>2,008</td>
<td>1,989</td>
<td>2,008</td>
<td>1,989</td>
</tr>
<tr>
<td>Research and development (excluding employee expenses)</td>
<td>222</td>
<td>292</td>
<td>222</td>
<td>292</td>
</tr>
<tr>
<td>Transport (staff travel)</td>
<td>494</td>
<td>516</td>
<td>494</td>
<td>516</td>
</tr>
<tr>
<td>Transport (patient transport services)</td>
<td>166</td>
<td>442</td>
<td>166</td>
<td>442</td>
</tr>
<tr>
<td>Premises</td>
<td>10,932</td>
<td>11,185</td>
<td>10,932</td>
<td>11,022</td>
</tr>
<tr>
<td>Increase (decrease ) in bad debt provision</td>
<td>472</td>
<td>487</td>
<td>472</td>
<td>487</td>
</tr>
<tr>
<td>Increases in other provisions</td>
<td>18</td>
<td>58</td>
<td>18</td>
<td>58</td>
</tr>
<tr>
<td>Inventories written down</td>
<td>64</td>
<td>115</td>
<td>64</td>
<td>115</td>
</tr>
<tr>
<td>Drugs inventories consumed</td>
<td>29,061</td>
<td>25,934</td>
<td>29,061</td>
<td>25,934</td>
</tr>
<tr>
<td>Operating lease payments</td>
<td>132</td>
<td>143</td>
<td>132</td>
<td>143</td>
</tr>
<tr>
<td>Depreciation on property, plant and equipment</td>
<td>7,735</td>
<td>7,112</td>
<td>7,735</td>
<td>7,112</td>
</tr>
<tr>
<td>Amortisation on intangible assets</td>
<td>332</td>
<td>346</td>
<td>332</td>
<td>346</td>
</tr>
<tr>
<td>Impairments of property, plant and equipment</td>
<td>121</td>
<td>(290)</td>
<td>121</td>
<td>(290)</td>
</tr>
</tbody>
</table>
Operating expenses continued

<table>
<thead>
<tr>
<th>Description</th>
<th>2014/15</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>External audit services - statutory audit</td>
<td>63</td>
<td>62</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>External audit services - audit-related assurance services</td>
<td>16</td>
<td>13</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>External audit services - charitable fund accounts</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Clinical negligence premium</td>
<td>2,321</td>
<td>2,543</td>
<td>2,321</td>
<td>2,543</td>
</tr>
<tr>
<td>Loss on disposal of land and buildings</td>
<td>0</td>
<td>251</td>
<td>0</td>
<td>251</td>
</tr>
<tr>
<td>Loss on disposal of other property, plant and equipment</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Legal fees</td>
<td>115</td>
<td>186</td>
<td>115</td>
<td>186</td>
</tr>
<tr>
<td>Consultancy costs (including internal audit services)</td>
<td>525</td>
<td>621</td>
<td>525</td>
<td>621</td>
</tr>
<tr>
<td>Training, courses and conferences</td>
<td>743</td>
<td>733</td>
<td>672</td>
<td>641</td>
</tr>
<tr>
<td>Insurance - other NHSLA</td>
<td>215</td>
<td>170</td>
<td>215</td>
<td>170</td>
</tr>
<tr>
<td>Other services, e.g. external payroll</td>
<td>532</td>
<td>509</td>
<td>532</td>
<td>509</td>
</tr>
<tr>
<td>Losses, ex gratia and special payments</td>
<td>26</td>
<td>23</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>NHS charitable funds: Other resources expended (balance not analysed above)</td>
<td>460</td>
<td>383</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1,786</td>
<td>3,269</td>
<td>1,786</td>
<td>3,274</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>267,555</strong></td>
<td><strong>255,856</strong></td>
<td><strong>266,870</strong></td>
<td><strong>254,861</strong></td>
</tr>
</tbody>
</table>

Other restructuring amounts provided in the year are disclosed in note 24.

8 Operating leases

8.1 Operating leases as lessee

The Foundation Trust leases some medical equipment and vehicles under non-cancellable operating leases. The leases are between three to five years. None of the leases include contingent rents or onerous restrictions on the Foundation Trust’s use of the assets concerned. The expenditure charged to the Statement of Comprehensive Income during the year is disclosed below:

<table>
<thead>
<tr>
<th>Description</th>
<th>Group / Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
</tr>
<tr>
<td>Total operating leases</td>
<td>132</td>
</tr>
</tbody>
</table>

The future aggregate minimum lease payments under non-cancellable operating leases are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Group / Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>132</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>0</td>
</tr>
<tr>
<td>Over five years</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>132</strong></td>
</tr>
</tbody>
</table>
8.2 Operating leases as lessor

The Foundation Trust owns some properties from which rental income is derived. These are properties that are leased out to members of staff and the contracts are normally one year. The Foundation Trust also leases some office spaces to some contractors and service providers at the hospital sites. None of the leases include contingent rents and there are no onerous restrictions. The income recognised through the Statement of Comprehensive Income during the year is disclosed as:

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000</td>
<td>£’000</td>
<td></td>
</tr>
<tr>
<td>Accommodation operating leases</td>
<td>956</td>
<td>786</td>
</tr>
</tbody>
</table>

The future aggregate minimum lease payments under non-cancellable operating leases are as follow:

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>965</td>
<td>792</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>282</td>
<td>347</td>
</tr>
<tr>
<td>Over five years</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>1,262</td>
<td>1,184</td>
</tr>
</tbody>
</table>

9 Staff costs and numbers

9.1 Staff costs

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000</td>
<td>£’000</td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>128,080</td>
<td>125,353</td>
</tr>
<tr>
<td>Social security costs</td>
<td>9,538</td>
<td>9,312</td>
</tr>
<tr>
<td>Employer’s contributions to NHS Pensions</td>
<td>14,761</td>
<td>14,076</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>646</td>
<td>98</td>
</tr>
<tr>
<td>Agency/contract staff</td>
<td>12,752</td>
<td>7,660</td>
</tr>
<tr>
<td>Total</td>
<td>165,777</td>
<td>156,499</td>
</tr>
</tbody>
</table>

This note excludes non-executive directors, in line with national guidance.

9.2 Average number of persons employed

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>Medical and dental</td>
<td>423</td>
<td>438</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>1,204</td>
<td>1,181</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>806</td>
<td>704</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>1,042</td>
<td>1,040</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>393</td>
<td>403</td>
</tr>
<tr>
<td>Agency/contract staff</td>
<td>153</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>4,021</td>
<td>3,861</td>
</tr>
</tbody>
</table>

This note excludes non-executive directors, in line with national guidance.
9.3 Staff exit packages

<table>
<thead>
<tr>
<th></th>
<th>Group / Trust</th>
<th>Group / Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15</td>
<td>2014/15</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>£10,001 - £25,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>1</td>
<td>41</td>
</tr>
<tr>
<td>Over £50,000</td>
<td>3</td>
<td>591</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>646</strong></td>
</tr>
</tbody>
</table>

Each of the above exit packages is in relation to compulsory redundancy.

10 Retirements due to ill-health

There were nine early retirements from the Foundation Trust agreed on the grounds of ill-health (2013/14: three). The estimated additional pension liabilities of these ill-health retirements will be £715,000 (2013/14: £280,000). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

11 The Late Payment of Commercial Debts (Interest) Act 1998

There were minimal payments of interest for commercial debts.

12 Investment revenue

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15</td>
<td>2013/14</td>
</tr>
<tr>
<td>Interest on bank accounts</td>
<td>148</td>
<td>140</td>
</tr>
<tr>
<td>Interest on loans and receivables</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>NHS charitable funds: investment income</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154</strong></td>
<td><strong>169</strong></td>
</tr>
</tbody>
</table>

12.1 Investments

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2015</td>
<td>31 March 2014</td>
</tr>
<tr>
<td>Opening balance</td>
<td>3,167</td>
<td>2,957</td>
</tr>
<tr>
<td>Movement in fair value</td>
<td>286</td>
<td>210</td>
</tr>
<tr>
<td><strong>Closing balance</strong></td>
<td><strong>3,453</strong></td>
<td><strong>3,167</strong></td>
</tr>
</tbody>
</table>
### 12.2 Other financial assets

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2015</td>
<td>31 March 2014</td>
</tr>
<tr>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Stocks and equities</td>
<td>73</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>77</td>
</tr>
</tbody>
</table>

### 13 Finance costs

<table>
<thead>
<tr>
<th></th>
<th>Group / Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15</td>
</tr>
<tr>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Loans from the Independant Trust Financing Facility</td>
<td>196</td>
</tr>
<tr>
<td>Finance leases</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
</tr>
</tbody>
</table>
Intangible assets, property, plant and equipment - 2014/15

The above includes £925,000 of restricted use assets, in relation to the Heart Club which is leased to the Bournemouth Heart Club until the year 2046.

The Foundation Trust leases various medical equipment IT under non-cancellable finance lease agreements. The lease terms are between five and seven years.
<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross cost at 1 April 2013 as previously stated</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Intangible Tangible TOTAL</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Gross cost at 31 March 2014</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Net book value</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Cost or valuation at 31 March 2014</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Additions - purchased</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Additions - donated of assets (non-cash)</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Reversal of impairments credited to operating income</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Impairments - Operating expenses</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Disposals</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Revaluations</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Disposals - Operating expenses</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Revaluations</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Disposals - Operating expenses</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Revaluations</td>
<td>£'000</td>
<td>£'000</td>
</tr>
</tbody>
</table>

The above includes £905,000 of restricted use assets, in relation to the Heart Club, which is leased to the Bournemouth Heart Club until the year 2046.
15 Impairment of property, plant and equipment

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Changes in market price (as advised by the District Valuer)</td>
<td>121</td>
<td>143</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>121</td>
<td>143</td>
</tr>
</tbody>
</table>

16 Capital commitments

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>8,890</td>
<td>8,937</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>258</td>
<td>430</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9,148</td>
<td>9,367</td>
</tr>
</tbody>
</table>

17 Inventories

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Drugs</td>
<td>1,364</td>
<td>1,460</td>
</tr>
<tr>
<td>Consumables</td>
<td>5,251</td>
<td>3,660</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,615</td>
<td>5,120</td>
</tr>
</tbody>
</table>

17.1 Inventories recognised in expenses

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Inventories recognised as an expense in the period</td>
<td>37,398</td>
<td>35,467</td>
</tr>
<tr>
<td>Write-down of inventories (including losses)</td>
<td>64</td>
<td>115</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>37,462</td>
<td>35,582</td>
</tr>
</tbody>
</table>
18 Trade and other receivables

18.1 Amounts falling due within one year:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>NHS receivables - revenue</td>
<td>5,060</td>
<td>7,923</td>
<td>5,060</td>
<td>7,923</td>
</tr>
<tr>
<td>Provision for impaired receivables</td>
<td>(942)</td>
<td>(701)</td>
<td>(942)</td>
<td>(701)</td>
</tr>
<tr>
<td>Prepayments</td>
<td>1,561</td>
<td>2,082</td>
<td>1,561</td>
<td>2,082</td>
</tr>
<tr>
<td>Accrued income</td>
<td>1,524</td>
<td>1,207</td>
<td>1,524</td>
<td>1,207</td>
</tr>
<tr>
<td>PDC dividend receivable</td>
<td>202</td>
<td>126</td>
<td>202</td>
<td>126</td>
</tr>
<tr>
<td>VAT receivable</td>
<td>314</td>
<td>140</td>
<td>314</td>
<td>140</td>
</tr>
<tr>
<td>Other receivables - revenue</td>
<td>2,449</td>
<td>1,275</td>
<td>2,560</td>
<td>1,337</td>
</tr>
<tr>
<td>NHS charitable funds: Trade and other receivables</td>
<td>14</td>
<td>130</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,182</strong></td>
<td><strong>12,182</strong></td>
<td><strong>10,279</strong></td>
<td><strong>12,114</strong></td>
</tr>
</tbody>
</table>

18.2 Age analysis of trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Age of impaired receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 30 days</td>
<td>102</td>
<td>481</td>
<td>102</td>
<td>481</td>
</tr>
<tr>
<td>31 - 60 days</td>
<td>282</td>
<td>0</td>
<td>282</td>
<td>0</td>
</tr>
<tr>
<td>61 - 90 days</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>91 - 180 days</td>
<td>103</td>
<td>96</td>
<td>103</td>
<td>96</td>
</tr>
<tr>
<td>over 180 days</td>
<td>449</td>
<td>123</td>
<td>449</td>
<td>123</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td><strong>942</strong></td>
<td><strong>701</strong></td>
<td><strong>942</strong></td>
<td><strong>701</strong></td>
</tr>
<tr>
<td>Age of non-impaired receivables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 30 days</td>
<td>7,175</td>
<td>10,110</td>
<td>7,272</td>
<td>10,042</td>
</tr>
<tr>
<td>31 - 60 days</td>
<td>643</td>
<td>362</td>
<td>643</td>
<td>362</td>
</tr>
<tr>
<td>61 - 90 days</td>
<td>713</td>
<td>169</td>
<td>713</td>
<td>169</td>
</tr>
<tr>
<td>91 - 180 days</td>
<td>473</td>
<td>622</td>
<td>473</td>
<td>622</td>
</tr>
<tr>
<td>over 180 days</td>
<td>236</td>
<td>218</td>
<td>236</td>
<td>218</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td><strong>9,240</strong></td>
<td><strong>11,481</strong></td>
<td><strong>9,337</strong></td>
<td><strong>11,413</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,182</strong></td>
<td><strong>12,182</strong></td>
<td><strong>10,279</strong></td>
<td><strong>12,114</strong></td>
</tr>
</tbody>
</table>
18.3 Provision for impairment of receivables

<table>
<thead>
<tr>
<th>At 1 April</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>£'000</td>
<td>£'000</td>
<td></td>
</tr>
<tr>
<td>18.3 Provision for impairment of receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group / Trust</td>
<td>31 March 2015</td>
<td>31 March 2014</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>At 1 April</td>
<td>701</td>
<td>819</td>
</tr>
<tr>
<td>Increase in provision</td>
<td>472</td>
<td>487</td>
</tr>
<tr>
<td>Amounts utilised</td>
<td>(231)</td>
<td>(605)</td>
</tr>
<tr>
<td>At 31 March</td>
<td>942</td>
<td>701</td>
</tr>
</tbody>
</table>

19 Cash and cash equivalents

<table>
<thead>
<tr>
<th>Group / Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 March 2015</td>
</tr>
<tr>
<td>19 Cash and cash equivalents</td>
</tr>
<tr>
<td>£'000</td>
</tr>
<tr>
<td>£'000</td>
</tr>
<tr>
<td>Balance 1 April</td>
</tr>
<tr>
<td>Net movement in year</td>
</tr>
<tr>
<td>Balance at 31 March</td>
</tr>
<tr>
<td>Made up of:</td>
</tr>
<tr>
<td>Cash at commercial banks and in hand</td>
</tr>
<tr>
<td>Cash with the Government Banking Service</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
</tr>
</tbody>
</table>

The patient monies amount held on trust was £1,339 (2013/14 £2,192) which is not included in the above figures.

20 Trade and other payables

<table>
<thead>
<tr>
<th>Group / Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 March 2015</td>
</tr>
<tr>
<td>20 Trade and other payables</td>
</tr>
<tr>
<td>£'000</td>
</tr>
<tr>
<td>£'000</td>
</tr>
<tr>
<td>Amounts falling due within one year:</td>
</tr>
<tr>
<td>NHS payables - revenue</td>
</tr>
<tr>
<td>Other trade payables - capital</td>
</tr>
<tr>
<td>Other trade payables - revenue</td>
</tr>
<tr>
<td>Accruals</td>
</tr>
<tr>
<td>NHS charitable funds: Trade and other payables</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Amounts falling due over one year:</td>
</tr>
<tr>
<td>Other trade payables</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

This includes outstanding pensions contributions at 31 March 2015 of £2,080,760 (2013/14 £2,010,078).
21 Borrowings

<table>
<thead>
<tr>
<th>Finance lease liabilities</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Current</td>
<td>£389</td>
<td>£389</td>
</tr>
<tr>
<td>- Non current</td>
<td>£1,019</td>
<td>£1,409</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£1,408</strong></td>
<td><strong>£1,798</strong></td>
</tr>
</tbody>
</table>

Independent Trust Financing Facility (ITFF) Loan

| - Current | 357 | 0 |
| - Non current | 12,864 | 0 |
| **Total** | **13,221** | 0 |

22 Finance lease obligations

The Foundation Trust operates as lessee on a number of medical equipment leases. These leases generally run for between five to seven years with options to extend the terms at the expiry of the initial period. None of the leases include contingent rents or onerous restrictions on the Foundation Trust’s use of assets concerned.

<table>
<thead>
<tr>
<th>Amounts payable under finance leases</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within one year</td>
<td>£428</td>
<td>£441</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>£983</td>
<td>£1,275</td>
</tr>
<tr>
<td>After five years</td>
<td>£102</td>
<td>£237</td>
</tr>
<tr>
<td>Less future finance charges</td>
<td>(£105)</td>
<td>(£155)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£1,408</strong></td>
<td><strong>£1,798</strong></td>
</tr>
</tbody>
</table>
### 23 Provisions for liabilities and charges

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>£’000</th>
<th>£’000</th>
<th>£’000</th>
<th>£’000</th>
<th>£’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Early Retirement</td>
<td>Legal claims</td>
<td>Re-structuring</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>At 1 April 2014</td>
<td>154</td>
<td>471</td>
<td>1,242</td>
<td>0</td>
<td>1,867</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>12</td>
<td>6</td>
<td>0</td>
<td>135</td>
<td>153</td>
</tr>
<tr>
<td>Utilised during the year - accruals</td>
<td>(5)</td>
<td>(5)</td>
<td>0</td>
<td>0</td>
<td>(10)</td>
</tr>
<tr>
<td>Utilised during the year - cash</td>
<td>(14)</td>
<td>(18)</td>
<td>(811)</td>
<td>0</td>
<td>(843)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>0</td>
<td>0</td>
<td>(431)</td>
<td>0</td>
<td>(431)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>3</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td><strong>At 31 March 2015</strong></td>
<td>150</td>
<td>463</td>
<td>0</td>
<td>135</td>
<td>748</td>
</tr>
</tbody>
</table>

**Expected timing of cashflows:**

<table>
<thead>
<tr>
<th></th>
<th>Within one year</th>
<th>Between one and five years</th>
<th>After five years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18</td>
<td>73</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>76</td>
<td>67</td>
<td>320</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>135</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>229</td>
<td>140</td>
<td>379</td>
</tr>
</tbody>
</table>

#### Legal claims

**Liability to Third Party and Property Expense Schemes:**

The Foundation Trust has liability for the excess of each claim.

The calculation is based on estimated claim values and probability of settlement.

#### Injury Benefit

The provision for permanent injury benefit has been created as at 31/03/04 and is calculated using the award value and life tables discounted over the period.

£17,651k is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of the Foundation Trust (£10,805k at 31 March 2014).
24 Related party transactions

The Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board members or parties related to them has undertaken any material transactions with the Foundation Trust.

During the year the Foundation Trust has had a number of material transactions with public organisations together with other government bodies that fall within the whole of the government accounts boundary. Entities are listed below where the transaction total (excluding recharges) exceeds £500,000:

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>Income £’000</th>
<th>Expenditure £’000</th>
<th>Receivables £’000</th>
<th>Payables £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Dorset CCG</td>
<td>166,564</td>
<td>156</td>
<td>1,316</td>
<td>902</td>
</tr>
<tr>
<td>NHS West Hampshire CCG</td>
<td>24,080</td>
<td>0</td>
<td>181</td>
<td>0</td>
</tr>
<tr>
<td>NHS Wiltshire CCG</td>
<td>810</td>
<td>0</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>Bournemouth Borough Council</td>
<td>0</td>
<td>1,642</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dorset County Council</td>
<td>2,427</td>
<td>0</td>
<td>254</td>
<td>0</td>
</tr>
<tr>
<td>Wessex Area Team</td>
<td>43,661</td>
<td>0</td>
<td>1,476</td>
<td>0</td>
</tr>
<tr>
<td>Poole Hospital NHS FT</td>
<td>5,234</td>
<td>5,175</td>
<td>840</td>
<td>1,150</td>
</tr>
<tr>
<td>University Hospitals Southampton NHS FT</td>
<td>1,134</td>
<td>59</td>
<td>339</td>
<td>42</td>
</tr>
<tr>
<td>Health Education England</td>
<td>5,680</td>
<td>112</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Dorset Healthcare NHS FT</td>
<td>883</td>
<td>599</td>
<td>264</td>
<td>134</td>
</tr>
<tr>
<td>Portsmouth Hospitals NHS Trust</td>
<td>23</td>
<td>473</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>NHS Litigation Authority</td>
<td>0</td>
<td>2,536</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>National Insurance Fund</td>
<td>0</td>
<td>9,538</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Pension Scheme</td>
<td>0</td>
<td>14,761</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Department of Health</td>
<td>133</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other transactions less than £500,000</td>
<td>3,299</td>
<td>3,338</td>
<td>1,247</td>
<td>514</td>
</tr>
</tbody>
</table>

The Foundation Trust is an agent on behalf of employees and below are material transactions exceeding £500,000:

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>Income £’000</th>
<th>Expenditure £’000</th>
<th>Receivables £’000</th>
<th>Payables £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Pensions Agency</td>
<td>0</td>
<td>9,985</td>
<td>0</td>
<td>836</td>
</tr>
<tr>
<td>HM Revenue and Customs</td>
<td>0</td>
<td>18,783</td>
<td>0</td>
<td>1,556</td>
</tr>
<tr>
<td>National Insurance Fund</td>
<td>0</td>
<td>8,072</td>
<td>0</td>
<td>675</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>36,840</td>
<td>0</td>
<td>3,067</td>
</tr>
</tbody>
</table>
25 Post statement of financial position events

There are no post Statement of Financial Position events to report within these accounts.

26 Financial risk management

Financial instruments are held for the sole purpose of managing the cash flow of the Foundation Trust on a day to day basis or arise from the operating activities of the Foundation Trust. The management of risks around these financial instruments therefore relates primarily to the Foundation Trust’s overall arrangements for managing risks in relation to its financial position.

**Market risk**

**Interest rate risk**

The Foundation Trust has a fixed rate loan from the Independant Trust Financing Facility; plus capitalised finance lease obligations which each have fixed interest rates. As a result of these fixed rates, any interest rate fluctuations will only affect our ability to earn additional interest on our short-term investments.

The Foundation Trust earned interest of £148,000 during 2014/15; therefore, a change in the interest rate would have minimal affect the amount earned.

**Currency risk**

The Foundation Trust has minimal risk of currency fluctuations. Most transactions are in sterling, although there are some purchases of goods from Ireland where prices are based on the Euro, all payments are made in sterling.

**Other risk**

The inflation rate on NHS service level agreements is based on the NHS funded inflation and therefore there is a small risk of budgetary financial pressure.

The majority of pay award inflation is based on the nationally agreed Agenda for Change pay scale, and although funding through the Payment by Results (PbR) tariff does not cover the entire cost (there is an assumed efficiency requirement within the tariff), this represents a small risk.

**Credit risk**

**Receivable control**

The Foundation Trust has a receivable treasury function which includes a credit controller. The Foundation Trust actively pursues and use an external company to support specific aged receivables.

The majority of the Foundation Trust’s payables are short term and the Foundation Trust participates in the national NHS payables reconciliations at 31 December and 31 March each year. This helps to identify any significant NHS receivable queries.

**Provision for impaired receivables**

The Foundation Trust reviews non-NHS receivables that are in excess of three months old as at 31 March and as a result of this review, has provided £258,379 in relation to impaired receivables. A further £100,600 has been provided for in relation to the Injury Scheme, in accordance with scheme guidance.
The Foundation Trust has also reviewed any significant NHS receivables and has provided for impaired receivables amounting to a total of £583,142. This represents either the maximum or probable risk in specific areas and reflects the uncertainty of the financial climate within the healthcare market.

**Liquidity risk**

**Loans**

The Foundation Trust has a fixed rate loan from the Independent Trust Financing Facility. Repayments commence in March 2016 after the full loan has been received.

**Payables**

While the Foundation Trust has reported a deficit in the current financial year, it continues to have a surplus on the retained earnings reserve. In addition, the Foundation Trust has a cash and investment balance of £48.3m. As such, the Trust is a minimal risk to its payables.

### 27 Financial instruments

#### 27.1 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2015</td>
<td>31 March 2014</td>
</tr>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Loans and receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets at fair value through Income &amp; Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables excluding non financial assets</td>
<td>9,959</td>
<td>0</td>
</tr>
<tr>
<td>Cash and cash equivalents at bank and in hand</td>
<td>48,316</td>
<td>0</td>
</tr>
<tr>
<td>NHS charitable funds: financial assets as at 31 March</td>
<td>2,469</td>
<td>3,526</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60,744</strong></td>
<td><strong>3,526</strong></td>
</tr>
<tr>
<td><strong>Assets held in £ sterling</strong></td>
<td>64,270</td>
<td>70,199</td>
</tr>
</tbody>
</table>

The above amount excludes PDC receivables of £202,000 (2013/14 £126,000).
### 27.2 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Other financial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liabilities as per the Statement of Financial Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrowings excluding finance lease and PFI liabilities</td>
<td>13,221</td>
<td>0</td>
<td>13,221</td>
<td>0</td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>1,408</td>
<td>1,798</td>
<td>1,408</td>
<td>1,798</td>
</tr>
<tr>
<td>Trade and other payables excluding non financial assets</td>
<td>22,831</td>
<td>24,878</td>
<td>22,831</td>
<td>24,878</td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>748</td>
<td>1,867</td>
<td>748</td>
<td>1,867</td>
</tr>
<tr>
<td>NHS charitable funds: financial liabilities as at 31 March</td>
<td>373</td>
<td>519</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>38,581</td>
<td>29,062</td>
<td>38,208</td>
<td>28,543</td>
</tr>
<tr>
<td>Liabilities held in £ sterling</td>
<td>38,581</td>
<td>29,062</td>
<td>38,208</td>
<td>28,543</td>
</tr>
</tbody>
</table>

The above figures excludes statutory/non contracted payables of £5,070,000 (2013/14 £4,987,000).

### 27.3 Financial assets / liabilities - fair values

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Financial assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receivables over one year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS charitable funds: non-current financial assets</td>
<td>3,453</td>
<td>3,453</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3,453</td>
<td>3,453</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Financial liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current trade and other payables excluding non financial liabilities</td>
<td>1,048</td>
<td>1,048</td>
<td>1,048</td>
<td>1,048</td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>748</td>
<td>748</td>
<td>748</td>
<td>748</td>
</tr>
<tr>
<td>Total</td>
<td>1,796</td>
<td>1,796</td>
<td>1,796</td>
<td>1,796</td>
</tr>
</tbody>
</table>
## 28 Intra-Government and NHS balances

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>31 March 2015</th>
<th>Payables: amounts falling due within one year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Foundation Trusts</td>
<td>1,552</td>
<td>1,707</td>
</tr>
<tr>
<td>NHS and Department of Health</td>
<td>3,710</td>
<td>1,031</td>
</tr>
<tr>
<td>Local Government</td>
<td>374</td>
<td>0</td>
</tr>
<tr>
<td>Central Government</td>
<td>314</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,950</strong></td>
<td><strong>2,761</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group</th>
<th>31 March 2014</th>
<th>Payables: amounts falling due within one year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Trusts</td>
<td>3,204</td>
<td>2,257</td>
</tr>
<tr>
<td>NHS and Department of Health</td>
<td>4,845</td>
<td>1,051</td>
</tr>
<tr>
<td>Central Government</td>
<td>140</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,189</strong></td>
<td><strong>3,341</strong></td>
</tr>
</tbody>
</table>

## 29 Losses and special payments

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number £’000</td>
<td>Number £’000</td>
</tr>
<tr>
<td><strong>Losses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losses of cash due to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>overpayment of salaries</td>
<td>45</td>
<td>19 (23)</td>
</tr>
<tr>
<td>bad debts and claims abandoned</td>
<td>43</td>
<td>242</td>
</tr>
<tr>
<td>damage to buildings, property and equipment</td>
<td>6</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Total losses</strong></td>
<td>94</td>
<td>250</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group / Trust</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number £’000</td>
<td>Number £’000</td>
</tr>
<tr>
<td><strong>Special Payments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex gratia payments in respect of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>loss of personal effects</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>other negligence and injury</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>other employment payments</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>miscellaneous other</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total special payments</strong></td>
<td>78</td>
<td>53</td>
</tr>
</tbody>
</table>

There were no cases where the net payment exceeded £10,000.

**Note:** The total costs in this note are compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.
30 Judgement and estimations

Key sources of estimation uncertainty and judgements

In the application of the Foundation Trust’s accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

- expenditure ‘accruals’ are included within the total expenditure reported with these financial statements. These accruals represent estimated costs for specific items of committed expenditure for which actual invoices have yet to be received, together with the estimated value of capital works completed, but not formally valued as at 31 March 2015. Estimates are based on the Foundation Trust’s current understanding of the actual committed expenditure.
- an estimate of £1.3m is made in relation to the income due from incomplete patient spells as at 31 March 2015 as the true income in relation to these episodes of care will not be known with certainty until the patient is discharged. This estimate is based on historic trend analysis, together with other relevant factors.
- an estimate of £0.9m is made in relation to the value of income received through the new maternity pathway tariff in relation to the un-delivered element of the pathway as at 31 March 2015. The exact length of the patient pathway will not be known with certainty until the patient is discharged, this estimate is based on expected pathway duration together with historic trend analysis.
- an estimate of £0.5m is made in relation to the value of unpaid annual leave outstanding as at 31 March 2015 for which the Foundation Trust has a current liability. This estimate is based on records on the Electronic Staff Record system, together with a detailed review undertaken by Human Resources and Finance teams.
- an estimate is made for depreciation and amortisation of £8m. Each capital or donated asset is added to the asset register and given a unique identifier. The value and an estimated life is assigned (depending on the type of asset) and value divided by the asset life (on a straight line basis) is used to calculate an annual depreciation charge.
- a revaluation of land and buildings of £1.8m and £0.1m has been included in operating expenses. This was advised by the District Valuation Office.
- an estimate is made for provision for doubtful receivables of £0.9m. NHS and Non-NHS receivables are reviewed, together with guidance for specific areas of income, which reflect the uncertainty of the financial climate of the healthcare and commissioning market.

31 Senior manager remuneration

Directors’ remuneration totalled £1,271,000 in 2014/15 (2013/14: £1,338,000). Full details are provided within the Remuneration Report on page 156.

32 Senior manager pension entitlements

There were benefits accruing to seven of the Foundation Trust’s executive directors under the NHS Pension Scheme in 2014/15. Full details are provided within the Remuneration Report.
# 33 Charitable Fund Reserve

The Charitable Fund Reserve comprises.

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted funds</td>
<td>2,282</td>
<td>2,249</td>
</tr>
<tr>
<td>Unrestricted funds</td>
<td>3,225</td>
<td>3,345</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,507</strong></td>
<td><strong>5,594</strong></td>
</tr>
</tbody>
</table>
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

Further copies of this report can be found online at www.rbch.nhs.uk

If you would like a copy of the Annual Report and Accounts in a different format please contact the Communications Department on 01202 704271.
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Findings and Recommendations from the 2014/15 NHS Quality Report External Assurance Review

26 May 2015
This report sets out the findings from our work on the 2014/15 Quality Accounts.

We would like to take this opportunity to thank Trust staff involved with this work for their assistance during the course of our review

<table>
<thead>
<tr>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Summary</strong></td>
</tr>
<tr>
<td><strong>Content and Consistency Review</strong></td>
</tr>
<tr>
<td><strong>Performance Indicator testing</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Recommendations for improvement</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Appendices</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
1. Executive Summary

We have completed our Quality Report testing and are in a position to issue our limited assurance opinion.

<table>
<thead>
<tr>
<th>Q3 Governance Risk Rating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Review. Monitor is requesting further information following multiple breaches of the A+E and cancer wait time targets.</td>
</tr>
<tr>
<td>2014/15</td>
</tr>
<tr>
<td>Length of Quality Report</td>
</tr>
<tr>
<td>Quality Priorities</td>
</tr>
<tr>
<td>Future year Quality Priorities</td>
</tr>
</tbody>
</table>

**Status of our work**

- We have still to receive the final signed Quality Report and letter of Representation, at which point we will issue our final report to the Governors.
- We are finalising the KPIs that are to be reported and were tested during our audit.
- The scope of our work is to support a “limited assurance” opinion, which is based upon procedures specified by Monitor in their “Detailed Guidance for External Assurance on Quality Reports 2014/15”.
- We anticipate signing an unmodified opinion for inclusion in your 2014/15 Annual Report.

**Scope of work**

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in Monitor’s Annual Reporting Manual (“ARM”).
- Review the content of the Quality Report for consistency with various information sources specified in Monitor’s detailed guidance, such as Board papers, the Trust’s complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - For 2014/15, Monitor required the 18 week referral to treatment (RTT) waiting time to be publicly reported. In addition, the Trust selected the 62 day cancer wait time indicator for public reporting; and
  - For 2014/15, all Trusts were also required to identify a third “local indicator” for testing and the Trust selected the proportion of stroke patients directly admitted to a Stroke Unit within four hours.
- The scope of testing includes an evaluation of the key processes for reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources;
  - There is evidence to suggest that the RTT and 62 day cancer wait time indicators have not been reasonably stated in all material respects in accordance with the ARM requirements; and
- Provide a signed limited assurance report, covering whether:Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested.
1. Executive Summary (continued)

Content and consistency review

We have completed our content and consistency review and note the progress made in providing examples of performance in specific areas of trust activity. Nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015, the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

<table>
<thead>
<tr>
<th>Overall conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
</tr>
<tr>
<td>Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?</td>
</tr>
<tr>
<td><strong>Consistency</strong></td>
</tr>
<tr>
<td>Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?</td>
</tr>
</tbody>
</table>

Performance indicator testing

Monitor requires auditors to undertake detailed data testing on a sample basis of three indicators. We perform our testing against the six dimensions of data quality that Monitor specifies in its guidance. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the “Detailed Guidance for External Assurance on Quality Reports 2014/15”.

<table>
<thead>
<tr>
<th>18 week RTT wait time</th>
<th>62 day cancer wait time</th>
<th>Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuracy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is data recorded correctly and is it in line with the methodology?</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Validity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the data been produced in compliance with relevant requirements?</td>
<td>G</td>
<td>A</td>
</tr>
<tr>
<td>Reliability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has data been collected using a stable process in a consistent manner over a period of time?</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Timeliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is data captured as close to the associated event as possible and available for use within a reasonable time period?</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Relevance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does all data used generate the indicator meet eligibility requirements as defined by guidance?</td>
<td>G</td>
<td>B</td>
</tr>
<tr>
<td>Completeness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is all relevant information, as specific in the methodology, included in the calculation?</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Conclusion</th>
<th>Unmodified Opinion</th>
<th>Unmodified Opinion</th>
<th>No opinion required</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Satisfactory – minor issues only</td>
<td>A</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>
2. Content and consistency review findings

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders. Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report, based upon the points identified in our NHS Briefing on Quality Accounts.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the length and balance of the content of the report appropriate?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there an introduction to the Quality Report that provides context?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there a glossary to the Quality Report?</td>
<td>G</td>
</tr>
<tr>
<td>• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?</td>
<td>G</td>
</tr>
<tr>
<td>• Has the Trust set itself SMART objectives which can be clearly assessed?</td>
<td>G</td>
</tr>
<tr>
<td>• Does the Quality Report clearly present whether there has been improvement on selected priorities?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there appropriate use of graphics to clarify messages?</td>
<td>G</td>
</tr>
<tr>
<td>• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?</td>
<td>G</td>
</tr>
<tr>
<td>• Does the Annual Governance Statement appropriately discuss risks to data quality?</td>
<td>G</td>
</tr>
</tbody>
</table>

Deloitte view

Overall, the Quality Account is in line with the requirements as set out in the Monitor Guidance. Stakeholders have been involved in the indicator selection process and the report makes reference to initiatives being undertaken both across the Trust and in specific parts of the Trust.

Particular areas of good practice are:

• Clearly defined objectives, with progress against objectives in the year clearly communicated, including clear explanation of where targets were not achieved;
• The report is set out in clear, understandable terms; and
• Stakeholders have been Involved on a timely basis for input on quality priorities.

Possible areas for improvement next year include:

• Including more details about how performance against quality priorities is to be measured.
3. 18 week referral-to-treatment waiting times

<table>
<thead>
<tr>
<th>Year</th>
<th>Trust reported performance</th>
<th>Target</th>
<th>Overall evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>94.3%*</td>
<td>&gt;92%</td>
<td>G</td>
</tr>
<tr>
<td>2013/14</td>
<td>96.2%</td>
<td>&gt;92%</td>
<td>Not tested</td>
</tr>
<tr>
<td>2012/13</td>
<td>97.1%</td>
<td>&gt;92%</td>
<td>Not tested</td>
</tr>
</tbody>
</table>

**Indicator definition**

**Definition:** “The percentage of patients on an incomplete pathway who have been waiting no more than 18 weeks, as a proportion of the total number of patients on incomplete pathways,” reported as the average of each month end position through the year.

The NHS Constitution gives patients a legal right to start NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate to do so. This right is about improving patients’ experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

There are three 18 week Referral-To-Treatment (RTT) metrics:

- Admitted: The pathway ends (first definitive treatment) with the patient being admitted e.g. for surgery;
- Non-admitted: The pathway ends (first definitive treatment) with the patient not being admitted e.g. an outpatient attendance OR no treatment required; and
- Incomplete: The pathway has not ended and the patient is still waiting for treatment.

Our work has focused on the **incomplete 18 week RTT metric**.

The national performance standard for the incomplete RTT metric (92%) was introduced in 2012.

For the first time, this year Monitor has specified that the 18 week RTT incomplete metric should be subject to substantive testing as part of the Quality Report external assurance process for all acute FTs.

The Trust’s performance, in comparison with other trusts is set out below.
3. 18 week referral-to-treatment waiting times

**Indicator process**

Referral for 18 week RTT pathway received by Trust from:
- GP referral
- Choose and Book
- Tertiary referral.

Referral is processed and the 18 week RTT clock is started. Referral appears on the Incomplete Waiting List each month.

Patient seen by Consultant:
- Decision not to treat
- Decision for active monitoring made by the patient
- Decision for active monitoring made by the Consultant

Yes:
- Pathway is complete and clock stops. Referral appears on Non-Admitted list for this month.

No:
- Course of treatment confirmed and commenced:
  - Medicine prescribed
  - Outpatient Clinic Therapy.

Yes:
- Pathway is complete and clock stops. Referral appears on Non-Admitted list for this month.

No:
- Course of treatment confirmed and commenced:
  - Inpatient admission.

Yes:
- Pathway is complete and clock stops. Referral appears on Admitted list for this month.

No:
- Patient continues to wait on 18 week RRT pathway until treatment provided or a decision not to treat. Referral continues to appear on the Incomplete Waiting List each month.
3. 18 week referral-to-treatment waiting times

Approach

- We met with the Trust's team for the 18 week RTT metric to understand the process from patient referral to the result being included in the Quality Report.
- We discussed with management and used analytical procedures to identify whether there were any periods during the year that represented a higher risk and required more focus in our sample testing.
- We selected a sample of 40 from 1 April 2014 to 31 March 2015, following patient records through until treatment. In our work we identified one error and therefore extended our sample to test three additional records.
- With the exception of the single error, we agreed our sample to supporting documentation.

Findings

- As noted above, we identified one error. However, we are satisfied that this was an isolated exception and accordingly did not identify any pervasive issues with the Trust's processes. The Trust has introduced a new system which commenced in April 2015 and therefore it is appropriate to continue to monitor the robustness of the information produced.
- We are currently finalising the work to confirm the final reported figure.

Deloitte View:

In Deloitte’s opinion, the indicator is correctly stated as at year end. The process behind recording and validation of data is also robust with no weaknesses noted.
4. 62 day cancer waiting times

<table>
<thead>
<tr>
<th>Year</th>
<th>Trust reported performance</th>
<th>Target</th>
<th>Overall evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>84%</td>
<td>85%</td>
<td>B</td>
</tr>
<tr>
<td>2013/14</td>
<td>80.3%</td>
<td>85%</td>
<td>Not selected</td>
</tr>
<tr>
<td>2012/13</td>
<td>88.6%</td>
<td>85%</td>
<td>A</td>
</tr>
</tbody>
</table>

**Indicator definition and process**

**Definition:** “Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.”

The NHS Cancer Plan set the goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons.

```
Patient seen by GP. GP suspects cancer
62 day pathway begins from date referral received
Letter
GP refers to hospital
Choose & book
62 day pathway begins from date on Choose and Book system
Appointment made
Patient accepts and attends appointment
Yes
No
Referral to another trust?
First treatment within 62 days?
Yes
No
Full breach recorded
First treatment within 62 days?
No
Half breach recognised by both trusts
No breach

If applicable, other valid adjustments to pathway may “stop the clock”
```

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4. 62 day cancer waiting times (continued)

The chart below shows how the Trust compares to other organisations nationally for 2014/15.

**National 62 day cancer wait performance - Q1-3 2014-15**

| Source: Deloitte analysis of Health and Social Care Information Centre data |

**Approach**

- We met with the Trust’s lead for 62 day cancer waits to understand the process from an urgent referral to the Trust to the result being included in the Quality Report.
- We discussed with management and used analytical procedures to focus on pathways which appeared to be most at risk of error e.g. patients with manual adjustments and pathways close to the 62 day breach date.
- We selected a sample of 24 from 1 April 2014 to 31 March 2015 including in our sample a mixture of cases in-breach and not in-breach of the target.

**Findings**

- During our work we identified two errors in connection with cases where an adjustment had been made and the adjustment had led to a case which had breached the 62 day target being categorised as a pass. In addition, there were a further five cases where the evidence supporting the adjustment was unclear.
- We have made recommendations to strengthen this area.
- Management is currently assessing the impact of the identified errors before finalising the reported indicator for this KPI.

**Deloitte View:**

Based on our testing of the underlying data, it would appear that the overall indicator is correctly stated at year end, subject to appropriate adjustment being made for the errors identified.

To strengthen this area, the Trust should clarify its internal guidance in connection with adjustments ensuring that non-allowable adjustments are made clear to staff. In addition, when testing individual cases, it was on occasions difficult to establish clearly the relevant dates from the patient file. Accordingly, attention should be paid to this area in order to standardise recording of data and record a clear audit trail which justifies any adjustments made as permitted under DH guidance.
5. Proportion of patients directly admitted to a Stroke Unit within 4 hours

<table>
<thead>
<tr>
<th></th>
<th>Trust reported performance</th>
<th>National Average</th>
<th>Overall evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15 Q1</td>
<td>64.8%</td>
<td>58.0%</td>
<td>-</td>
</tr>
<tr>
<td>2014/15 Q2</td>
<td>66.7%</td>
<td>59.8%</td>
<td>-</td>
</tr>
<tr>
<td>2014/15 Q3</td>
<td>59.8%</td>
<td>56.9%</td>
<td>-</td>
</tr>
<tr>
<td>2014/15 Q4</td>
<td>68.2%</td>
<td>Not available</td>
<td>-</td>
</tr>
</tbody>
</table>

**Approach**
- We met with the Trust’s lead to discuss the process for recording stroke data and also assessed the design and implementation of the process for maintaining the data.
- We selected a sample of 24 cases which occurred in the period from 1 April 2014 to 31 March 2015 and tested these records back to the Trust’s supporting information.

**Findings**
- No issues identified and all items selected for sample testing were successfully tested back to base records and supporting information.
- The Trust had previously been reporting information that had been provided to the Trust by SSNAP rather than report the performance implied by the Trust’s own information system.

**Deloitte View:**
Deloitte are able to conclude on the accuracy of the performance recorded for this indicator.
6. Recommendations for improvement

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Deloitte Recommendation</th>
<th>Management Response</th>
<th>Priority (H/M/L)</th>
</tr>
</thead>
</table>
| Cancer 62 day wait time    | The Trust should clarify its internal guidance in connection with adjustments ensuring that non-allowable adjustments are made clear to staff. | Recommendation Agreed  
**Responsible Officer:** Alison Ashmore  
**Timeline:** July 2015  
**Process for updating Council of Governors:** Via Performance Report to Council of Governors after July 2015 | M                |
| Cancer 62 day wait time    | When testing individual cases, it was on occasions difficult to establish clearly the relevant dates from the patient file. Accordingly, attention should be paid to this area in order to standardise recording of data and record a clear audit trail which justifies any adjustments made as permitted under DH guidance. | Recommendation Agreed  
**Responsible Officer:** Alison Ashmore  
**Timeline:** July 2015  
**Process for updating Council of Governors:** Via Performance Report to Council of Governors after July 2015 | M                |
## 7. Update on prior year recommendations

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Deloitte Recommendation</th>
<th>Updated management comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-Difficile</td>
<td>The PA to the Director of Nursing left the Trust in 2013/14. The Infection Control Team carry out the monthly reconciliation between results that should have been reported to HPA and the results that were actually reported. This task was previously performed by the PA.</td>
<td>Resolved and new procedures in place.</td>
</tr>
<tr>
<td>28-day readmissions</td>
<td>The Trust has been using the wrong denominator to calculate the readmission rate that is disclosed in the Quality Report. The indicator states that a number of readmissions are out of scope for reporting (e.g. Cancer, day cases) and as such these should not be included in the denominator. We have asked management to amend the rate disclosed in the Quality report to be consistent with Monitor’s scope of calculation.</td>
<td>Resolved and new procedures in place.</td>
</tr>
</tbody>
</table>
## Purpose of our report and responsibility statement

### What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under Monitor’s Audit Code to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

### What we don’t report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

### Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.
- This report should be read alongside the supplementary “Briefing on audit matters” previously circulated to you.

We welcome the opportunity to discuss our report with you and receive your feedback.

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Deloitte LLP  
Chartered Accountants  
26 May 2015

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This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose, but as made clear in our engagement letter dated 1 May 2015, only on the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.
The new False or Misleading Information offence applies to this year’s Quality Accounts.

New legal responsibilities over data quality

From 1 April 2015, health providers are subject to the False or Misleading Information (“FOMI”) offence, introduced in response to issues over data quality in the NHS. The FOMI offence applies to:

• specified information which trusts already report regularly to the Health and Social Care Information Centre; and
• the contents of the Quality Accounts.

The FOMI offence is a two stage offence:

• firstly, a NHS or private sector provider organisation is guilty of the offence if it provides information that is false or misleading whether intentionally or through negligence i.e. this is a strict liability offence where intent is not relevant to the offence being committed.
• secondly, if a provider has committed and offence, it is possible that a director or other senior manager or other individual playing such a role may be personally guilty of an equivalent of the FOMI offence as well.

The potential penalties for providers include fines, a requirement to take specific action to remedy failures in data reporting, or to publicise that the offences have been committed and corrected data. For an individual, penalties can be an unlimited fine or up to 2 years in jail.

Providers and individuals are able to make a defence that they reported information having taken “took all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information”– however it is currently unclear what would be interpreted as “reasonable” in this context. In practise, there is likely to be significant discretion exercised in determining whether to mount a prosecution.

Deloitte view

Over the course of the year, we have updated the Trust on the potential implications of the offence and have discussed with management the findings from our Quality Accounts work in the context of the offence. We have recommended additional wording that has been included in the Quality Accounts to make clear the inherent limitations of recording and reporting some metrics, which the Trust has included in order to present reported data in the appropriate context.

The scope of the FOMI offence is wide ranging, and covers many more indicators and data sets than are considered in our Quality Accounts data testing of three indicators, or than Internal Audit are able to cover in their data work each year. In order to be able to demonstrate across all reported metrics that they have taken “all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information”, providers are ultimately reliant upon the quality of their systems for data recording and information reporting.

However, accurately reported data is not just a compliance requirement – it is necessity for creating an insight driven organisation. A lack of accurate, complete and timely data can increase operational and financial risk. Failure to govern and use data effectively can lead to poor patient experiences and reputational damage. Data issues can also undermine a Trust’s ability to run an efficient service, as key information that should influence decision making is not available or accurate.

To support boards in considering their use of data, our latest NHS Briefing on Data Quality highlights areas of good practice for Trusts to consider in improving how they govern and use data. Key questions for Trust boards to consider include:

• Is there a risk that your reported data is not accurate or that you are making decisions on unreliable data?
• What sources of assurance has the Board sought around the quality of data? Do you place too much reliance on the mandatory external data governance reviews to assure data quality?
• Is there an opportunity to improve patient outcomes, patient experience, operational efficiency and financial performance of your Trust by using data in a more sophisticated way?
• Has your Trust adequately identified the costs and benefits associated with a data governance effort?
• Does your Trust have in place a system of Data Governance designed to address data quality concerns and enable more effective data usage?
• Is your data governance effort owned at a sufficiently senior level and is the Board aware of data governance issues and concerns?
• Has your Trust set out its analytics and information vision and strategy?
• Is your analytics and information strategy aligned to other Trust strategies?
• Does your Trust have the analytics capacity, capability and technology to exploit its data assets effectively?
Appendix 3

Events and Publications

Our events and publications to support the Trust.

Governor seminars
We run a regular programme of seminars for Governors of trusts we audit. Recent areas covered have included:

- Themes from our Connected Health study, led by Karen Taylor, Director of our Centre for Health Solutions, looking at how digital technology is transforming health and social care;
- 2014/15 Reporting Requirements, focusing on areas for Governors to be aware of such as Quality Accounts changes;
- Findings from governance reviews under Monitor’s “Well Led” framework; and
- “Hot topics” in the sector ahead of the year-end reporting and audit process.

The sessions provide an opportunity for Governors to share both challenges and examples of successful approaches from across their Trusts. We would welcome suggestions for themes for future sessions. The Trust has been represented by a Governor at previous events. Our next session will be in the autumn: we will send an invitation via the Lead Governor for the Council of Governors to nominate an attendee.

Deloitte UK Centre for Health Solutions

The Deloitte Centre for Health Solutions generates insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry. Working closely with other centres in the Deloitte network, including our US centre in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors; health providers and purchasers; and consumers and suppliers.

Recent reports include:

- Connected Health;
- Healthcare and Life Science Predictions 2020;
- Better care for frail older people;
- Guideposts Dementia Information Prescription, in partnership with the Guideposts Trust; and
- Working differently to provide early diagnosis.

Upcoming studies include End of Life Care, and the Cost of Compliance

For access to our latest studies and opinion pieces, please sign up to receive our weekly blog at http://blogs.deloitte.co.uk/health/ or email centreforhealthsolutions@deloitte.co.uk:

NHS Briefings and publications for the Trust

We provide the Trust through the year with publications and access to webinars and information on accounting requirements, including our “Stay Tuned Online” accounting update sessions.

We regularly publish NHS Briefings designed to disseminate our insights on topical issues within the NHS in general, and Foundation Trusts in particular. They focus on current issues facing the sector and ask questions to help readers assess if the issue is being appropriately addressed at their Trust.

Briefings have covered a range of topics including Data Quality, The Dalton Review: Implications for providers, Joined up QIPP, Patient Administration Systems, Effective Boards, the Evolving Role of Governors, Narrative Reporting, Quality Accounts requirements, Human Resources, Mergers & Acquisitions in the NHS, Transforming Community Services, and the challenges of Monitor’s Quality Governance framework.

We also run regular NHS Foundation Trust dinners for directors, with speakers from across the sector on key current issues. Recent events have focussed on Quality Governance and on the Dalton Review.
Other than as stated below, this document is confidential and prepared solely for your information and that of other beneficiaries of our advice listed in our engagement letter. Therefore you should not, refer to or use our name or this document for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. If this document contains details of an arrangement that could result in a tax or National Insurance saving, no such conditions of confidentiality apply to the details of that arrangement (for example, for the purpose of discussion with tax authorities). In any event, no other party is entitled to rely on our document for any purpose whatsoever and thus we accept no liability to any other party who is shown or gains access to this document.

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Royal Bournemouth and Christchurch Hospital NHS Foundation Trust

Final report to the Audit Committee on the 2014/15 audit

26 May 2015
A reminder of our audit plan:

- **Materiality:** £2.59m (2013/14: £2.53m).

- **Threshold for reporting misstatements:** £129k (2013/14: £126k).

- Significant risks have been identified over recognition of NHS revenue, property valuations, accounting for capital expenditure, and management override of controls.

- We have taken a substantive audit approach to gain assurance.

- Since the plan was issued, we have identified an additional significant risk in respect of going concern, discussed further on page 10.
I have pleasure in presenting our final report to the Audit Committee for the 2014/15 audit. I would like to draw your attention to the key messages of this paper:

### Conclusions from our testing

- The key judgements in the audit process related to:
  - going concern, due to the reforecasting of 2014/15 figures and the level of forecast losses for 2015/16;
  - the 2014/15 revaluation of the Trust’s estate; and
  - provisioning for disputes with commissioners - the bad debt provision is 12% of total receivables (2013/14: 9%).
- We have not identified any uncorrected misstatement or any significant disclosure deficiencies.
- Based on our audit work to date, we envisage issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust’s arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.
- We have not identified any inconsistencies between the financial statements and the FTCs.

### Quality Accounts

- Based on the current status of our audit work, we plan to issue a clean quality report opinion. The findings from our work are set out in the accompanying paper, which will also be presented to the Council of Governors at their next meeting.

### Status of the audit

- We anticipate issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust’s arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance statement.
- The audit is substantially complete subject to the completion of the following principal matters:
  - Completion of sundry audit matters remaining and internal quality assurance procedures;
  - NAO reporting documents and final review of financial statements;
  - Completion of Quality Report review and resolution of outstanding matters;
  - Our review of events since 31 March 2015; and
  - Receipt of signed management representation letter.
- Our Independent Examination of the Royal Bournemouth and Christchurch Hospital Charitable Fund’s financial statements will be completed over the summer.

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**Sue Barratt**  
Lead audit partner

Audit quality is our number one priority. When planning our audit we set the following audit quality objectives for this audit:

- **A robust challenge of the key judgements taken in the preparation of the financial statements.**
- **A strong understanding of your internal control environment.**
- **A well planned and delivered audit that raises findings early with those charged with governance.**
Our audit explained

We tailor our audit to your business and your strategy

Identify changes in your Trust and environment
In our planning report we identified the key changes and articulated how these impacted our audit approach.

Scoping
Our risk assessment process has included benchmarking your results against other trusts and reviewing 18 week RTT data to plan our Quality Accounts work. Our findings are set within our accompanying Quality Accounts report.

Other findings
As well as our conclusions on the significant risks we are required to report to you our observations on the internal control environment as well as any other findings from the audit. We would like to draw to your attention to the controls recommendations, further detail of which is found on page 12.

Identify changes in your business and environment

Determine materiality
When planning our audit we set our materiality at £2.5m, which was revised to £2.6m (2013/14: £2.5m) based on actual revenue for the year.

Significant risk assessment
In our planning report we explained our risk assessment process and detailed the significant risks we have identified on this engagement. We report our findings and conclusions on these risks in this report. Note we have added Going concern as a significant risk from planning due to the increase in the forecast deficit for the year.

Conclude on significant risk areas
We draw to the Audit Committee’s attention our conclusions on the significant audit risks. In particular the Audit Committee must satisfy themselves that management’s judgements in relation to going concern are appropriate.

Our audit report
Based on the current status of our audit work, we envisage issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust’s arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.
## Significant risk dashboard

<table>
<thead>
<tr>
<th>Fraud risk</th>
<th>Results of controls approach testing</th>
<th>Consistency of judgements with Deloitte expectations</th>
<th>Expected to be included in our audit report</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of NHS revenue and recoverability of receivables</td>
<td></td>
<td></td>
<td></td>
<td>NHS receivables of £5.6m are significantly lower than in prior year (£8.4m) reflecting a higher proportion of managed Payment by Results (PbR) and better recovery of over-performance. The level of provisioning against these receivables is a key judgement in the financial statements.</td>
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<tr>
<td>Property valuations</td>
<td></td>
<td></td>
<td></td>
<td>The Trust’s revaluation has increased land values by £4.0m (16%), and reduced the value of buildings by £0.11m (0.1%). The impact of this will be to increase PDC dividends payable in the coming year by £0.14m. The Depreciated Replacement Cost method, used for valuing most of the Trust’s properties in line with other NHS bodies, is particularly judgemental.</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td>Going concern assessment</td>
<td></td>
<td></td>
<td></td>
<td>The Trust has reported a deficit of £5.2m in 2014/15, with a forecast deficit of £12.9m in 15/16. Considered alongside the uncertainties surrounding tariff options in 2015/16, we identified an additional significant risk on the going concern assessment.</td>
</tr>
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<td></td>
</tr>
<tr>
<td>Capital additions</td>
<td></td>
<td></td>
<td></td>
<td>The Trust had a significant capital programme of £17.6m and decisions to capitalise costs can be judgmental.</td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Management override of controls</td>
<td></td>
<td></td>
<td></td>
<td>We presume a risk of material misstatement due to fraud related to management override of controls. Management is in a unique position to perpetrate fraud because of management's ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.</td>
</tr>
</tbody>
</table>

Overly prudent, likely to lead to future credit ø ø ø ø ø. Overly optimistic, likely to lead to future debit.
Recognition of NHS revenue and recoverability of receivables

Risk identified

As set out in our Audit Plan, we identified recognition of NHS revenue and associated provisions as a key risk due to:

- the complexity of the payment by results regime, in particular in determining the level of over-performance and Commission for Quality and Innovation (CQUIN) revenue to recognise;
- the judgemental nature of provisions for disputes with commissioners, including in respect of outstanding over-performance income for quarters 3 and 4;
- the challenges experienced in 2013/14 in recovering income and increases in debtor aging across the sector; and
- the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts.

Key judgements

The table below summarises the Trust’s gross and net receivable recognised

<table>
<thead>
<tr>
<th></th>
<th>Gross NHS receivables £'000</th>
<th>Provisions as at 31 March £’000</th>
<th>Net NHS receivables £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>5,060</td>
<td>(583)</td>
<td>4,477</td>
</tr>
<tr>
<td>2013/14</td>
<td>7,923</td>
<td>(413)</td>
<td>7,510</td>
</tr>
</tbody>
</table>

Deloitte response

- We have agreed baseline contract income to underlying contracts and a sample of significant year-end income balances to activity data with no issues noted
- Whilst income is predominantly contract driven, we have involved our IT specialist to assess the design and implementation of key controls in the payment by results (‘PbR’) systems at the Trust. No issues have been noted from this review of internal control.
- We have tested the year-end calculations for partially completed patient spells (£1.3m accrued compared to £1.4m at 31 March 2014) and net CQUIN underachievement (£0.2m compared to £4.9m of CQUIN income at 31 March 2014) with no issues noted
- Our clearance to the National Audit Office will note where the provisions made are outside the Agreement of Balances exercise.
- We have reviewed with management the key changes and any open areas in setting 2015/16 contracts, and have confirmed that, taken together with the settlement of current year disputes, there are not any factors that would affect the revenue to be recognised in the current year.

Inclusion in our audit report

We expect to include this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.
Risk Identified

The Trust is required to hold property assets within Property, Plant and Equipment at valuation, which will usually be on a modern equivalent use basis. As detailed in our Audit Plan, valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value. The Trust has had a valuation carried out by the district valuer. The report was issued by the district valuer on 27 April 2015 and consider the period up to 31 March 2015.

Key judgements

The Trust’s revaluation has increased land values by £4.0m (16%), and reduced the value of buildings by £0.11m (0.1%). The impact of this will be to increase PDC dividends payable in the coming year by £0.14m (Valuation movement x 3.5%).

£2.7m of the Trust’s property assets have no associated revaluation reserve, meaning that any impairment to those assets would be recognised directly in the surplus for the year, rather than in comprehensive income.

Deloitte response

• We engaged our property specialists Deloitte Real Estate to review the assumptions and methodology used to value the estate. We have used their findings to challenge management’s assumptions. They have confirmed that the general assumptions and caveats adopted for the asset valuation exercise are considered appropriate for the purposes of the valuation. We are discussing with management a reduction in assumed floor area for certain properties under renovation, the potential amounts involved are not material.
• It was noted that the change in valuation between 2013 and 2015 largely reflects:
  • Purchase of Abbotsbury House in year
  • The general increase in forecast build costs over the last two years, which has a direct impact on any asset valued using the Depreciated Replacement Cost approach
  • Significant capital expenditure spent on CSSD Alderney accounting for almost all of the increase in this asset
  • At Christchurch Hospital, the DVS included a functional obsolescence charge
• We are tracing the movements arising from the valuation to the general ledger to ensure the recognition of the revaluation movement in the income statements and revaluation reserve is in line with IAS 16 guidance. This work is to be finalised, but we do not anticipate it resulting in any material misstatement to the financial statements.

Inclusion in audit report

We expect to include this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.
**Risk Identified**

The Trust has an extensive five year £72.3m capital programme running from 2014-2019, with spend for the year of £17.2m in FY15. As detailed in our Audit Plan, accounting for capital expenditure can involve significant judgements.

**Key judgements**

The table below summarises the cumulative spending compared to the budget approved by the Board in March 2014

![Cumulative Capital Expenditure vs. Plan](chart.png)

**Deloitte response**

- We have tested the design and implementation of controls around the capitalisation of costs. This includes confirmation of board approvals, review of capitalisation criteria and overspending authorisation.
- We have tested spending on a sample basis to confirm that it complies with the relevant accounting requirements, and that the depreciation rates adopted are appropriate. We also reviewed the nature of the projects selected as part of our sampling to determine appropriateness of capitalisation and whether there were any associated disposals not accounted for.
- We have reviewed the project breakdowns and the status of individual projects to evaluate whether they have been depreciated from the appropriate point as part of our depreciation testing.
- We have also completed fixed asset verification testing to ensure existence.

The results of the testing listed above was satisfactory and no issues have been noted. We believe the Trust has appropriately accounted for capital expenditure.

**Inclusion in audit report**

We expect to include this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.
Management override of controls

Risk Identified

International Standards on Auditing requires auditors to identify a presumed risk of management override of control. This presumed risk cannot be rebutted by the auditor. This recognises that management may be able to override controls that are in place to present inaccurate or even fraudulent financial reports.

Key judgements

Our audit work is designed to test management override of controls and key estimates. We have summarised our findings above on the key estimates around revenue recognition and recoverability and property valuations.

Deloitte response

We have considered these factors and other potential sensitivities in evaluating the judgements made in the preparation of the financial statements. Specific areas of work are:

Journals

We have used our centralised analytics platform, Spotlight, for journal profiling to test a sample of higher risk journals. All journals selected by Spotlight fit with our understanding of the business and were sufficiently supported by underlying documents. However it was noted that not all journals are reviewed by management. Therefore we have recommended going forward all journals over agreed upon threshold are reviewed and correcting journals should be authorised.

Accounting estimates

In addition to the key estimates discussed above or identified as separate significant audit risk areas, we have reviewed the annual paper summarising the key areas of judgments prepared by management and challenged the basis for other estimates used in the financial statements. We have also considered the key areas of judgements in comparison to prior year to ensure completeness and consistency of accounting estimates and provisions. We have concluded that the accounting estimates are appropriate.

Significant transactions

We did not identify any significant transactions outside the normal course of business or transactions with unclear business rationale.
Risk Identified

The Annual Reporting Manual requires that accounts are prepared on a going concern basis. However, if the Trust considers there are material uncertainties over the Trust’s status as a going concern, these would need to be disclosed and we would need to include an Emphasis of Matter in our audit report.

Our audit plan did not identify a significant risk in respect of going concern. Since the issue of that plan:

• The proposed 2015/16 Tariff was published, and rejected by providers;
• NHS England proposed an alternative, “Enhanced Tariff Offer”;
• The Trust had to significantly reforecast FY2014/15 from the initial deficit of £1.9m to £5.2m and is currently forecasting a £12.9m deficit for FY2015/16

We therefore updated our plan to include the Trust’s going concern assessment as a significant risk.

Deloitte response

• We have reviewed the Trust’s financial performance in 2014/15 including its achievement of planned cost improvements in the year, which amounted to approximately £7.5m and represented more than 100% of the Trust’s target for the year.
• We have also considered the reasons behind why the Trust did not meet its initial budgeted deficit (primarily due to the premium cost incurred for increase in agency staff) and what has been done differently for 2015/16 forecasting procedures.
• We have reviewed the Trust’s available cash flow forecasts to the end of 2015/16 and we have performed a high level review of the Trust’s financial plan for 2015/16. We have challenged management as to the assumptions that have been incorporated within the forecasts and compared to actuals achieved in 2014/15. We have also considered the headroom available within the forecast, with £24m of cash balance expected at 2015/16 financial year end.
• We have benchmarked the Trust’s projections with other acute foundation trusts nationally and noted the results to be in line with the rest of the sector.
• We have held discussions with management to understand the current status of contract negotiations with its commissioners.

From review of the Trust’s cash flow forecast, consideration of the assumptions in producing the budget, and the headroom available in the budget, we have concluded that there is not a material uncertainty with regards to the Trust’s ability to meet debts as they fall due for a period of at least 12 months from the date of signing.

Inclusion in audit report

We expect to include this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.
Value for money

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Our work takes account of:

- the Accounting Officer’s statement in the Annual Governance Statement; and
- the results of work of relevant regulators, including the Care Quality Commission and Monitor.

Overall financial and quality performance

The table below illustrates how the Trust’s performance compares to plan and prior year:

<table>
<thead>
<tr>
<th>Current year 2014/15</th>
<th>Planned 2014/15</th>
<th>Variance</th>
<th>Prior year 2013/14</th>
<th>Planned 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Deficit)/Surplus</td>
<td>£(5.2)m</td>
<td>£(1.9)m</td>
<td>£0.6m</td>
<td>£12.9m</td>
</tr>
<tr>
<td>EBITDA margin</td>
<td>3.4%</td>
<td>4.4%</td>
<td>-1.0%</td>
<td>4.6%</td>
</tr>
<tr>
<td>CIP target and identified to date</td>
<td>£7.5m</td>
<td>£7.4m</td>
<td>£133k</td>
<td>£8.8m identified by May 2014</td>
</tr>
<tr>
<td>Monitor Continuity of Service Risk Rating</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Monitor governance risk rating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Breaches of Monitor performance targets</td>
<td>Information Governance</td>
<td>None</td>
<td>None</td>
<td>-</td>
</tr>
<tr>
<td>CQC Intelligent Monitoring Rating</td>
<td>December: 2.66%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CQC report conclusions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3 breaches</td>
</tr>
</tbody>
</table>

The table below shows how the Trust’s CIP delivery and programme compares to our other Foundation Trust clients.

<table>
<thead>
<tr>
<th>Sector average</th>
<th>Trust 2014/15</th>
<th>Trust 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIP - plan</td>
<td>£7.4m</td>
<td>£9.6m</td>
</tr>
<tr>
<td>CIP - actual</td>
<td>£7.5m</td>
<td>£8.8m</td>
</tr>
<tr>
<td>Actual CIPs as % of plan</td>
<td>&gt;100%</td>
<td>91.3%</td>
</tr>
<tr>
<td>CIPs as a percentage of operating expenses</td>
<td>2.8%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Work performed

We have obtained an understanding of the Trust’s arrangements for securing “value for money”, through a combination of:

- “high level” interviews with Audit Committee Chair, Chief Operating Office and Finance Director;
- review of the Trust’s draft Annual Governance Statement;
- consideration of issues identified through our other audit and assurance work;
- consideration of the Trust’s results, including benchmarking of actual performance (including on CIP delivery) and the 2015/16 Annual Plan;
- review of the Care Quality Commission’s report on the Trust dated November 2014;
- review of Monitor’s continuity of service and governance risk ratings; and
- consideration of the Trust’s Information Governance toolkit score of 37%

Conclusion

We have not identified any specific risks in respect of Value for Money

We have not identified any issues which we need to report in our audit opinion in respect of:

- the Trust’s arrangements for securing the economy, efficiency and effectiveness of the use of resources; or
- the Annual Governance Statement.
Other significant findings

Financial reporting findings

Below are the findings from our audit surrounding your financial reporting process.

### Qualitative aspects of your accounting practices
We have considered the accounting policies, accounting estimates and financial statement disclosures as included within the current year financial statements in terms of changes on prior year and appropriateness in line with IFRS and ARM. We have noted the only change to be that of the bad debt provision. Previously only specific debts have been provided for, in the current year all debts greater than six months have had a provision of 50% applied and all debts greater than one year have been 100% provided for. We have challenged this change and considered in line with the amount of debt written off in the prior year and deemed the policy to be appropriate. No additional disclosure is required.

### Significant difficulties encountered
The Trust revalued its estate at 31 March 2015. Management responsibility for maintaining the Trust’s fixed asset register requires input from ELFS to ensure that the register is robust.

In order to help ensure effective control over the fixed asset register, it is recommended that the Trust and ELFS clarify their respective responsibilities around the year end closure process.

### Significant matters discussed with management
We noted a recent oil leak at the Christchurch site and discussed with management whether a provision or contingent liability was appropriate. Management confirmed that the likelihood of substantial costs for the Trust are not probable and as such a provision has not been recognised. In addition, no contingent liability has been disclosed as management believe that there will not be any material future costs in connection with this event that will fall to the Trust.

### Other significant matters
No additional matters noted.

We will obtain written representations from those charged with governance on matters material to the financial statements when other sufficient appropriate audit evidence cannot reasonably be expected to exist. A copy of the draft representations letter will be circulated separately.
Our audit report

Summary of the risks we report on

The table below shows how the risks reported through the Annual Report and Accounts and in our Audit Report align.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Principal Risks and Uncertainties</th>
<th>Audit Committee Report’s list of significant issues</th>
<th>Critical Accounting Judgements and Key Sources of Estimation Uncertainty (Note 30)</th>
<th>Audit report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of NHS revenue</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Property valuations</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Accounting for capital expenditure</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Going concern</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Management override of controls</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

We have noted that the audit committee reports significant issues as being progress of the clinical audit plan, delivery of Trust’s transformation savings programme and monitoring of clinical governance. While there is a general statement about considering major judgemental areas, there are no explicit references to individual judgement areas with regards to accounting policies and treatment. In our view, we believe this could be improved by adding specific areas that have been considered in the preparation of the annual financial statements.
Purpose of our report and responsibility statement
Our report is designed to help you meet your governance duties

What we report
Our report is designed to help the Audit Committee and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under ISA 260 (UK and Ireland) to communicate with you regarding your oversight of the financial reporting process and your governance requirements. Our report includes:
• Results of our work on key audit judgements and our observations on the quality of your Annual Report.
• Other insights we have identified from our audit and in following our audit plan, Audit Quality Promise and Insight Plan.

What we don’t report
• As you will be aware, our audit was not designed to identify all matters that may be relevant to the board.
• Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
• Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

The scope of our work
• Our observations are developed in the context of our audit of the financial statements.
• We described the scope of our work in our audit plan and the supplementary “Briefing on audit matters” circulated to you previously.
• The Insight and Additional assurance findings sections of this report provide details of additional work we have performed alongside the audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP
Chartered Accountants
Southampton
26 May 2015

This report has been prepared for the Board of Directors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.
Appendices
Audit adjustments

Unadjusted misstatements

At the time of issuing the audit committee report, we have not identified unadjusted misstatements identified in the current year.

The only unadjusted item identified in the prior year relates to the property revaluation for which we are finalising our audit work.

Note we only report to you misstatements that are either qualitatively material or exceed the clearly trivial threshold of £129k.
Responsibilities explained

<table>
<thead>
<tr>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance, including establishing and maintaining internal controls over the reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations. As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit work performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In our planning we identified the risk of fraud in revenue recognition and management override of controls as a key audit risk for the Trust.</td>
</tr>
<tr>
<td>• During course of our audit, we have had discussions with management and those charged with governance.</td>
</tr>
<tr>
<td>• The Trust has adequate processes and internal controls in place to identify and respond to the risks of fraud. There have been a number of minor frauds in the year, which have been communicated to the Board and passed down to the relevant Directorates where the fraud occurred to investigate the causes and derive recommendations.</td>
</tr>
<tr>
<td>• In addition, we have reviewed management’s own documented procedures regarding the fraud and error in the financial statements.</td>
</tr>
<tr>
<td>• We have reviewed the reports prepared by the Local Counter Fraud Specialist for the audit committee on the overview of the work undertaken in each of the four key sections that underpin NHS Protects strategy, i.e. Strategic Governance, Inform and Involve, Prevent and Deter, and Hold to Account.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required representations</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have asked the Board to confirm in writing that you have disclosed to us the results of your own assessment of the risk that the financial statements may be materially misstated as a result of fraud and that you have disclosed to us all information in relation to fraud or suspected fraud that you are aware of and that affects the entity or group.</td>
</tr>
<tr>
<td>We have also asked the Board to confirm in writing their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The most prevalent type of fraud recorded in the NHS during FY2014/15 was noted to be payroll fraud. Of this the most prevalent case involved working elsewhere whilst sick, or on NHS time. We note this continues to be an area of focus for Local Counter Fraud Specialist</td>
</tr>
</tbody>
</table>
Independence and fees

As part of our obligations under International Standards on Auditing (UK & Ireland), we are required to report to you on the matters listed below:

| Independence confirmation | We confirm that we comply with APB Ethical Standards for Auditors and that, in our professional judgement, we and, where applicable, all Deloitte network firms are independent and our objectivity is not compromised. |
| Fees | Our audit fee for the year from 1 April 2014 to 31 March 2015 is £69,425. There were no non-audit services for the period. The details of the fees charged this year are shown in the table below. |
| Non-audit services | In our opinion there are no inconsistencies between APB Ethical Standards for Auditors and the Trust’s policy for the supply of non-audit services or of any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary. |
| Relationships | As part of our obligations under International Standards on Auditing (UK & Ireland) and the APB’s Ethical Standards we are required to report to you on all relationships (including the provision of non-audit services) between us and the audited entity. We are not aware of any relationships (including the provision of non-audit services) between us and the audited entity, its directors and senior management and its affiliates, including all services provided by us and the DTTL network to the audited entity, its directors and senior management and its affiliates, and other services provided to other known connected parties that we consider may reasonably be thought to bear on our objectivity and independence. |

The professional fees earned by Deloitte in the period from 1 April 2014 to 31 March 2015 are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>2014/15 £m</th>
<th>2013/14 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial statement audit</td>
<td>42,975</td>
<td>42,975</td>
</tr>
<tr>
<td>Charity Consolidation</td>
<td>3,750</td>
<td>3,750</td>
</tr>
<tr>
<td>Whole of Government Accounts</td>
<td>3,000</td>
<td>3,000</td>
</tr>
<tr>
<td>Quality Accounts work</td>
<td>13,000</td>
<td>13,000</td>
</tr>
<tr>
<td>Enhanced Audit Report</td>
<td>2,500</td>
<td>-</td>
</tr>
<tr>
<td>Overrun costs</td>
<td>-</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>Total audit service</strong></td>
<td><strong>65,225</strong></td>
<td><strong>67,725</strong></td>
</tr>
<tr>
<td>Audit of the Trust’s charity</td>
<td>4,200</td>
<td>4,200</td>
</tr>
<tr>
<td><strong>Total assurance services</strong></td>
<td><strong>4,200</strong></td>
<td><strong>4,200</strong></td>
</tr>
<tr>
<td><strong>Total fees</strong></td>
<td><strong>69,425</strong></td>
<td><strong>71,975</strong></td>
</tr>
</tbody>
</table>
Your Annual Governance Statement

The Governance Statement should give the reader a clear understanding of the dynamics of the organisation and its control structure, recording the stewardship of the organisation, providing a sense of how vulnerable the organisation’s performance is or might be; and of how successfully the organisation has coped with the challenges it faces.

<table>
<thead>
<tr>
<th>Critical components</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has the required format been followed?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there a balanced discussion?</td>
<td>G</td>
</tr>
<tr>
<td>• Does discussion cover quality governance arrangements, include routinely obtaining assurance on compliance with CQC registration requirements”?</td>
<td>G</td>
</tr>
<tr>
<td>• Does the Value for Money discussion link to the rest of the Annual report and KPIs?</td>
<td>A</td>
</tr>
<tr>
<td>• Is there discussion of how assurance is obtained on quality of data used by the board, covering financial and quality data?</td>
<td>A</td>
</tr>
<tr>
<td>• Has adequate disclosure been made around this year’s additional requirements to discuss risks and assurances over the quality of elective waiting time data?</td>
<td>A</td>
</tr>
<tr>
<td>• Is there a meaningful discussion of the outline of the actions taken, or proposed to deal with any significant internal control issues and gaps in control, if applicable?</td>
<td>G</td>
</tr>
<tr>
<td>• Are there meaningful highlights of board committee reports?</td>
<td>G</td>
</tr>
</tbody>
</table>

G  No issues noted  A  Acceptable but could be improved  R  Requires significant improvement
Your Audit Committee report

The Audit Committee report is required to cover the significant issues considered and how they were addressed, plus further details on audit tenure, tendering policy and an explanation of how the Audit Committee has assessed the effectiveness of the external audit process.

<table>
<thead>
<tr>
<th>Critical components</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has the audit committee implemented an effective process around the fair,</td>
<td>G</td>
</tr>
<tr>
<td>balanced and understandable statement and the sufficiency of other disclosures?</td>
<td></td>
</tr>
<tr>
<td>• Are there any inconsistencies with the issues that the audit committee is planning</td>
<td>G</td>
</tr>
<tr>
<td>to discuss in its own audit committee report, the risks which will be included in</td>
<td></td>
</tr>
<tr>
<td>the audit report and in the critical judgement section in accounting policies?</td>
<td></td>
</tr>
<tr>
<td>• In discussing the significant issues considered has the audit committee described</td>
<td>G</td>
</tr>
<tr>
<td>how it is has challenged management’s key assumptions and estimates?</td>
<td></td>
</tr>
<tr>
<td>• Has the Trust used an appropriate framework to assess the effectiveness of the</td>
<td>G</td>
</tr>
<tr>
<td>audit process?</td>
<td></td>
</tr>
<tr>
<td>• Is the length of audit tenure disclosed? Has a tendering policy been agreed and</td>
<td>G</td>
</tr>
<tr>
<td>disclosed?</td>
<td></td>
</tr>
</tbody>
</table>

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Your fair, balanced and understandable statement

The board is required to state that “the annual report, taken as a whole is fair, balanced and understandable and provides the information necessary to assess the business model, strategy and performance”.

<table>
<thead>
<tr>
<th>Critical components</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has the board/audit committee documented a process to underpin the new board statement? How effective is it?</td>
<td>G</td>
</tr>
<tr>
<td>• A “fair” story does not omit important elements - is the whole story being presented? Have any sensitive material areas been omitted?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there a good level of consistency between the front and back sections of the annual report? Do you get the same message from reading the two sections independently?</td>
<td>G</td>
</tr>
<tr>
<td>• Are the key issues facing the board included and appropriately described?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there an appropriate balance between statutory and adjusted measures and are any adjustments explained clearly and with appropriate prominence?</td>
<td>G</td>
</tr>
</tbody>
</table>

6 No issues noted  A Acceptable but could be improved  R Requires significant improvement
Your remuneration committee report

The remuneration committee report is required to include the remuneration policy for the shareholder vote, the detail of implementation for the current year (including the new ‘single figure’) plus a statement from the remuneration committee chairman.

<table>
<thead>
<tr>
<th>Critical components</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has the appropriate table of “single figure” remuneration for each director been prepared in line with the regulations?</td>
<td>G</td>
</tr>
<tr>
<td>• Does the chairman of the remuneration committee’s statement indicate good governance?</td>
<td>G</td>
</tr>
<tr>
<td>• Has sufficient attention has been given by the committee to broader remuneration matters?</td>
<td>G</td>
</tr>
<tr>
<td>• Does the remuneration report appropriately discuss the Hutton guidance and how it relates to the overall remuneration approach?</td>
<td>A</td>
</tr>
<tr>
<td>• Is there sufficient, transparent disclosure regarding the link between pay and performance?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there a clear account of the policy for senior manager’s remuneration (a new disclosure requirement this year)?</td>
<td>G</td>
</tr>
<tr>
<td>• Is there a clear statement of the Trust’s policy for using off-payroll arrangements (a new disclosure requirement this year)?</td>
<td>A</td>
</tr>
</tbody>
</table>

G No issues noted  A Acceptable but could be improved  B Requires significant improvement
## Sufficiency of other disclosures

<table>
<thead>
<tr>
<th>Topic</th>
<th>Current position</th>
<th>Consideration points</th>
</tr>
</thead>
</table>
| Strategy and business model disclosures | 🟢 No issues noted | • Are the disclosures clear and consistent with our knowledge of the Trust and external messaging?  
• Are possible business model risks and disruptions adequately drawn out? Are there implications for asset carrying values or segment disclosures?                                                                                                                                                   |
| Risk disclosures                      | 🟢 No issues noted | • Are the disclosures focused on principal risks only?  
• Is it clear why those are the principal risks to the achievement of the stated strategy and impact on the ability of the entity to deliver the business model?  
• Is there adequate discussion of potential strategic risks from wider NHS issues and pressures such as the Better Care Fund changes?  
• Is there meaningful discussion of risk management in the Annual Governance Statement?  
• Is it clear how the risks have moved during the year, i.e. increased, decreased or stayed the same?  
• Consistency of risks with other disclosures in the annual report (e.g. contingencies disclosures, IAS 1 critical judgement disclosures)  
• Are mitigating activities disclosed?                                                                                                                                                                                                                                                                   |
| Human rights and diversity            | 🟢 No issues noted | • Has the Trust presented information on human rights issues, including the Trust’s policy and the effectiveness of that policy (this information should appear alongside social and community issues)?  
• Has the Trust given detailed, qualitative information regarding gender diversity – at the board, management and employee levels (on a numeric, rather than a percentage, basis)?  
• Have they disclosed not only their current position, but future plans for improving their position and achieving diversity across the business as a whole?                                                                                                                                                  |
| Sustainability reporting              | 🟢 No issues noted | • Does the Sustainability Report reflect the (optional) guidance in the FREM? [http://www.hm-treasury.gov.uk/frem_sustainability.htm ] - not required but encouraged. If commenting on this, consider the guidance in the NAO factsheet on sustainability reporting - http://www.nao.org.uk/report/sustainability-reporting-factsheet/. This highlights some common omissions, and five areas of good practice:]  
• Does the report reflect issues that are material to the Trust and its stakeholders?  
• Have any non-financial KPIs been included? If so, is there a reference to the basis for reporting these KPIs – and are any targets for performance improvement disclosed?  
• Is the Trust’s approach to sustainability embedded within the strategy and business model?                                                                                                                                                                                                                   |
| Equality reporting                    | 🟢 No issues noted | • Does the equality report follow the (mandatory) Home Office guidance?  
• Does the report reflect issues that are material to the Trust and its stakeholders?  
• Have any non-financial KPIs been included? If so, is there a reference to the basis for reporting these KPIs – and are any targets for performance improvement disclosed?                                                                                                                                              |
Other than as stated below, this document is confidential and prepared solely for your information and that of other beneficiaries of our advice listed in our engagement letter. Therefore you should not, refer to or use our name or this document for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. If this document contains details of an arrangement that could result in a tax or National Insurance saving, no such conditions of confidentiality apply to the details of that arrangement (for example, for the purpose of discussion with tax authorities). In any event, no other party is entitled to rely on our document for any purpose whatsoever and thus we accept no liability to any other party who is shown or gains access to this document.

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### COUNCIL OF GOVERNORS

<table>
<thead>
<tr>
<th>Meeting Date and Part:</th>
<th>15 July 2015 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>Forward Planner</td>
</tr>
<tr>
<td>Section:</td>
<td>For Information</td>
</tr>
<tr>
<td>Author of Paper:</td>
<td>Sarah Anderson</td>
</tr>
<tr>
<td>Details of previous discussion and/or dissemination:</td>
<td>None</td>
</tr>
<tr>
<td><strong>Key Purpose:</strong></td>
<td>Patient Engagement</td>
</tr>
<tr>
<td></td>
<td>Governance</td>
</tr>
<tr>
<td></td>
<td>Performance</td>
</tr>
<tr>
<td></td>
<td>Strategy</td>
</tr>
<tr>
<td>Action Required by Council of Governors:</td>
<td>Note for information</td>
</tr>
<tr>
<td>Summary:</td>
<td>Copy of the Council of Governors Forward Programme</td>
</tr>
<tr>
<td>Strategic Goals &amp; Objectives:</td>
<td></td>
</tr>
<tr>
<td>Links to CQC Registration:</td>
<td>N/A</td>
</tr>
<tr>
<td>(Outcome reference)</td>
<td></td>
</tr>
<tr>
<td>What</td>
<td>Who</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Annual Plan</strong></td>
<td></td>
</tr>
<tr>
<td>Annual Plan - Draft for Public Consultation</td>
<td>RR</td>
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<tr>
<td>Annual Plan - Feedback from Consultation to COG</td>
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<tr>
<td><strong>Annual Report &amp; Accounts</strong></td>
<td></td>
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<tr>
<td>Annual Report &amp; Accounts First Draft</td>
<td>SH</td>
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<tr>
<td>Annual Report &amp; Accounts - Final draft presented</td>
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<tr>
<td><strong>Quality</strong></td>
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<tr>
<td>Inpatient Survey Results</td>
<td>PS</td>
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<tr>
<td>Quality Performance Report</td>
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<td>PLACE Inspection</td>
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<td>Quality Accounts - First Draft</td>
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<td>Quality Accounts - Final Draft presented</td>
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<td><strong>Election Results</strong></td>
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<tr>
<td>Deputy Chair Election</td>
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<td>Public Governor Election</td>
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<td><strong>Infection Control</strong></td>
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<tr>
<td>Infection Control - Annual Report</td>
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<td><strong>Constitutional Documents</strong></td>
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<td>Constitution</td>
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<td>Membership Development Strategy</td>
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<td>Policy on Composition of COG</td>
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<tr>
<td>Policy on NED Composition</td>
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<td>Register of Interests</td>
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<td>Meeting Dates for Next Year</td>
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<td>Forward Programme</td>
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<td>Actions Matrix</td>
<td>Trust Sec</td>
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<td>Annual Members’ Meeting</td>
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<td>Governor Attendance</td>
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<td>What</td>
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<td>Reports from COG Committees/Groups</td>
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<tr>
<td>Governor Induction and Training Committee</td>
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<tr>
<td>Governor Involvement with Patient and Public Engagement Committee</td>
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<tr>
<td>Nomination Committee</td>
<td>JS</td>
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<tr>
<td>Non-Executive Director Remuneration Committee</td>
<td>EF</td>
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<tr>
<td>Governor Scrutiny Committee</td>
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<td>Reports from Trust-led Committees/Groups</td>
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<tr>
<td>Carbon Management Committee</td>
<td>MAiI</td>
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<tr>
<td>Charitable Funds Committee</td>
<td>GS</td>
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<tr>
<td>Diversity Committee</td>
<td>CP</td>
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<td>Editorial Group</td>
<td>Various</td>
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<td>End of Life Strategy Group</td>
<td>KM</td>
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<td>Finance Briefing Group</td>
<td>PM/RP/GS</td>
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<td>Healthcare Assurance Committee</td>
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<tr>
<td>Organ Transplant Committee</td>
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<td>Patient Engagement and Communications Committee</td>
<td>EF/DB/DT</td>
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<tr>
<td>Patient Information Group (PIG)</td>
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<td>Valuing Staff and Wellbeing</td>
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<tr>
<td>Performance Reporting</td>
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<td>Financial Reporting</td>
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<td>RR</td>
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<td>Governors’ Work Programme</td>
<td>Chairs Relevant Committees</td>
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<tr>
<td>Non-Executive Director Role</td>
<td>NEDs</td>
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<td>Review Performance &amp; Terms of Reference of Subordinate Committees and Groups</td>
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<tr>
<td>Governor Training Committee</td>
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<td>EF</td>
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<td>General Reports</td>
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<tr>
<td>NHS Providers</td>
<td>All</td>
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<tr>
<td>SWGEN</td>
<td>All</td>
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<tr>
<td>Outside the Trust engagements</td>
<td>All</td>
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# COUNCIL OF GOVERNORS

<table>
<thead>
<tr>
<th><strong>Meeting Date and Part:</strong></th>
<th>15 July 2015 – Part 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subject:</strong></td>
<td>Governor Sub-Committee Meetings Report</td>
</tr>
<tr>
<td><strong>Section:</strong></td>
<td>For Information</td>
</tr>
<tr>
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<td>Representatives of the Trust Committees/Groups</td>
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<tr>
<td><strong>Details of previous discussion and/or dissemination:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Key Purpose:</strong></td>
<td>Patient Engagement</td>
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<tr>
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<td>To note</td>
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<tr>
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<td>Key Decisions/Discussions/Actions from committee meetings held during the past quarter</td>
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<tr>
<td><strong>Strategic Goals &amp; Objectives:</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Links to CQC Registration:</strong> (Outcome reference)</td>
<td>N/A</td>
</tr>
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</table>
GOVERNOR SUB-COMMITTEE MEETINGS REPORTS
28 April – 15 July 2015

MEMBERSHIP DEVELOPMENT COMMITTEE (MDC)
Chair: David Triplow
Meeting Date: June meeting cancelled

Key Committee Decisions/Discussions
1. Terms of reference are being distributed

Activities and Events in Previous Quarter

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Attendance and Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bransgore fun day</td>
<td>May 4th</td>
<td>Bob and other governors, new members signed up.</td>
</tr>
<tr>
<td>Lytchett Manor School talk</td>
<td>July 1st</td>
<td>Dave gave the talk, 70+ new members</td>
</tr>
</tbody>
</table>

Future Activities and Events

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Location</th>
<th>Opportunities for Governors to be Involved*</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Ambrose church fete</td>
<td>18th July</td>
<td>At the church 11 to 4</td>
<td>Volunteers needed</td>
</tr>
<tr>
<td>Burley show</td>
<td>3 August</td>
<td>Burley</td>
<td>Volunteers needed</td>
</tr>
</tbody>
</table>

*Please contact Governor Co-ordinator if you are interested in getting involved in a particular event

GOVERNOR INVOLVEMENT with PATIENT and PUBLIC ENGAGEMENT (GIPPE)
Chair: David Bellamy
Meeting Date: 15 June 2015

No report received
GOVERNOR TRAINING COMMITTEE (GTC)
Chair: Colin Pipe
Meeting Date: 4 June 2015

Key Committee Decisions/Discussions

1. Terms of Reference were discussed and would be a CoG item in July for approval
2. New Governor Induction event was discussed and agreed.
3. Away Day draft programme agreed and sent to CX for approval
4. Safeguarding training
   Not all Governors attended the training on 11 May. DR to collate a full list of who is up to date with their mandatory training
5. Mandatory Training
   SA been in touch with Training department and is awaiting a definitive list of the training Governors are required to do
   DR to write to Governors requesting to confirm their date of birth and that this information can be shared with Training Department as part of the electronic training access
6. DBS
   DR to contact Governors to request they get their DBS updated if more than 3 years. These need to be in place before the Outpatient Survey (arrangements through GIPPE) takes place
7. Committee currently has two vacancies

Activities and Events in Previous Quarter

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<th>Date</th>
<th>Attendance and Outcome</th>
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<tbody>
<tr>
<td>A Governor Workshop was held</td>
<td>30 March 2015</td>
<td></td>
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<tr>
<td>Governor Training Seminar</td>
<td>11 May 2015</td>
<td></td>
</tr>
<tr>
<td>Induction Day for three new Governors</td>
<td>29 June 2015</td>
<td></td>
</tr>
</tbody>
</table>

*Please contact Governor Co-ordinator if you are interested in getting involved in a particular event*
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</table>
TRUST COMMITTEE MEETING REPORTS
28 April – 15 July 2015

CARBON MANAGEMENT COMMITTEE
Governor Representatives: Mike Allen
Meeting Dates: 26 May 2015

Key Decisions/Discussions/Actions

1. Sustainable Management Plans are being written/updated to cover: Green ICT, Energy and utilities, Biodiversity, Climate change, Sustainable Procurement including Food, Travel arrangements and Waste Management.

2. The Sustainability Day was a success with electric cars and bicycles available for short trials.

3. Computer Power Management is continuing. Non-essential computers that are not in use will be switched off remotely, generally at night, and always with user agreement. Electricity cost savings will be about £20K, but this may be countered by new scanners, iPads etc. New equipment is more efficient than the old. There will be a re-assessment of the number and location of printers.

4. Traffic Plans are being considered in great detail with Police involvement. Car sharing will continue and be further encouraged as will bicycles.

5. Costs will be saved by segregating domestic waste from clinical waste which is four times more expensive to deal with.

6. Gas has been turned off at Christchurch Hospital rebuild for safety reasons and is being replaced by Oil, which will change the site’s carbon footprint.

CHARITABLE FUNDS COMMITTEE
Governor Representatives: Graham Swetman
Meeting Dates:

Key Decisions/Discussions/Actions

1. The committee received presentations from the Diabetic and Colorectal Departments concerning their plans to utilise the charitable funds at their disposal.

2. The committee reviewed the progress of the Jigsaw Building, and plans for a formal opening.

3. The committee approved the objectives for 2015/6, with an improved focus on education and training, and awareness of the role of the charity within the hospital.

4. The terms of reference of the committee were reviewed, with the role of Governor representation being clarified.
DIVERSITY COMMITTEE
Governor Representative: Colin Pipe
Meeting Dates: 14 May 2015
Key Decisions/Discussions/Actions

1. The Trust had to complete the first annual workforce race equality standard looking at our staff and the community to compare how many staff are from a Black or ethnic background and to ascertain if they are being disadvantaged.

Draft report completed and circulated for comment.

EDITORIAL GROUP
Governor Representative: Mike Allen, Dean Feegrade, Bob Gee, Paul McMillan and Colin Pipe
Meeting Dates:

Key Decisions/Discussions/Actions

1. Theme: With the Members’ Annual Meeting coming up, all agreed this issue should focus on achievements for the past year and how we are looking to a bold, bright year ahead

END OF LIFE STRATEGY GROUP
Governor Representatives: Keith Mitchell
Meeting Dates: 8 May, 12 June

No report received

GOVERNOR FINANCE BRIEFING GROUP
Governors: Graham Swetman, Paul McMillan and Roger Parsons
Meeting Date:

Key Decisions/Discussions/Actions

1. We reviewed the comparable financial results from other Trusts. RBCH had been better than the average in the last two years, but was forecast to be similar in 15/16, although below peers in the South.

2. We reviewed the impact of agency costs, reduced tariffs and wage increases. Agency spending had increased from £1.5 million to £10 million. The resultant Trust deficit could be halved by filling the vacant medical and nursing staff posts (c.100). The premium payable to agencies, above substantive vacant posts equates to £5.2 million.

3. The largest adverse variances occurred in Care Group B last year (£4.2 million), although it did deliver on its re-forecast. Also, Anaesthesia in Care Group A had failed to make planned savings.
4. The deficit was budgeted to rise to £12.9 million in the coming year, compared with £5.2 million in 2014/5.

HEALTHCARE ASSURANCE COMMITTEE  
Governor Representatives: Eric Fisher and Ian Knox  
Meeting Dates: 30 April, 28 May and 24 June 2015 monthly meetings and 15 May 2015 to approve the Annual Plan and Quality Report

Key Decisions/Discussions/Actions

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Each of the Heads of Nursing and Quality made presentations at each meeting on their Care Group, highlighting strong performance, issues of concern and action taken. This reinforces the more statistical based Ward dashboards and helps ensure consistency in high standards of safety, quality of care and leadership across the Trust in line with the purpose of HAC.</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Similarly, the number and nature of complaints are assessed and the “You said, we did” initiative on the Trust’s website was endorsed.</td>
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<tr>
<td><strong>3.</strong></td>
<td>Preparations for the forthcoming visit by the Care Quality Commission in October 2015 was set out and it is intended future meetings of HAC will review the action plan.</td>
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<tr>
<td><strong>4.</strong></td>
<td>The Trust’s Annual Reports on Quality and Complaints were approved.</td>
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<td><strong>5.</strong></td>
<td>The Trust’s Patient Safety Walkround programme was reviewed.</td>
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<td><strong>6.</strong></td>
<td>There was an annual review of the Trust’s Risk Management Strategy and the individual risks were scrutinised in detail.</td>
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<td><strong>7.</strong></td>
<td>Consideration was given to the Lampard Report on the Savile recommendations enquiry and a rigorous action plan put into force.</td>
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<td><strong>8.</strong></td>
<td>The next meeting is to take place on 30 July 2015.</td>
</tr>
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</table>

INFECTION PREVENTION AND CONTROL COMMITTEE  
Governor Representative: Keith Mitchell  
Meeting Dates:  
No report received

ORGAN TRANSPLANT COMMITTEE  
Governor Representative: Sarah Berridge  
Meeting Dates: No meeting held since the last Council of Governor meeting

PATIENT EXPERIENCE AND COMMUNICATIONS COMMITTEE  
Governor Representatives: Eric Fisher / David Triplow / David Bellamy  
Meeting Dates:  
No report received
PATIENT INFORMATION GROUP (PIG)
Governor Representative: David Bellamy
Meeting Dates: Monthly

No report received

VALUING STAFF AND WELLBEING
Governor Representative: Keith Mitchell
Meeting Dates:

No report received

WORKFORCE COMMITTEE
Governor Representative: David Triplow
Meeting Dates:

No report received