University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Council of Governors meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*	*Time*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman		14:00
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman		14:02
3. Minutes from the Previous Meeting To consider the minutes of the meeting of the Council of Governors on 30 October 2014 for **approval**.	Chairman	3	14:05
4. Matters Arising (Action Log) To consider the status of Actions from previous meetings.		11	
5. Performance Update and Strategic Outlook a) **Chief Executive's report** To receive and **note** a verbal update from the Chief Executive. b) **Quarter 2 Patient Experience and Complaints Reports** To receive and **note** these reports from the Chief Nurse.	Chief Executive Chief Nurse	 12	14:10
Governors' Questions			
6. Governors' Questions arising from the meeting of the Trust Board of Directors To respond to questions arising from matters of business discussed at the preceding meeting of the Trust Board of Directors, including quality and performance.	Chairman		14:25
7. Governors' Log of Communications To **note** the current position of the Governors' Log of Communications.	Chairman	53	14:40
Statutory and Foundation Trust Constitutional Duties			
8. Foundation Trust Constitution To consider the following for **approval**: a) Revised Foundation Trust Constitution (including new model election rules) b) Revised Code of Conduct for Governors c) Role Description for Governors	Trust Secretary	57	14:50

Page 2 of 2 of an agenda for a Council of Governors meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*	*Time*
9. Nominations and Appointments Committee report To receive and **note** this report. To **approve** the Committee's recommendation to re-appoint Lisa Gardner for a further 3-year term of office as Non-executive Director. To **approve** the formal appointment of Jill Youds as Non-executive Director.	Chairman	159	15:00
10. Governor Development Seminar report To receive and **note** this report.	Lead Governor	160	15:05
11. Governor Project Focus Groups reports To receive and **note** the following reports: a) Annual Plan Project Focus Group b) Quality Project Focus Group c) Constitution Project Focus Group	Project Focus Group Governor Leads	162	15:10
12. Governor and Membership Activity update To receive and **note** the following reports: a) Membership Activity Report b) Governors' Activity Report	Trust Secretary	168	15:15
13. Any Other Business To **note** any other relevant matters.	Chairman		15:20
Members' Questions			
14. Foundation Trust Members' Questions To **receive** questions from Foundation Trust members and members of the public present (notified in advance of the meeting).	Chairman		15:25
Close			
15. Date of Next Meeting The next meeting of the Council of Governors will be held at 2pm on Thursday 30 April 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.			

University Hospitals Bristol NHS
NHS Foundation Trust

ENC 1

Minutes of the Council of Governors Meeting held on 30 October 2014 at 2:00pm in the Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU

Present:
John Savage – Chairman
Sue Silvey – Lead Governor and Public Governor
Pauline Beddoes – Public Governor
Bob Bennett – Public Governor
Clive Hamilton – Public Governor
Tony Rance – Public Governor
Brenda Rowe – Public Governor
Tony Tanner – Public Governor
Edmund Brooks – Patient Governor
Angelo Micciche – Patient Governor
John Steeds – Patient Governor
Pam Yabsley – Patient Governor
Wendy Gregory – Patient Governor – Carer
Philip Mackie – Patient Governor – Carer
Thomas Davies – Staff Governor
Nick Marsh – Staff Governor
Karen Stevens – Staff Governor
Ben Trumper – Staff Governor
Marc Griffiths – Appointed Governor
Jeanette Jones – Appointed Governor
Bill Payne – Appointed Governor
Tim Peters – Appointed Governor
Sue Hall – Appointed Governor
Jim Petter – Appointed Governor

Board of Directors present:
Robert Woolley – Chief Executive
Sean O'Kelly – Medical Director
Sue Donaldson – Director of Workforce and Organisational Development
James Rimmer – Chief Operating Officer
Aidan Fowler – Fast-track Executive
Emma Woollett – Non-executive Director
David Armstrong – Non-executive Director
Alison Ryan – Non-executive Director
Kelvin Blake – Non-executive Director
Jill Youds – Non-executive Observer

01/10/14 Chairman's Introduction and Apologies
The Chairman, John Savage, welcomed everyone to the meeting. He extended a particular welcome to Debbie Henderson, new Trust Secretary. Apologies had been received from:
Abbas Akram (Appointed Governor), Graham Briscoe (Public Governor), Mani Chauhan (Public Governor), Ian Davies (Staff Governor), Florene Jordan (Staff Governor), Sue Milestone

(Patient/Carer Governor), Mo Schiller (Public Governor), Anne Skinner (Patient Governor), Lorna Watson (Patient/Carer Governor) Elliott Westhoff (Patient Governor), Deborah Lee (Deputy Chief Executive/Director of Strategic Development), Paul Mapson (Director of Finance and Information), Carolyn Mills (Chief Nurse), Julian Dennis (Non-Executive Director), Lisa Gardner (Non-Executive Director) and Penny Hilton (Fast Track Executive).

02/10/14 Declarations of Interest
In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the Meeting Agenda. There were no declarations of interest

03/10/14 Minutes and Actions from Previous Meeting
Governors considered the minutes of the meeting of the Council of Governors on 30 July 2014 and the minutes of the Annual Members' Meeting on 18 September 2014, and approved them as an accurate record of the meetings. It was:

RESOLVED:
- **That the minutes of the meetings held 30th July and 18th September be approved as an accurate record of proceedings**

04/10/14 Performance Update and Strategic Outlook

Chief Executive's Report
Governors received and noted a verbal update from the Chief Executive, Robert Woolley. Robert highlighted the following issues:

The National Perspective
The publication of the King's Fund quarterly monitoring report focussed on pressures in the NHS across the country. Robert made particular reference to the lowest national A&E performance in Quarter 2 for a decade and the increasing challenge for providers relating to delayed transfers of care and achieving the cancer 62-day referral to treatment target. Waiting lists have also increased nationally with more than 12% of patients waiting longer than 18 weeks for treatment. In relation to the financial challenge and efficiency targets, one in three Trusts in England are forecasting a financial deficit by the end of March 2015.

University Hospital Bristol NHS Foundation Trust Performance
Robert referred to pressures with regard to access and noted that the Trust will recommend a declaration of non-compliance to Monitor around the A&E target, referral-to-treatment targets, and the 62-day GP cancer target. Performance outlook in terms of Access was challenging, and the Trust was working very hard to recover its position. The Trust had however been formally commended for its partnership and collaboration with local health system partners, particularly the Clinical Commissioning Group, around its plans to recover performance on the urgent care system and to address elective waiting times.

Robert reported that the Trust's position in relation to quality performance was still broadly strong, with positive trends in key indicators such as falls and pressure ulcers. The Trust maintains a strong financial position, but is expected to face greater challenge next year. Robert provided assurance that the Trust was facing many challenges but was working hard to address them, including a focus on support for staff as well as planned initiatives to address the Trust's sickness absence and staff turnover rate.

Robert re-affirmed the Trust's commitment to its transformation objectives and in particular the infrastructure changes planned for 2014/15. Levels 5, 7 and 8 of the new block of the Bristol Royal Infirmary (BRI) were now open, and Levels 3 and 4 would open week commencing 3rd November.

Through its Transforming Care Programme, the Trust had introduced processes around managing its beds to allow emergency surgical admissions to be managed in a single area and allow elective planned work. As a result, there had been a significant fall in the number of last-minute cancelled operations, for lack of an available bed.

Robert referred to NHS England's recently published five-year forward plan which sets out the vision for the NHS over the next five years. The report had been broadly well-received; however, there were still questions regarding the delivery of the proposed changes, particularly the continuing emphasis on integrating health and social care, and breaking down the boundaries between care sectors. The report laid out new models of organisation and joint working that the NHS needed to adopt to meet the national challenge of an increasingly elderly population. Robert encouraged Governors to read the report, and stated that it would inform UH Bristol's strategy development.

Robert also informed Governors of the announcement of the first year of the Better Care Fund: the pooling of funds between the NHS and local authorities around social services with the ambition of averting 160,000 emergency admissions nationally next year. This marked the commencement of the government's drive towards the convergence of the social care system and the NHS. Robert provided assurance that UH Bristol would work closely with its partners in this area.

Robert reported that the independent review into children's congenital heart services at UH Bristol had not yet commenced interviewing families or staff due to delays in recruiting external clinical experts. The process would therefore not conclude before summer next year. The Trust Board of Directors had expressed its disappointment at the delay because of the resulting continuing pressure on staff and families involved and the need to support other families who currently use UH Bristol's services.

Robert informed Governors that an inquest had taken place following the death of a baby in October. A narrative judgement was applied which stated that the management of the baby's condition was appropriate and there were no missed opportunities. Media coverage was nevertheless extensive. Robert apologised that Governors were not warned about the coverage in advance, and informed them that there would be two more inquests in January and two in December relating to children.

Finally, with regard to the Care Quality Commission (CQC) full formal inspection of UH Bristol in September, Robert confirmed that the report is scheduled for publication in December. Robert informed Governors that he would see a draft report of the narrative next week and would have ten days to respond to issues of factual accuracy.

Wendy Gregory, Patient/Carer Governor requested clarification on the criteria for an inquest being held. Robert Woolley clarified that an inquest was not held automatically as protocol, but would be held as a result of a judgment made by the Coroner following a referral from the Trust or the family. He added that every death of a child in hospital also underwent a statutory child death review.

Referring to the integration of Histopathology services across UH Bristol and North Bristol Trust (NBT), John Steeds, Patient Governor, sought assurance that the previous problems envisaged about cost and effective operation were now being resolved. Robert responded that both UH Bristol and NBT were endeavouring to submit a business case for the centralisation of histopathology services at NBT to both Trust Boards in November. The business case would have to demonstrate that the

benefits of centralisation outweighed any financial shortfall. Robert confirmed that there was a joint clinical lead working across both Trusts to provide assurance to the leadership teams.

In response to a query from Clive Hamilton, Public Governor, regarding the NHS England five-year strategic view and its reference to the need for change, Robert stated that the report had acknowledged the changes undergone by the NHS in the past decade and the improvements made, particularly in the area of accessibility of care. However, there remain three areas still to be addressed: the health and wellbeing gap; the care and quality gap; and the funding and efficiency gap.

Following a query from Ben Trumper, Staff Governor, regarding the format and structure of staff interviews that would constitute part of the independent review of children's heart services, Robert stated that the review would consider documentary evidence before deciding which staff to interview; however, they had indicated that they would only interview staff in person where they felt it was essential.

John Steeds, Patient Governor, referred to the report published this week into paediatric cardiac services at Leeds General Infirmary, and enquired how it would affect the service overall in the country. Robert responded that the report had made a number of recommendations for NHS England in terms of commissioning services nationally. He added that the New Review of Congenital Heart Services led by NHS England was currently in consultation over a set of draft service standards.

Quarterly Patient Experience and Complaints Report

Helen Morgan, Deputy Chief Nurse spoke to the report and noted that it had been presented at September's public Trust Board meeting. The report represents attempts to pull together various themes originating from patient surveys and included information on the areas in which the Trust was receiving positive feedback, as well as the areas requiring improvement and associated action plans.

Following a query from Ben Trumper, Staff Governor, regarding processes for reporting positive feedback to staff, Helen Morgan confirmed that positive feedback is reported at ward level on a regular basis.

Clive Hamilton, Public Governor, reminded governors that the report had previously been discussed at the Quality Project Focus Group. He sought assurance that staff shortages in the Patient Support and Complaints Team were now resolved. In response, Robert Woolley explained that there had been a backlog of complaints, but that the Trust had moved quickly to resolve these. Complaints were running at a higher level than they had done historically, particularly around delays, appointments and cancellations. He expressed dissatisfaction about the temporary closures of the drop-in aspect of the patient support service, but understood that staff had been under pressure. John Steeds, Patient Governor, referred to staff shortages at Bristol Heart Institute Outpatient Department and enquired whether appointments had now been made. Robert explained that it had partly related to issues of long-term sickness of secretarial staff and the situation had not yet been resolved. It was:

RESOLVED:

- **That the Council of Governors receive the performance update and strategic outlook and the quarterly patient experience and complaints report**

05/10/14 Governors' Questions arising from the meeting of the Trust Board of Directors

Governors were invited to ask questions arising from matters of business on the agenda of the preceding meeting of the Trust Board of Directors. Clive Hamilton, Public Governor, asked for an update on the position regarding the Trust's reporting of cases of C. Difficile. Robert Woolley

explained that clarifying the position on reporting C. Difficile was challenging this year due to reporting issues including: reporting of a validated figure which was well under trajectory; and reporting of an unvalidated figure which was more challenging in terms of performance. Helen Morgan added that the limit had been 40 for the year, and there had been in fact five cases to date that were potentially avoidable.

Ben Trumper, Staff Governor, sought assurance from the Trust Board that staff would be adequately protected in the event of an Ebola patient being on the premises, particularly in terms of availability of appropriate personal protective equipment. Robert provided assurance that work was ongoing to determine the procedures that would need to apply and that appropriate PPE was in place. Sean O'Kelly, Medical Director, confirmed that a number of actions were in place to ensure that the equipment was readily available and that staff were having the appropriate training to ensure that the Trust was as prepared as possible in any eventuality. Ben Trumper further asked that this assurance be communicated to staff, and Jeanette Jones, Appointed Governor, noted the need for ongoing reassurance on this issue.

In relation to the ongoing work regarding staff retention, Ben Trumper requested that exit interviews be carried out consistently for all staff, and asked the Board to give attention to the lack of training and education of staff. Sue Donaldson, Director of Workforce and Organisational Development, thanked him for his comments, adding that she was keen to engage with staff governors around issues of staff engagement and retention.

Clive Hamilton referred to the lessons learnt by the Trust through the Serious Incidents that it reported, and reminded Robert that he had undertaken to look at how this information could be best shared with governors. Robert responded that he had not yet concluded the best way of doing this but reiterated his commitment to the idea and undertook to liaise with the Chief Nurse and report back to the next Council of Governors meeting.

06/10/14 Governors Log of Communications
Governors received and noted the current position of the Governors' Log of Communications.
The Chairman, John Savage, gave his assurance to Governors that the questions on the Governors' Log of Communications were taken very seriously. However, he added that, while questions would not be removed, there may be questions that required greater sensitivity which were more appropriately directed through the Chairman himself.

John commented that the Log was a very important resource for assisting the Non-Executive Directors in their role and they would receive a regular update of the Governors' Log via email, working with Debbie Henderson, Trust Secretary, and Sue Silvey, Lead Governor, to ensure that both the questions and the responses are appropriate. It was:

RESOLVED:
- **That the Council of Governors receive the Governors' Log of Communications for information**

07/10/14 Nominations and Appointments Committee report
Governors received and noted this report. It was agreed to appoint Marc Griffiths to the Committee.

RESOLVED:
- **That the Council of Governors receive the Nomination and Appointments Committee report for information**

08/10/14 Governor Development Seminar report

Sue Silvey, Lead Governor, reported that there had been two Governor Development Seminars since the last Council of Governors meeting. Of particular note, Governors had received training on the Trust's Patient Support and Complaints Service, and had received an update on Weston Area Health NHS Trust. Sue asked that governors with suggestions for future seminars approach Debbie Henderson, Trust Secretary.

RESOLVED:

- **That the Council of Governors receive the Governor Development Seminar report for information**

09/10/14 Project Focus Group Meeting

Annual Plan Project Focus Group

Wendy Gregory, Lead Governor for the Annual Plan Project Focus Group, reported that the group had met on 8th October, and had discussed with David Relph, Head of Strategy, the Trust's 5-year Strategic Plan and the timeline for the Monitor Annual Plan. She asked Governors to note that dates for future meetings had been slightly changed by David Relph, and asked that Governors let her know any suggestions they may have for the group.

Quality Project Focus Group

Clive Hamilton, Lead Governor for the Quality Project Focus Group, reported back from the group's meeting on 3rd September, at which Governors had discussed in some detail the Trust's performance to date. There was discussion about access targets, MRSA, cleanliness monitoring, cancelled operations, stroke care, ambulance delays and complaints. Governors had also received presentations from Anne Gorman, Interim Deputy Director of Operations, on Patient Flow and Access Standards, and Simon Chamberlain, Transformation Director, on Breaking the Cycle and lessons learned. At the next meeting of the Quality Project Focus Group on 13 November, Steve Brown, Director of Pharmacy, would be speaking on medicines safety, and Governors would be asking questions about the recent cancer survey.

Constitution Project Focus Group

Sue Silvey, Lead Governor for the Foundation Trust Constitution Project Focus Group, reported that the group's September meeting had been cancelled. The next meeting was scheduled to take place on 4th December, and would look at proposed revisions to the constitution, the code of conduct, and the group's future programme of work. It was:

RESOLVED:

- **That the Council of Governors receive the following updates**
  - **Annual Plan Project Focus Group**
  - **Quality Project Focus Group**
  - **Constitution Project Focus Group**

10/10/2014 Governor and Membership Activity Reports

Membership Activity Report

Julie Dawes, Trust Secretary, reported that there had been a well-attended Health Matters event on 1st October. The next Health Matters Event was scheduled for 9th December focussing on

Rheumatology, and the 2015 Health Matters Events were yet to be decided. Julie reported that work had begun on the Trust's new membership strategy which would be focussing on engagement rather than recruitment and would be reported to the April Council of Governors meeting for consideration.

Governor Activity Report

Wendy Gregory requested that the Carers' Strategy steering group be included in the report. She also requested that the report include Governors' attendance, in order to place greater emphasis on involvement and attendance at meetings and events. It was:

RESOLVED:

- **That the Council of Governors receive the Governor and Membership activity report for information**
- **That the Membership and Engagement Strategy be submitted to the April 2015 meeting for consideration and approval**

11/10/14 Council of Governors Meeting Dates 2015/16 it was:

RESOLVED:

- **That the Council of Governors approve the proposed meeting dates for 2015**

12/10/14 Any Other Business

Clive Hamilton sought clarification on the statement in the Workforce Report of the Trust Board papers regarding the Trust's improved use of Bank staff in relation to options to view and offer shifts by text. Sue Donaldson, Director of Workforce and Organisational Development, explained that Bank staff were now being contacted via text message to inform them of shifts available. Jeanette Jones, Appointed Governor, confirmed that the initiative was proving successful at certain pinch points. As a result of using this texting process, the Trust had completely avoided the use of agency workers for a full weekend.

John Savage, Chairman, expressed his thanks to the Governors who undertake significant involvement in the Trust's work and encouraged other Governors to be equally involved where possible. He requested more information about Governors' attendance at meetings, and asked that if Governors would like John to attend particular meetings, he would be happy to do so.

John Savage expressed his thanks to Julie Dawes for her work as Interim Trust Secretary for last 6 months. He also expressed his thanks to Kelvin Blake, Non-executive Director, who was attending his final Council of Governors meeting as he had reached the end of his term of office. John took an opportunity to wish Julie and Kelvin best wishes for the future.

13/10/14 Foundation Trust Members' Questions

One pre-notified question had been received.

Question from Garry Williams, Foundation Trust member (Carer of patients aged 16 years and over):

Has the Trust so far made any attempt to survey wheelchair users to gauge their reaction to the new signage across the hospital sites, in particular regarding the accessibility of disabled toilets?

James Rimmer, Chief Operating Officer, responded that when the Trust had changed the signage, they had consulted both at design and implementation stage with Bristol Physical Access Chain (BPAC) and Bristol Healthwatch, and that Governors and staff had also been involved. BPAC had

also met with the Trust's Patient and Public Involvement Lead in September. James invited specific feedback regarding Garry's views on disabled access requirements outside the meeting so the issues could be addressed fully.

Governors provided feedback that people were finding it difficult to adapt to the signage changes. Robert Woolley responded that the Board had been aware of this, and expressed his appreciation for the volunteers at the front entrance to BRI. He added that as the first phase of the rollout of the new signage had now been concluded, an external evaluation would now take place to highlighted opportunities to identify improvements that could still be made. It was:

RESOLVED:

- **That the Council of Governors receive the Members' Question on Notice and note the response provided**

Meeting close and Date and Time of Next Meeting

There being no other business, the Chair declared the meeting closed.

The next meeting of the Council of Governors will be held on Thursday 29 January 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

……. ……2014

Chair Date

University Hospitals Bristol NHS
NHS Foundation Trust

Council of Governors meeting 30th October 2014
Action tracker

Outstanding actions following meeting held 30th October 2014				
Minute reference	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
10/10/14	**Governor and Membership Activity Report** Membership and Engagement Strategy to be submitted to the Council of Governors for consideration and approval	Trust Secretary	April 2015	No comment
Completed actions following meeting held 30th October 2014				
	NO ACTIONS TO NOTE			

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 5b: Q2 Complaints Report and Patient Experience Reports

Purpose

The attached reports describe patient-reported feedback from complaints and surveys during the second quarter of 2014/15. The reports are presented to together to enable and encourage discussion about common themes, however it should be remembered that the nature of the data presented in the two reports is different. The patient experience report describes trust and ward-level feedback around key predetermined quality themes, the overwhelming majority of which is positive; whereas the complaints themes are, by definition, an expression of the dissatisfaction of patients with one or more aspects of our services, wherever they have been provided.

Abstract

Patient Experience

In Q2, the Trust continued to achieve "green" ratings in the Trust Board Quality Dashboard, reflecting high quality patient-reported experience at UH Bristol as a whole, however there continues to be significant variation in patient-reported experience between wards. Detailed analysis of survey data suggests that these differences are primarily a reflection of differing patient populations, rather than an indication of care failings. Key improvement themes arising from written feedback received from patients (via surveys) in Q2 were communication and waiting times/delays.

Data from the annual UH Bristol Outpatient Survey for 2014 showed high levels of patient satisfaction. Improvement themes included: waiting times (for receiving appointments and whilst in clinic); being kept updated if there are delays in clinic; ease of contacting the Trust; and timely letters/test results/follow-up appointments.

The Trust received a disappointing set of results from the 2013/14 National Cancer Survey, with nearly half of the Trust's scores being among the lowest 20% nationally. An action plan has been developed and approved by the Trust Board in response to these results. The Cancer Board will oversee implementation.

Complaints

In Q2, the Trust received 518 complaints, compared to 427 during Q1. The Trust's performance in responding to complaints within the timescales agreed with complainants was 89.5% compared to 86.3% in Q1. Complaints relating to appointments and admissions continued to account for over a third of the total complaints received by the Trust (as per Q1). There was a decrease in the number of complainants telling us that they were unhappy with our investigation of their concerns: 14 compared to 21 in Q1. The number of cases where the original response deadline was extended continued to rise, with 41 cases in Q2, compared with 34 in Q1.

Triangulation

Ward B301 (formerly Ward 7), which is a care of the elderly ward, achieved disappointing patient experience ratings in Q2. This included the Trust's patient experience tracker, where the

"communication" and "involvement in care decisions" elements of this aggregate measure scored well below the Trust average. At the same time, the ward experienced a marked increase in complaints (seven compared to one in Q1), although there were no consistent themes. This was discussed at the Patient Experience Group in December: it has been agreed to focus January's *Face to face* wards interviews on Ward B301 in order to gather more information about patients' experience of care. This information will then be used to inform a decision about whether and when to adopt the Trust's *Patient experience at heart* co-design methodology to support the ward to explore patient experience in greater depth (either before or after the ward is relocated in 2015).
Recommendations
The Council of Governors is asked to receive these papers to **note**.
Report Sponsor or Other Author
Carolyn Mills, Chief Nurse
Appendices
Quarter 2 Patient Experience Report Quarter 2 Complaints Report

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Report

Quarter 2 2014/15

(1st July – 30th September 2014)

Author: **Paul Lewis, Patient Experience Lead (Surveys and Evaluation)**

1. Executive Summary

This report presents quality assurance data arising from the UH Bristol patient experience survey programme, principally: the Friends and Family Test survey, the monthly inpatient/parent and maternity postal surveys, and the national patient surveys. Summary analysis is provided which draws on discussions held at the Trust's Patient Experience Group, where the data is reviewed at each meeting. The key headlines from Quarter 2 (July-September 2014) are:

- The Trust continued to achieve "green" ratings in the Trust Board Quality Dashboard: reflecting the provision of a high quality patient experience at UH Bristol.
- Improved "communication" and reducing waiting/delays were key themes arising from the written feedback received from patients.
- There continues to be significant variation in patient-reported experience between wards within the Trust. Detailed analysis of the survey data suggests that these differences are primarily a reflection of differing patient populations, rather than an indication of deeper care failings.
- The UH Bristol 2014 Outpatient Survey showed high levels of patient satisfaction. Improvement themes centred on reduced waiting times (for appointments and in clinic), being kept updated if there are delays in clinic, ease of contacting the Trust, and timely letters/test results/follow-up appointments.
- UH Bristol received a disappointing set of results of the 2013/14 National Cancer Survey, with nearly half of the Trust's scores being among the lowest 20% nationally. A plan to understand and address the key issues raised was received and endorsed by the Board.

2. Overview of patient experience at UH Bristol

Overall, the feedback received via the UH Bristol corporate patient experience survey programme shows that a positive experience is provided to the majority of patients. However, there is significant variation between wards, and also between individual patients (as demonstrated by the compliments and complaints that the Trust receives - see the linked Quarter 2 Complaints report). By far the most frequent form of feedback from patients conveys praise for UH Bristol staff, but this praise is often accompanied by suggestions for improvement: most typically relating to better communication and reducing waiting/delays. The Trust broadly performs in line with the national average in patient experience surveys, with the exception of the 2013/14 National Cancer Survey where a number of below-average scores were received.

Surveys work most effectively at a population (or "system") level, and tend to offer less insight into the unique experience of each individual patient. Therefore, the survey data presented in this report should be used in conjunction with other sources of information to provide a coherent and reliable view of "quality".

3. Trust-level patient experience data

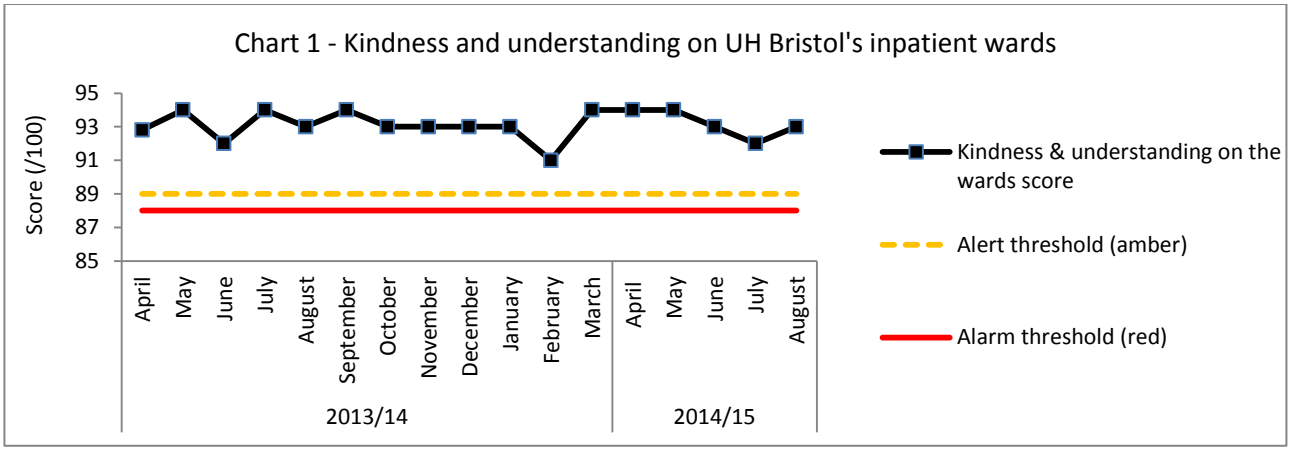
Charts 1 to 4 (over) show the four headline metrics that are used by the Trust Board to monitor the overall quality of patient-reported experience at UH Bristol[1]. These scores have been consistently rated "green" in the periods shown[2], indicating that a high standard of patient experience is being maintained at the Trust. The scores

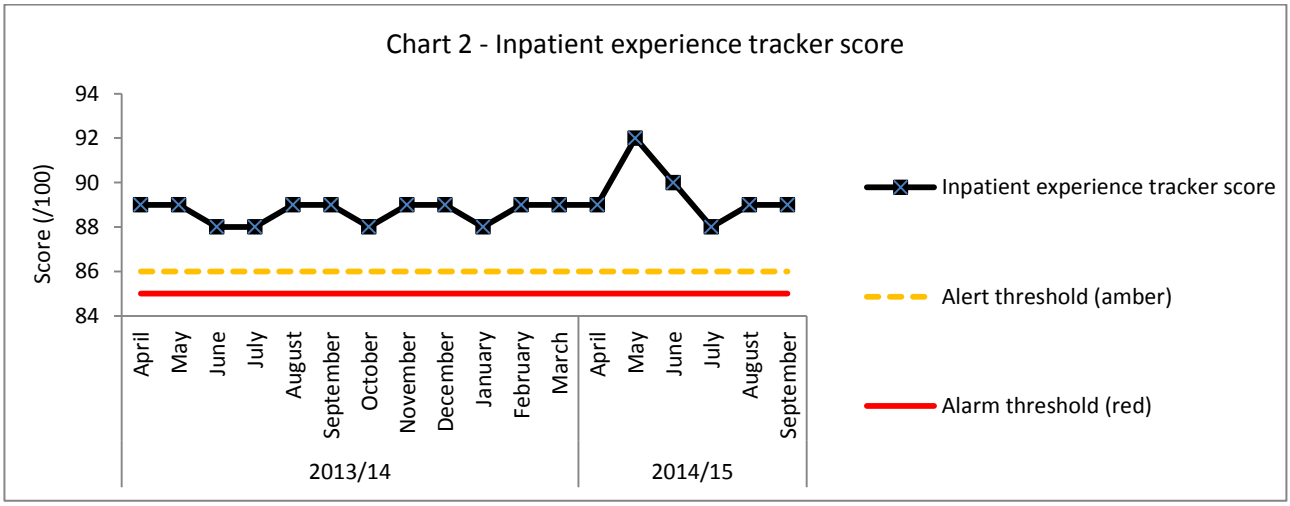
[1] Kindness and understanding is used as a key measure, because it is a fundamental component of compassionate care. The "patient experience tracker" is a broader measure of patient experience, made up of five questions from the UH Bristol monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via statistical analysis and patient focus groups conducted by the UH Bristol Patient Experience and Involvement Team.

[2] Note: the Friends and Family Test data is available around one month before the postal survey data.

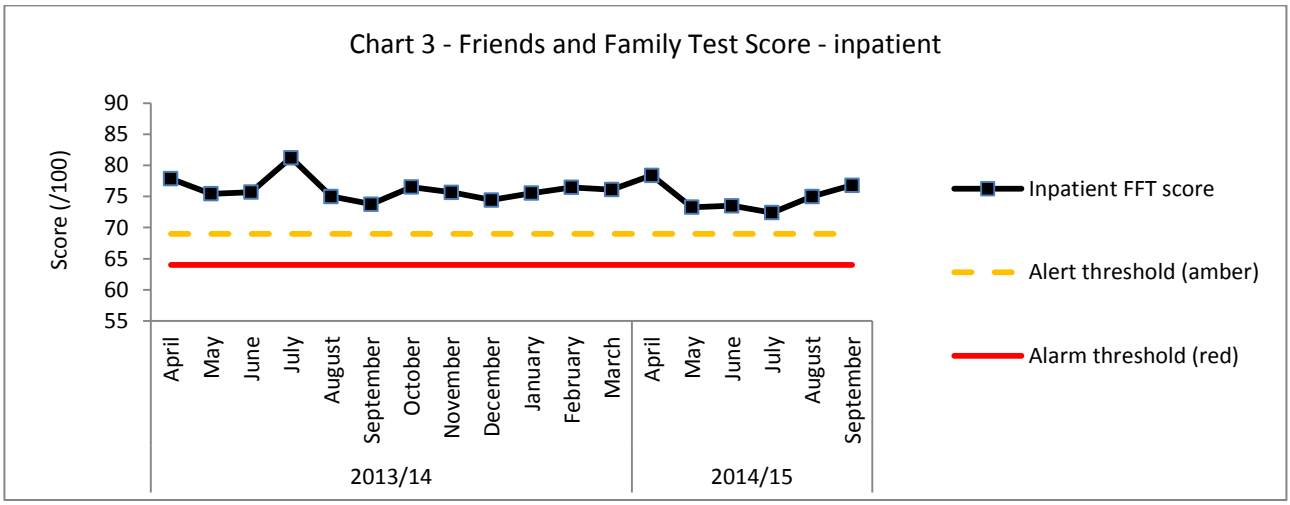
would turn “amber” or “red” if they fell significantly, alerting the senior management team to a deterioration in this position.

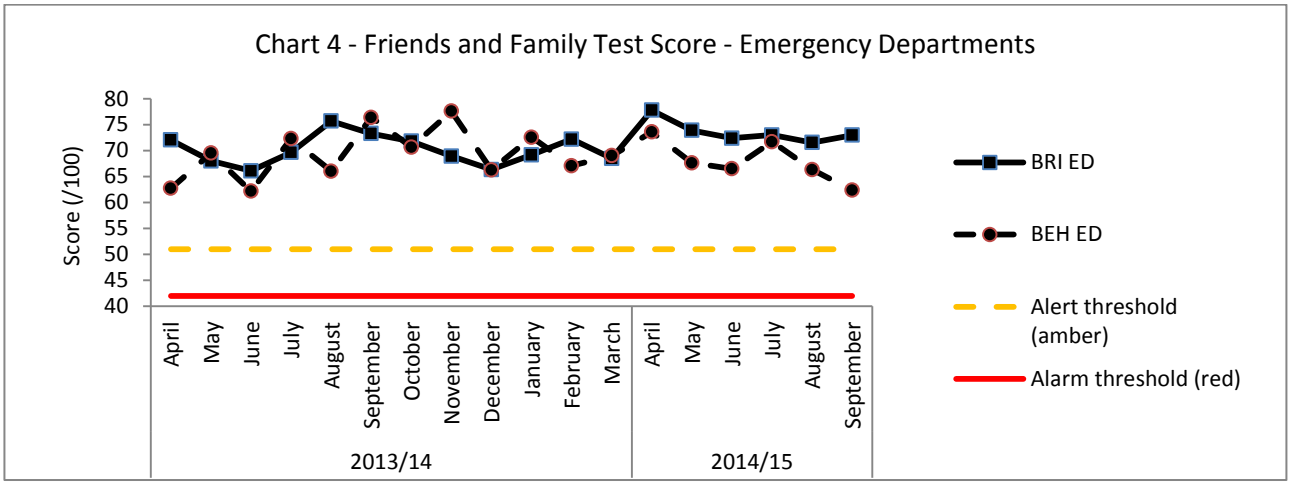
Chart 5 (on page 4) shows that 98% of outpatients rated their care as excellent, very good, or good in the 2014 UH Bristol annual outpatient survey[3]. Nevertheless, the survey encouraged respondents to put forward improvement suggestions: the main themes here were around waiting/delays (at all stages of the experience, particularly in clinic), ease of contacting the Trust, and timely letters/follow-up appointments/test results. The survey showed some positive improvements in scores for specialties involved in the Productive Outpatient programme, particularly in terms of keeping patients informed of waiting times in clinic (although at a Trust-level this remained among the lowest scores). There was no improvement in scores around ease of contacting the Trust, which is disappointing given the investment that has been made in this respect (including opening a new appointments centre - which itself attracted high satisfaction ratings), and because there has been a significant reduction in complaints around this issue. Further expansion of the appointments centre service may have an impact on this score in future surveys, or it may be that a single survey question cannot adequately measure this deceptively complex issue. The outpatient survey data is provided in full in Appendix C. An action plan is currently being formulated in response to the results.

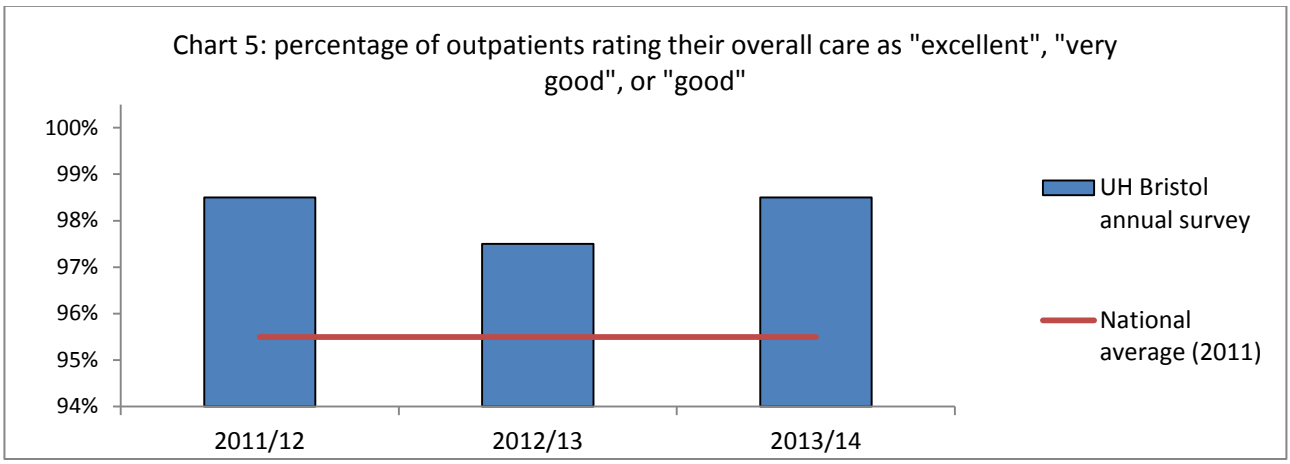




[3] Based on responses from 1,839 patients (or parents of 0-11 year olds) who attended in February 2014.







4. Divisional-level patient experience data

Charts 6-8 (over) split the headline patient experience metrics by UH Bristol Division. The Trust-level "alarm threshold" is shown in these charts, but this is a guide only - caution is needed in applying this directly because there is a higher margin of error in the data at this level. The Specialised Services Division tends to receive the highest (best) patient experience ratings, with the Division of Medicine attracting slightly lower survey ratings. An important factor here is that the Division of Medicine cares for a relatively high proportion of elderly patients with chronic, complex conditions: research has shown that this affects patient experience ratings over and above

the quality of the care provided[4]. Nevertheless, these scores are reflective of the experience as the survey respondents saw it, and so the Division of Medicine are carrying out a number of monitoring and improvement activities in this respect (see Sections 5 and 6). Postnatal maternity care also attracts lower survey ratings: although these scores are in line with (or better than) the national maternity average, a number of improvement initiatives are underway to improve these scores (see Section 5)[5].

Chart 6 - Inpatient kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)

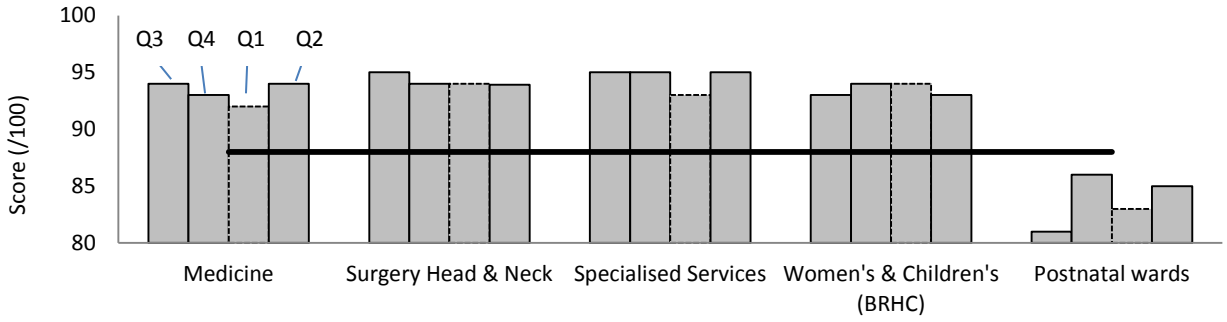


Chart 7- Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

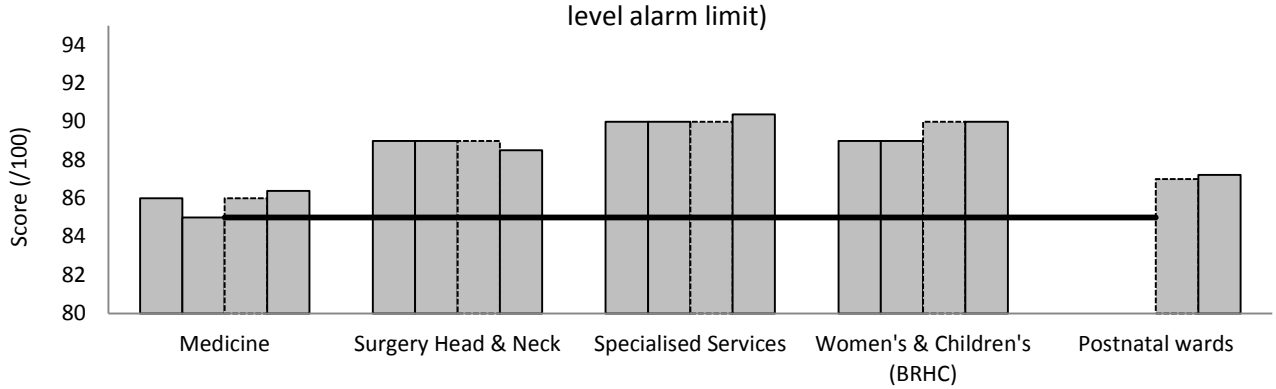
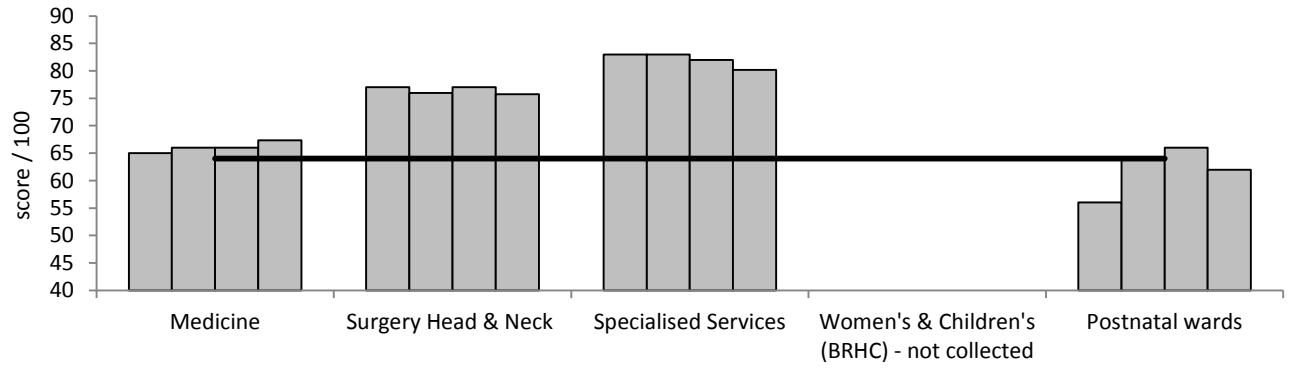


Chart 8 - Inpatient Friends and Family Test score - Last four quarters by Division (with Trust-level alarm limit)



[4] http://www.pickereurope.org/wp-content/uploads/2014/10/Multi-level-analysis-of-inpatient-experience.pdf

[5] The FFT is not currently in paediatric inpatient wards (it will be implemented by March 2015). The Patient Experience Tracker has been collected for postnatal wards since April 2014.

5. Hospital-level patient experience data

Charts 9-11 (over) show the headline survey results by hospital[6]. The only scores that fall below the Trust-level alarm thresholds relate to South Bristol Community Hospital (in Chart 10) and the postnatal wards (charts 9 and 11).

South Bristol Community Hospital (Wards 100 and 200)

The written feedback received for South Bristol Community Hospital (SBCH) via the surveys contains extensive praise for staff, and a recent Care Quality Commission inspection rated inpatient care at the hospital as "Good". However, the inpatient experience ratings for SBCH are difficult to explain: the Friends and Family Test (FFT) survey scores have seen step improvements over the four quarters shown, whilst the Patient Experience Tracker score (an aggregate of five questions from the UH Bristol post-discharge survey) has shown the opposite trend. Further analysis of the Tracker score has shown that it is the "communication" and "involvement in care decisions" elements of this measure that are below the UH Bristol average. Whilst this is a realistic reflection of the challenges in caring for the patient group at SBCH, the management team constantly strive to improve these elements of the service, for example:

- There are two "case manager" posts at SBCH, established to provide a dedicated link between staff and patients/families/carers, allowing clear lines of communication to be established.
- For each patient, the SBCH staff complete a daily diary which details conversations and actions relating to the patient's care. This can be read by the patient/family/carer at any point during their stay, and is given to the patient at discharge.
- On arrival, all patients are given an orientation of the ward and an explanation of how care is provided. A Standard Operating Procedure was also introduced to ensure patients are transferred into the hospital by 5pm, to ensure they have sufficient time to settle in. An audit is currently being carried out to assess adherence to this protocol, and actions will be undertaken to improve compliance if necessary.

Postnatal wards (71,74,76)

Postnatal ward satisfaction scores are typically lower than other inpatient areas of the Trust, but they are in line with (and in some respects much better than) the national maternity average (see Section 8). Nevertheless, since 2011/12 ongoing service improvement work has been undertaken at St Michael's Hospital in response to the survey results, including:

- In-depth analysis of survey data and regular "deep-dive" interviews with women on the postnatal wards
- Reconfiguration of the postnatal wards, based on service-user feedback
- Recruitment to additional midwifery and midwifery support worker posts
- Running workshops for doctors, midwives and midwifery support workers, focussing on how their role impacts on patient experience
- Identifying a consultant-level patient experience champion who leads patient experience and involvement initiatives in postnatal care
- A focus by the Facilities Department on improving food and cleanliness on the postnatal wards

[6] The FFT is not currently in paediatric inpatient wards (it will be implemented by March 2015). The Patient Experience Tracker has been collected for postnatal wards since April 2014.

These activities resulted in improvements in local survey scores, and a "kindness and understanding" score that was rated better than the national average by the Care Quality Commission in the 2013 national maternity survey (having been on the verge of being among the worst quintile of trusts nationally in 2011). There have also been improvements in satisfaction with food quality and availability, as monitored through the UH Bristol monthly maternity survey. Through the national maternity survey action plan (see Section 8) and Divisional quality objectives, there is a continued focus on improving experiences of maternity care in 2014/15.

Chart 9: Inpatient kindness and understanding score - Last four quarters by hospital (with Trust-level alarm limit)

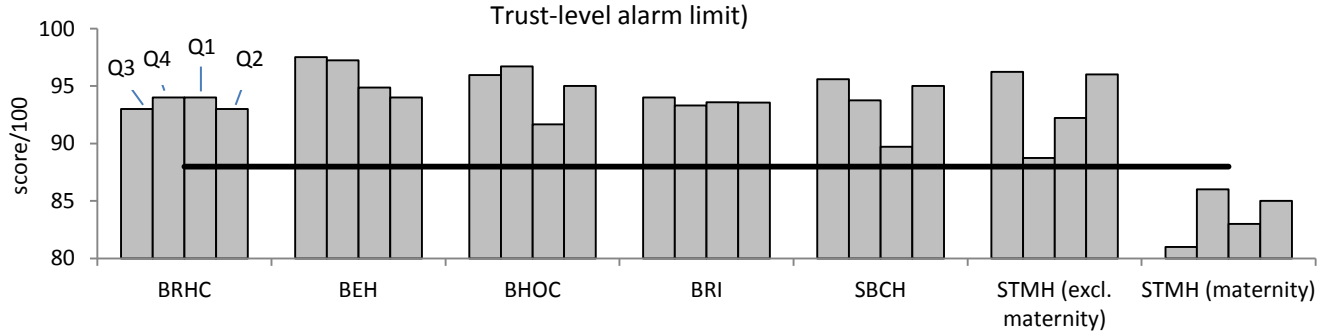


Chart 10: Inpatient experience tracker score by hospital - Last four quarters by hospital (with Trust-level alarm limit)

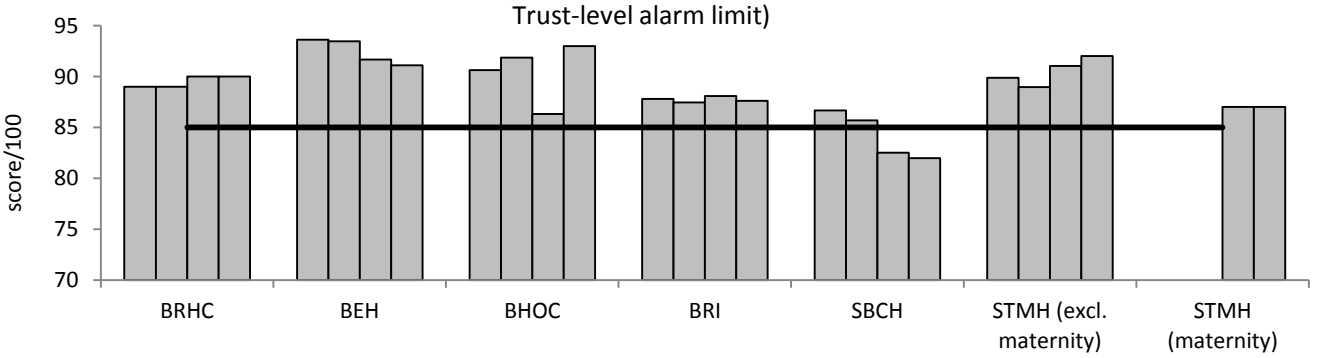
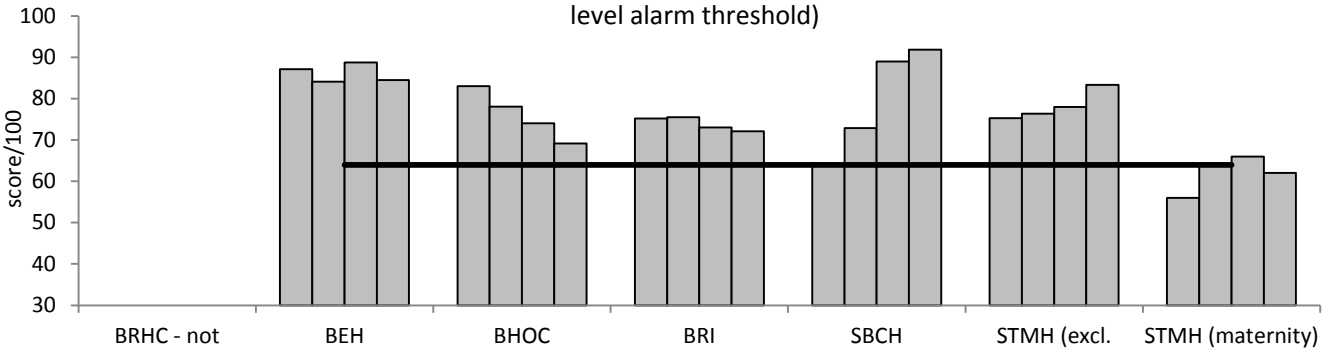


Chart 11: Inpatient Friends and Family Test score - Last four quarters by hospital (with Trust-level alarm threshold)



Key: BRHC (Bristol Royal Hospital for Children); BEH (Bristol Eye Hospital – Ward 41); BHOC (Bristol Haematology and Oncology Centre); BRI (Bristol Royal Infirmary); SBCH (South Bristol Community Hospital); STMH (St Michael's Hospital)

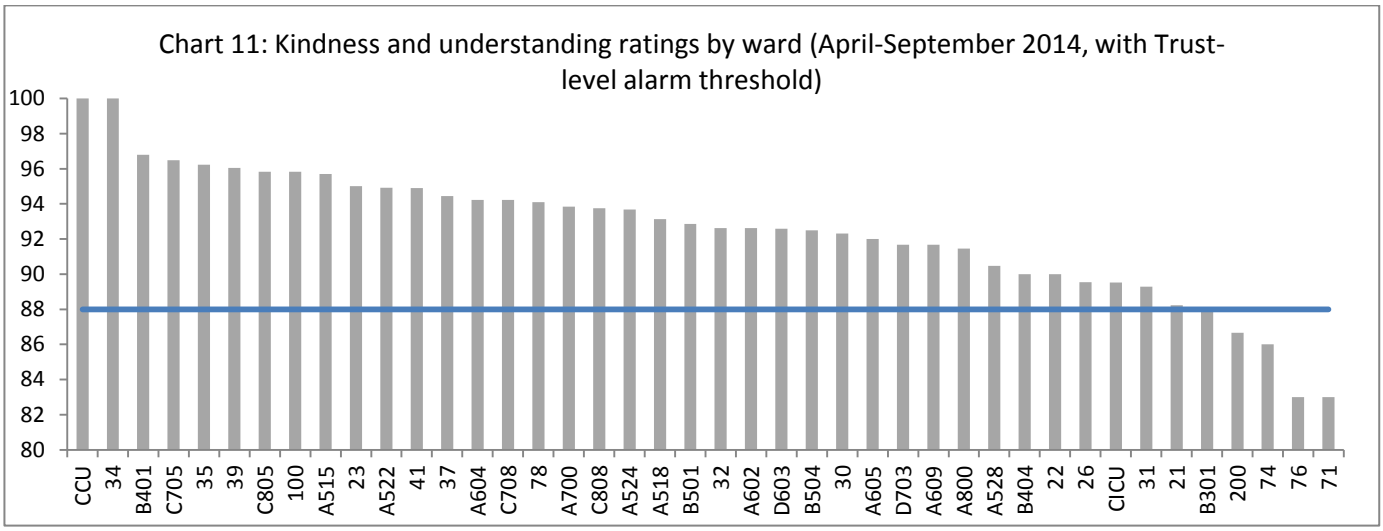
6. Ward-level data

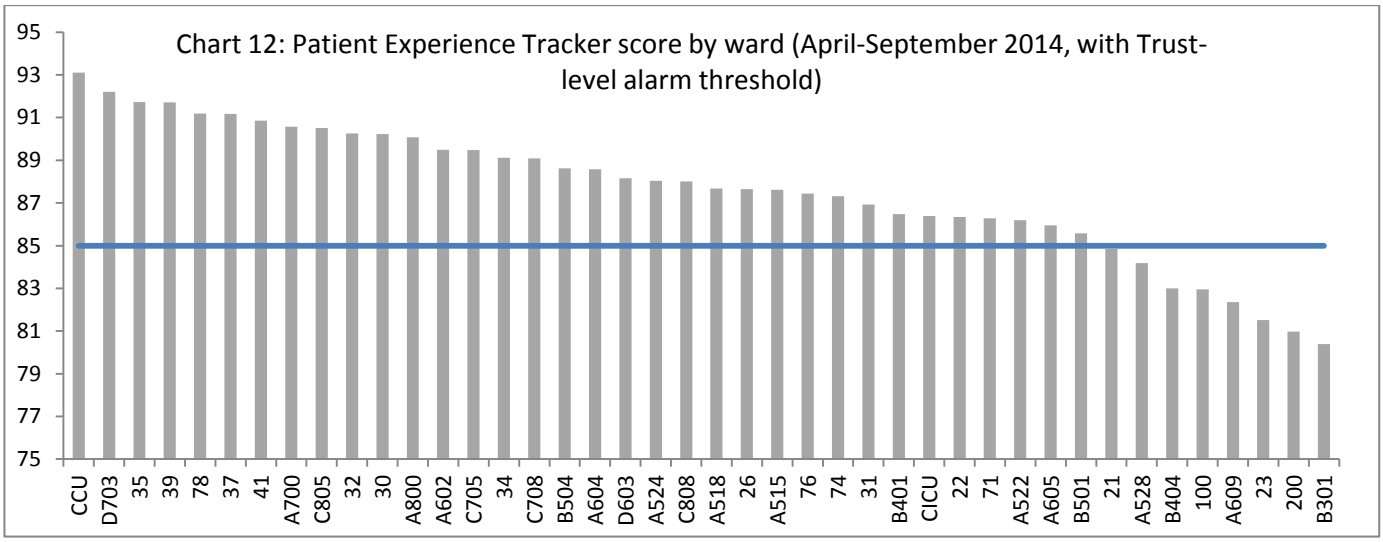
The ward-level inpatient survey and Friends and Family Test data is presented in charts 11 to 13 (over). As the sample sizes are relatively small at this level, to make the data more robust it has to be aggregated to a six-month period. This data is complicated by the ward name changes and ward moves that are currently taking place. However, in looking for consistency across the surveys ("triangulation"), some trends do emerge:

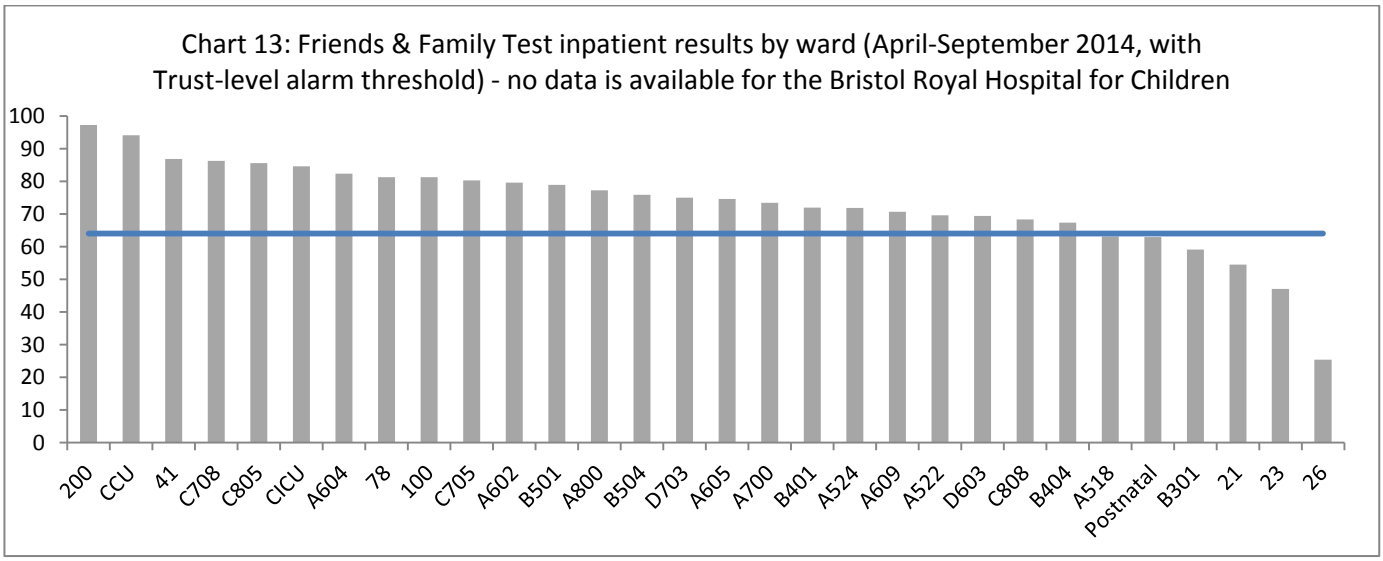
- The Coronary Care Unit (CCU) consistently achieves the highest scores.
- The postnatal wards tend to receive lower scores (see the previous discussion in Section 5)
- The wards in the Old Building (21, 23, 26) have now closed and are in the process of moving to new accommodation within the Trust, but they tended to receive lower ratings from patients. Further analysis of the data showed that this was primarily attributable to the ward environment (i.e. being in a very old building). A wider review of quality data carried out by the Division of Medicine also found no evidence of care failings.

Ward B301 (formally Ward 7), which is a care of the elderly ward in the Bristol Royal Infirmary, received relatively low patient experience ratings in the period shown. In particular, the ward had the lowest score on the Patient Experience Tracker (Chart 12), with the "communication" and "involvement in care decisions" elements of this aggregate measure being well below the Trust-average. As with South Bristol Community Hospital, this is in many ways a realistic reflection of the difficulties in caring for this patient group. A theme also emerges in the Friends and Family Test feedback for ward B301 around noise and disruption from other patients. This is likely to be because some patients on the ward will have severe Dementia: early discussions are taking place within Division of Medicine around whether it remains appropriate to care for these patients on the same ward(s) as patients with mild or no Dementia. Despite these challenges, the feedback for Ward B301 contains very high levels of praise for the staff and care provided. Furthermore, no evidence of deeper care failings has been found in a wider review of quality data for the ward that was carried out recently by the Head of Nursing for the Division of Medicine. This assurance will be further tested in early 2015, when the ward is a focus for the Trust's *Face2Face* interview survey (see Appendix C) and a "Back to the Floor" visit from a senior UH Bristol nurse (which encompasses a debrief and "next steps" discussion between the senior nurse and ward leads).

Table 1 (on page 10) provides an indication of ward performance on the "kindness and understanding" question over the last four quarters. At this level there can be quite large movements in scores from quarter-to-quarter, much of which can be attributable to margin of error (i.e. random fluctuation rather than a "real" change in service standards). Therefore, it is important to look for consistency in the scores (i.e. more than one quarter shaded red or green in this table). The margin of error also makes it difficult to determine the trend over time for individual wards, but an attempt has been made to do this in Table 1 by highlighting any large differences in scores between Quarter 3 2013/14 and Quarter 2 2014/15. Overall, the picture is one of relatively little substantive change in the ward scores over the twelve-month period shown.







Note: the Friends and Family Test Survey is not currently operating in paediatric inpatient wards (it will however be implemented by March 2015). The Patient Experience Tracker has been collected for postnatal wards since April 2014.

Table 1: Quarterly ward "kindness and understanding" score. The top five scores in each quarter are shaded green, the lowest five scores are shaded red. The "direction of travel" highlights changes of 10 points or more between Quarter 3 2013/14 and Quarter 2 2014/15. Wards marked with a * have now moved and/or closed.

New ward name	*Old ward name*	*October-December 2013 (Q3)*	*January-March 2014 (Q4)*	*April-June 2014 (Q1)*	Q2 (July-Sept 2014)	*Direction of travel (Q3 13/14 to Q214/15)*
19	19	88	86	89	93	No change
21*	21	85	92	85	n/a*	No change
22*	22	89	94	95	86	No change
23*	23	89	83	91	n/a*	No change
26*	26	91	81	88	94	No change
30	30	95	93	93	91	No change
31	31	95	95	89	90	No change
32	32	95	92	94	91	No change
34	34	95	100	100	100	No change
35	35	90	97	94	100	Better
37	37	88	88	95	92	No change
39	39	94	95	97	96	No change
41	41	98	97	95	95	No change
71	71	77	86	84	83	No change
74	74	87	88	85	87	No change
76	76	76	81	82	84	No change
78	78	96	89	92	96	No change
100	100	98	90	94	97	No change
200	200	94	94	84	92	No change
A515	17	96	95	97	95	No change
A518	18	97	93	91	98	No change
A522	10	98	95	92	98	No change
A524	4	91	98	93	96	No change
5B*	5B	96	98	95	89	No change
5A*	5A	94	95	96	90	No change
A605	6	96	92	93	93	No change
A609	14	90	88	89	95	No change
B301	7	83	86	92	85	No change
B401	9	91	85	95	100	No change
B404	11	92	92	87	94	No change
B501	12	98	88	91	95	No change
B504	15	93	94	95	89	No change
C705	51	96	96	97	95	No change
C708	52	94	93	95	94	No change
C805	53	97	95	95	97	No change
C808	54	95	93	94	96	No change
CCU	CCU	94	100	100	100	No change
CICU	CICU	92	91	93	87	No change
D603	61	95	96	89	96	No change
D703	62	98	98	93	94	No change

7. Themes arising from inpatient free-text comments in the monthly postal surveys

At the end of our postal survey questionnaires, patients are invited to comment on any aspect of their stay – in particular anything that was worthy or praise or that could have been improved. All comments are reviewed by the relevant Heads of Nursing and shared with ward staff for wider learning. In the twelve months to September 2014 around 5,000 written comments were received in this way. The over-arching themes from these comments are provided below. Please note that "**valence**" is a technical term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed).

All inpatients/parent comments (excluding maternity)

Theme	Valence	% of comments[7]	
Staff	Positive	61%	*61% of the comments received contained praise for UH Bristol staff, making this by far the most common theme. Improvement themes centre on communication, staff, waiting/delays, and food.*
Communication	Negative	14%	
Waiting/delays	Negative	10%	
Staff	Negative	9%	
Food/catering	Negative	8%	

Division of Medicine

Theme	Valence	% of comments	
Staff	Positive	57%	*Negative comments about "staff" are often linked to other thematic categories (e.g. poor communication from a member of staff). This demonstrates that our staff are often the key determinant of a good or poor patient experience.*
Communication	Negative	11%	
Waiting/delays	Negative	9%	

Division of Specialised Services

Theme	Valence	% of comments	
Staff	Positive	60%	*Negative comments about staff also often relate to a one-off experience with a single member of staff, showing how important each individual can be in a patient's experience of care.*
Communication	Negative	15%	
Waiting/delays	Negative	9%	

Division of Surgery, Head and Neck

Theme	Valence	% of comments	
Staff	Positive	62%	*Improving patient flow (including delays at discharge) is a key priority for the Trust. A number of major projects are being undertaken in relation to this during 2014/15.*
Communication	Negative	14%	
Waiting/delays	Negative	9%	

Women's & Children's Division (excl. maternity)

Theme	Valence	% of comments	
Staff	Positive	65%	*This data includes feedback from parents of 0-11 year olds who stayed in the Bristol Royal Hospital for Children. Again the themes are similar to other areas of the Trust.*
Communication	Negative	18%	
Staff	Positive	9%	

Maternity comments

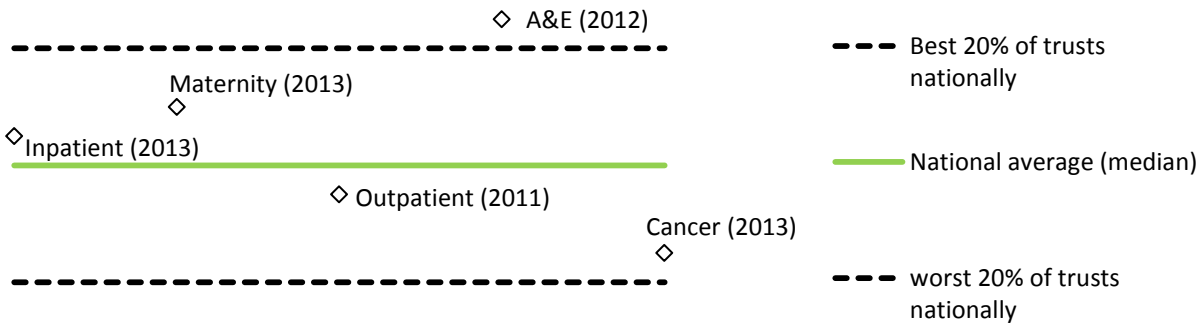
Theme	Valence	% of comments	
Staff	Positive	64%	*For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth.*
Care during labour	Positive	35%	
Information/advice	Negative	16%	

[7] Each of the patient comments received may contain several themes within it. Each of these themes is given a code (e.g. "staff: positive"). This table shows the most frequently applied codes, as a percentage of the total comments received (e.g. 61% of the comments received contained the "staff positive" thematic code).

8. National patient survey programme

Along with other English NHS trusts, UH Bristol participates in the Care Quality Commission (CQC) national patient survey programme. This provides useful benchmarking data - a summary of which is provided in chart 14 below[8] and Appendix A. It can be seen that UH Bristol broadly performs among the mid-performing trusts nationally. The main exception here is the 2012 national Accident and Emergency survey[9], where UH Bristol performed well above the national average. The national cancer survey (NCS) on the other hand tends to produce scores for UH Bristol that are lower than the national average. The latest set of NCS results were received during Quarter 2 (although the sample of patients surveyed had attended UH Bristol in late 2013). Despite a large number of service improvement actions at the Trust, the scores had not improved significantly from previous NCS results. A comprehensive engagement programme with patients receiving cancer services will be carried out by the Trust, in collaboration with the Patient's Association, to fully understand these results and inform the substantive action plan. In addition, the Trust will participate in an NHS England programme which will involve working closely with a peer Trust that performs consistently well in the NCS. These activities will lead to the development of a comprehensive and far-reaching action plan during 2015.

Chart 14: comparison of UH Bristol's national patient survey results (year in brackets)



It is interesting to ask: how good is the national average? This is a difficult question to answer as it depends on exactly which aspect of patient experience is being measured. However, the national inpatient survey asks people to rate their overall experience on a scale of 1-10, and the table below shows that around a quarter give UH Bristol the very highest marks (presumably reflecting an excellent experience), with around half giving a "good" rating of eight or nine.

Rating (0-10, with 10 being the best)	UH Bristol	Nationally
0 (I had a very poor experience)	0%	1%
1 to 4	5%	6%
5 to 7	23%	21%
8 and 9	47%	44%
10	26%	27%

[8] This analysis takes mean scores across all questions and trusts in each survey. The national mean score across all trusts is then set to 100, with upper and lower quintiles and the UH Bristol mean scores indexed to this.

[9] The 2014 national A&E survey results have just been received and will be explored in more detail in the next quarterly report. The results remain broadly positive, although scores have declined slightly compared to 2012.

Appendix A: summary of national patient survey results and key actions arising for UH Bristol

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan progress reviewed by Patient Experience Group*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2013 National Inpatient Survey	59/60 scores were in line with the national average. One score was below the national average (privacy in the Emergency Department)	May 2014	Quarterly	• Privacy in the Emergency Department • Awareness of the complaints process • Delays at discharge • Explaining potential medication side effects to patients at discharge	March 2015
2013 National Maternity Survey	14 scores were in line with the national average; 3 were better than the national average	January 2014	Six-monthly	• Continuity of antenatal care • Communication during labour and birth • Care on postnatal wards	January 2016
2013 National Cancer Survey	30/60 scores were in line with the national average; 28 scores were below the national average; 2 were better than the national average	November 2014	Six-monthly	• Providing patient-centred care • Validate survey results • Understanding the shared-cancer care model, both within UH Bristol and across Trusts	September 2015
2012 National Accident and Emergency surveys	21/37 scores in line with the national average; 16 scores were better than the national average	January 2013	Six-monthly	• Awareness of the complaints process • Waiting times in the Emergency Dept. and being kept informed of any delays • Patients feeling safe in the Department • Explaining potential medication side effects to patients at discharge	December 2014
2011 National Outpatient Survey	All UH Bristol scores in line with the national average	March 2012	Six monthly	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments • Copy patients in to hospital letters to GPs	Unknown

Appendix B: Full quarterly Divisional-level inpatient/parent survey dataset (Quarter 1 2014/15)

The following table contains a full update of the inpatient and parent data for April to June 2014. Where equivalent data is also collected in the maternity survey, this is presented also. All scores are out of 100 (see Appendix E), with 100 being the best. Cells are shaded amber if they are more than five points below the Trust-wide score, and red if they are ten points or more below this benchmark. See page 12 for the key to the column headings.

	MDC	SHN	SPS	WAC (Excl. maternity)	Maternity	Trust (excl Mat.)
Were you / your child given enough privacy when discussing your condition or treatment?	91	91	92	94	n/a	92
How would you rate the hospital food you / your child received?	60	58	56	64	57	59
Did you / your child get enough help from staff to eat meals?	79	87	84	77	n/a	82
In your opinion, how clean was the hospital room or ward you (or your child) were in?	92	93	96	94	87	93
How clean were the toilets and bathrooms that you / your child used on the ward?	88	90	91	91	80	90
Were you / your child ever bothered by noise at night from hospital staff?	78	86	80	87	n/a	83
Do you feel you / your child was treated with respect and dignity on the ward?	94	95	96	95	88	95
Were you / your child treated with kindness and understanding on the ward?	94	94	95	93	85	94
How would you rate the care you / your child received on the ward?	84	86	87	87	79	86
When you had important questions to ask a doctor, did you get answers you could understand?	82	86	87	89	84	85
When you had important questions to ask a nurse, did you get answers you could understand?	85	87	89	87	89	87
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	73	72	74	73	69	73
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	83	83	86	84	83	84
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	79	83	82	86	85	82
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	84	86	87	84	n/a	85
Did you / your child find someone to talk to about your worries and fears?	65	70	72	82	76	71

	MDC	SHN	SPS	WAC (Excl. Maternity)	Maternity	Trust (excl Mat.)
Staff explained why you needed these test(s) in a way you could understand?	82	86	85	91	n/a	85
Staff tell you when you would find out the results of your test(s)?	68	69	71	83	n/a	71
Staff explain the results of the test(s) in a way you could understand?	74	76	75	83	n/a	76
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	80	91	92	94	n/a	91
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	67	75	81	85	n/a	78
Staff were respectful any decisions you made about your / your child's care and treatement	89	91	92	92	n/a	91
During your hospital stay, were you asked to give your views on the quality of your care?	76	82	77	79	53	79
Do you feel you were kept well informed about your / your child's expected date of discharge?	84	89	88	90	n/a	88
On the day you / your child left hospital, was your / their discharge delayed for any reason?	63	63	57	63	55	61
% of patients delayed for more than four hours at discharge	20	19	25	12	29	20
Did a member of staff tell you what medication side effects to watch for when you went home?	53	66	60	63	n/a	60
Did a member of staff tell you who to contact if you were worried about your / your child's condition or treatment after you had left hospital?	77	85	87	90	n/a	84
Total responses	*424*	*508*	*345*	*259*	*301*	*1837*

<u>Key:</u> MDC (Division of Medicine); SHN (Division of Surgery, Head and Neck); SPS (Specialised Services Division); WAC (Women's and Children's Division, excludes maternity survey data); Maternity (maternity survey data); Trust (UH Bristol overall score from inpatient and parent surveys)

Appendix C: 2014 UH Bristol Outpatient Survey Results

Question	Response option	2014	2013	2011	Direction of travel[10]
Were you able to find a place to sit in the waiting area?	Yes	99%	99%	n/a	No change
Overall, how would you rate the care you received during the outpatient appointment?	Excellent, very good, good	98%	97%	98%	No change
Were you treated with respect and dignity during the outpatient appointment?	Yes, all of the time	96%	95%	95%	No change
How would you rate the courtesy of the receptionist?	Excellent, very good, good	95%	95%	n/a	No change
How likely are you to recommend the outpatient department to friends and family?	Extremely likely/likely	92%	90%	n/a	No change
Did (the medical professional) listen to you?	Yes, definitely	90%	90%	90%	No change
How would you rate the service that you received from the appointment centre?	Excellent, very good, good	90%	91%	n/a	No change
Was your appointment cancelled and re-arranged?	No	88%	85%	88%	No change
Did you find the text message reminder useful?	Yes	85%	n/a	n/a	
Did you have enough time to discuss your health or medical problem?	Yes, definitely	83%	82%	81%	No change
If you had important questions to ask, did you get answers that you could understand?	Yes, definitely	83%	82%	82%	No change
did the person you saw have all of the information needed to care for you?	Yes, definitely	81%	82%	n/a	No change
did a member of staff explain any risks and / or benefits of the treatment	Yes, completely	79%	76%	72%	**Better**
In your opinion, how clean was the outpatient dept?	Very clean	74%	73%	76%	No change
How long after the stated appointment time did the appointment start?	15 minutes or less	72%	70%	70%	No change
Did a member of staff explain the results of the test(s) in a way you could understand?	Yes, completely	71%	70%	66%	**Better**
Did the appointment centre resolve your query for you?	Yes, completely	66%	68%	n/a	No change
When you contacted the hospital, was it easy to get through to a member of staff who could help you?	Yes, definitely	58%	59%	n/a	No change
Did a member of staff tell you about medication side effects to watch for when you went home?	Yes, completely	54%	53%	55%	No change
Did you see a display board in the clinic with waiting time information on it?	Yes	47%	40%	n/a	**Better**
Were you told how long you would have to wait?	Yes	44%	42%	40%	No change
Were you told how much time you could expect to spend at the hospital for the appointment?	Yes	40%	40%	n/a	No change
When you first booked the appointment, were you given a choice of appointment date and time?	Yes	38%	40%	44%	**Worse**[11]
Were you told why you had to wait?	Yes	27%	27%	30%	No change

[10] Differences in scores of over five points from the baseline are highlighted as better or worse: this threshold represents a pragmatic combination of statistical significant (i.e. taking into account margins of error in the survey) and whether there has been a *significant impact* on patient's experience of our services.

[11] Note: UH Bristol is often not responsible for the initial booking of patients.

Appendix D – UH Bristol corporate patient experience programme

The Patient Experience and Involvement Team at UH Bristol manage a comprehensive programme of patient feedback and engage activities. If you would like further information about this programme, or if you would like to volunteer to participate in it, please contact Paul Lewis (paul.lewis@uhbristol.nhs.uk) or Tony Watkin (tony.watkin@uhbristol.nhs.uk). The following table provides a description of the core patient experience programme, but the team also supports a large number of local (i.e. staff-led) activities across the Trust.

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	At discharge from hospital, all adult inpatients, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view.
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

Appendix E: survey scoring methodologies

Postal surveys

For survey questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the survey questions have three or more response options. Based on the approach taken by the Care Quality Commission, each one of these response options contributes to the calculation of the score (note the CQC divide the result by ten, to give a score out of ten rather than 100).

As an example: Were you treated with respect and dignity on the ward?

	Weighting	**Responses**	**Score**
Yes, definitely	1	81%	81*100 = 81
Yes, probably	0.5	18%	18*50= 9
No	0	1%	1*0 = 0
Score			*90*

Friends and Family Test Score

The FFT score is calculated as follows:

The percentage of respondents ticking the “extremely likely to recommend the care” option

Minus

The percentage of respondents ticking the “neither likely nor unlikely”, “unlikely”, and “extremely unlikely” response options

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 2, 2014/2015

(1st July – 30th September 2014)

Authors: **Tanya Tofts, Patient Support and Complaints Manager**
Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)

1. Executive summary

The Trust received 518 complaints in Quarter 2 of 2014/15 (Q2), which equates to 0.29% of patient activity, against a target of 0.21%. In the previous quarter, the Trust had received 427 complaints, representing 0.25% of patient activity.

The Trust's performance in responding to complaints within the timescales agreed with complainants was 89.5% compared to 86.3% in Q1.

In Q2, complaints relating to appointments and admissions continued to account for over a third of the total complaints received by the Trust (in line with Q1). There was a decrease in complainants telling us that they were unhappy with our investigation of their concerns: 14 compared to 21 in Q1. The number of cases where the original deadline was extended continued to rise, with 41 cases in Q2 compared with 34 in Q1.

This report includes an analysis of the themes arising from complaints received in Q2, possible causes, and details of how the Trust is responding.

2. Complaints performance – Trust overview

The Board currently monitors three indicators of how well the Trust is doing in respect of complaints performance:

- Total complaints received, as a proportion of activity
- Proportion of complaints responded to within timescale
- Numbers of complainants who are dissatisfied with our response

The table on page 3 of this report provides a comprehensive 13 month overview of complaints performance including these three key indicators.

2.1 Total complaints received

The Trust's preferred way of expressing the volume of complaints it receives is as a proportion of patient activity, i.e. inpatient admissions and outpatient attendances in a given month.

We received 518 complaints in Q2, which equates to 0.29% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]; the figures do not include concerns which may be raised by patients and dealt with immediately by front line staff. The volume of complaints received in Q2 represents an increase of approximately 21% compared to Q1 (427) and a 55% increase on the corresponding period a year ago.

The Trust's current target is to achieve a complaints rate of less than 0.21% of patient activity, i.e. broadly-speaking, for no more than 1 in every 500 patients to complain about our services (although every complaint we receive is one too many).

[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.

Table 1 – Complaints performance

Items in italics are reportable to the Trust Board.

Other data items are for internal monitoring / reporting to Patient Experience Group where appropriate.

	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Total complaints received (inc. TS and F&E from April 2013)	115	120	109	104	127	124	164	131	130	166	178	170	170
Formal/Informal split	60/55	54/66	63/46	55/49	55/72	62/62	89/75	60/71	64/66	64/102	79/99	73/97	86/84
Number & % of complaints per patient attendance in the month	*0.20% 115 of 56869*	*0.19% 120 of 62480*	*0.19% 109 of 58783*	*0.20% 104 of 52194*	*0.21% 127 of 59288*	*0.23% 124 of 54507*	*0.28% 164 of 58180*	*0.24% 131 of 54981*	*0.23% 130 of 57463*	*0.28% 166 of 60027*	*0.28% 178 of 63,039*	*0.32% 170 of 52,879*	*0.27& 170 of 63,794*
% responded to within the agreed timescale (i.e. response posted to complainant)	*87.8% (43 of 49)*	*84.9% (62 of 73)*	*82.2% (37 of 45)*	*88.1% (37 of 42)*	*76.1% (51 of 67)*	*92.0% (46 of 50)*	*88.7% (47 of 53)*	*93.1% (54 of 58)*	*82.5% (47 of 57)*	*83.3% (50 of 60)*	*91.5% (65 of 71)*	*88.3% (53 of 60)*	*88.1% (52 of 59)*
% responded to by Division within required timescale for executive review	83.7% (41 of 49)	69.9% (51 of 73)	66.7% (30 of 45)	57.1% (24 of 42)	77.6% (52 of 67)	86.0% (43 of 50)	71.7% (38 of 53)	82.8% (48 of 58)	86.0% (49 of 57)	91.7% (55 of 60)	76.1% (54 of 71)	83.3% (50 of 60)	81.4% (48 of 59)
Number of breached cases where the breached deadline is attributable to the Division	4 of 6	10 of 11	5 of 8	3 of 5	7 of 16	2 of 4	3 of 6	2 of 4	2 of 10	6 of 10	4 of 6	4 of 7	6 of 7
Number of extensions to originally agreed timescale (formal investigation process only)	7	14	14	9	16	13	11	5	21	8	19	5	17
Number of Complainants Dissatisfied with Response	*1* 4***	*7* 8***	*2* 3***	*6* 6***	*6* 3***	*3* 5***	*5* 2***	*6* 10***	*4* 2***	*11* 4***	*8* 2***	*4* 5***	*2* 4***

* Dissatisfied – original investigation incomplete / inaccurate ** Dissatisfied – original investigation complete / further questions asked

Figures 1 and 2 show the increase in the volume of complaints received towards the end of 2013/14, continuing into the second quarter of 2014/15.

Figure 1: Number of complaints received

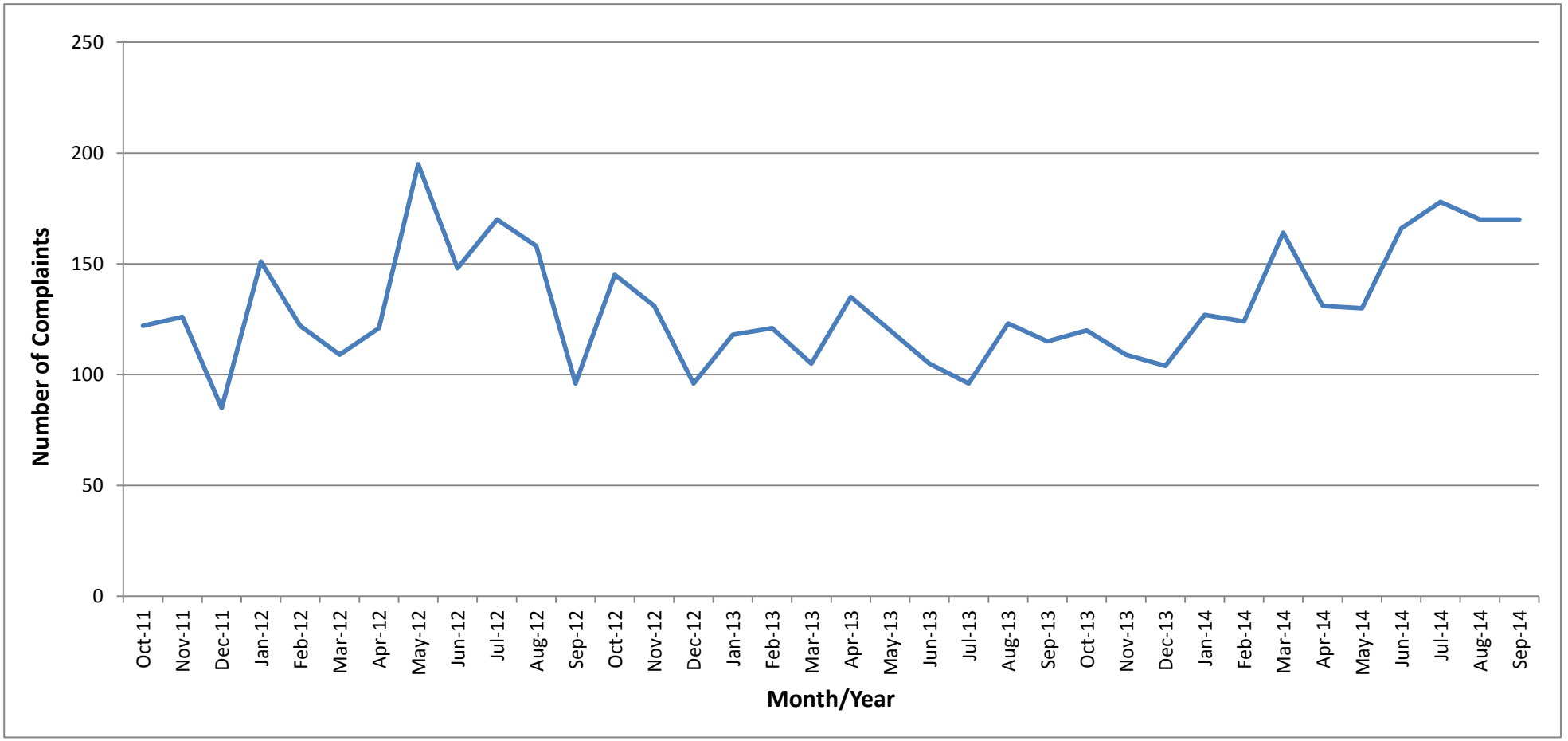
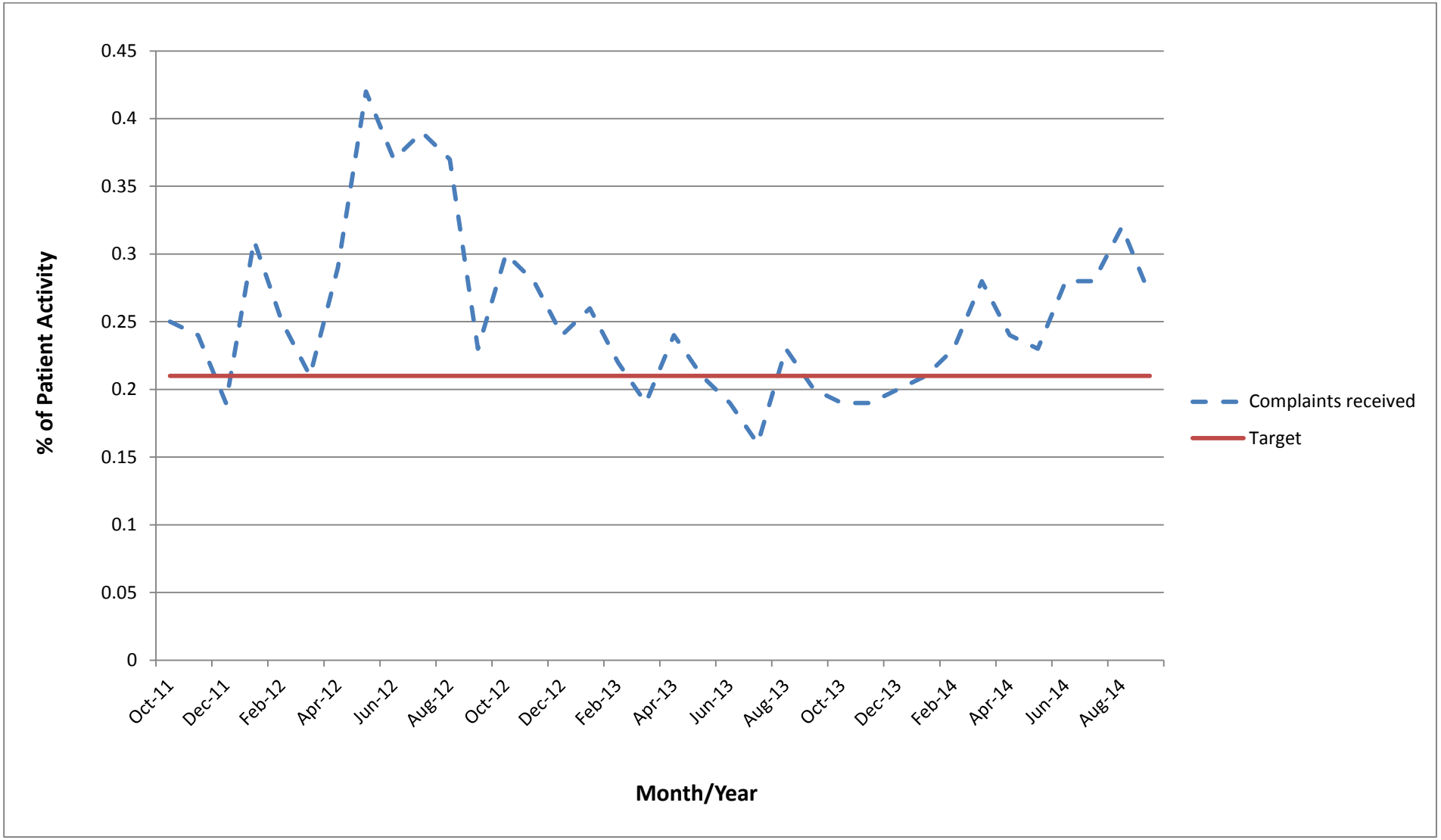


Figure 2: Complaints received, as a percentage of patient activity

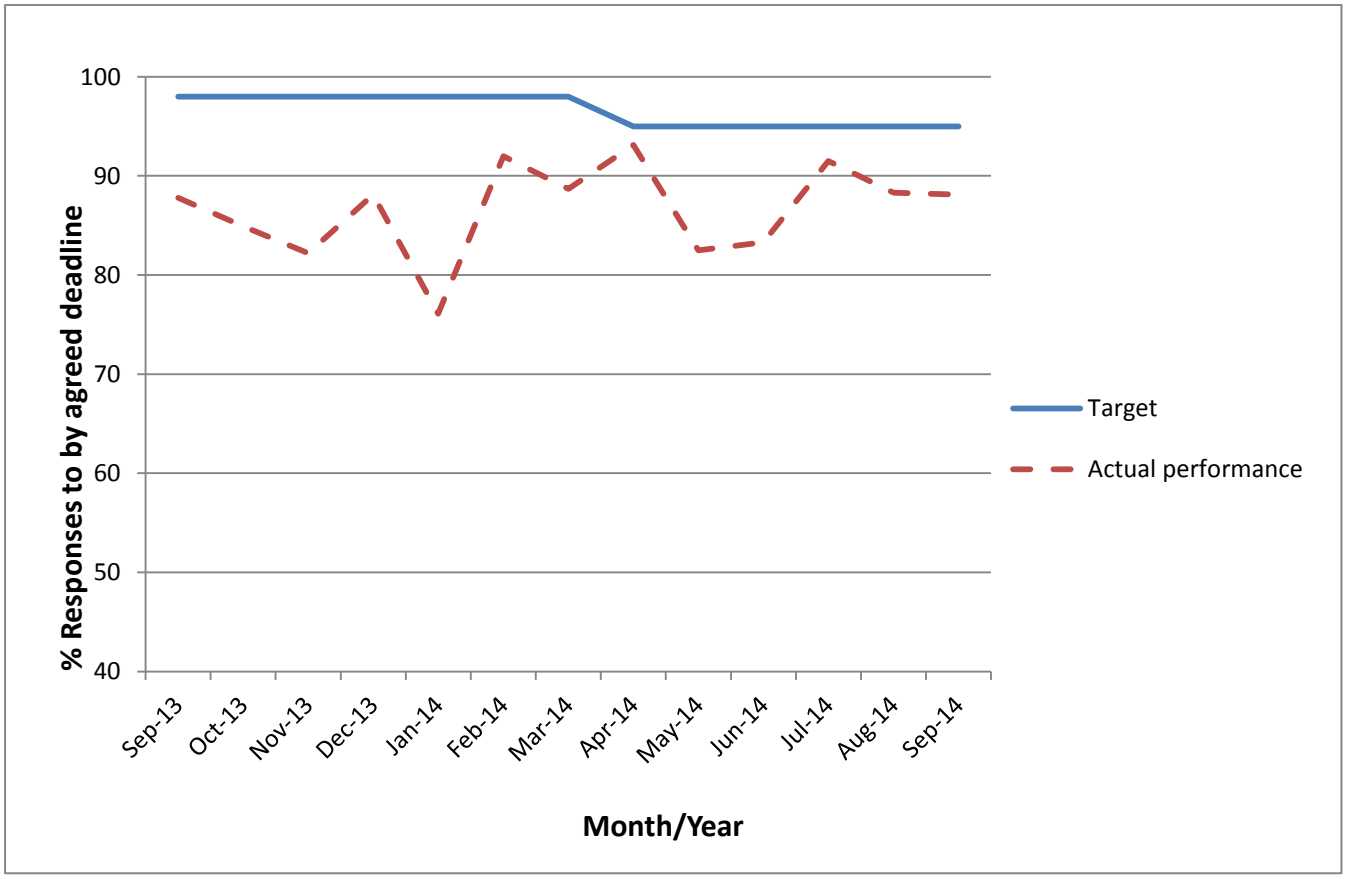


2.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days in Medicine, Surgery Head and Neck and Specialised Services[2] and 25 working days in other areas[3].

Prior to April 2014, our target was to respond to at least 98% of complainants within the agreed timescale. Since 1st April, this target has been adjusted slightly downwards to 95%. The end point is measured as the date when the Trust's response is posted to the complainant. In Q2, 89.5% of responses were made within the agreed timescale, compared to 86.3% in Q1. This represents 19 breaches out of 190 formal complaints which were due to receive a response during Q2[4]. Divisional management teams remain focussed on improving the quality and timeliness of complaints responses. Figure 3 shows the Trust's performance in responding to complaints since September 2013.

Figure 3. Percentage of complaints responded to within agreed timescale



[2] Based on experience, due to relative complexity and numbers received
[3] 25 working days used to be an NHS standard
[4] Note that this will be a slightly different figure to the number of complainants who *made* a complaint in that quarter.

2.3 Number of dissatisfied complainants

We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are dissatisfied with the quality of our investigation of their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation so that we don't make the same mistake again. Our target is that nobody should be dissatisfied with the quality of our response to their complaint. Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response.

In Q2, there were 14 cases where the complainant felt that the investigation was incomplete or inaccurate. This represents a 33% reduction on Q1 (21 cases). There were a further 11 cases where new questions were raised, compared to 16 cases in Q1.

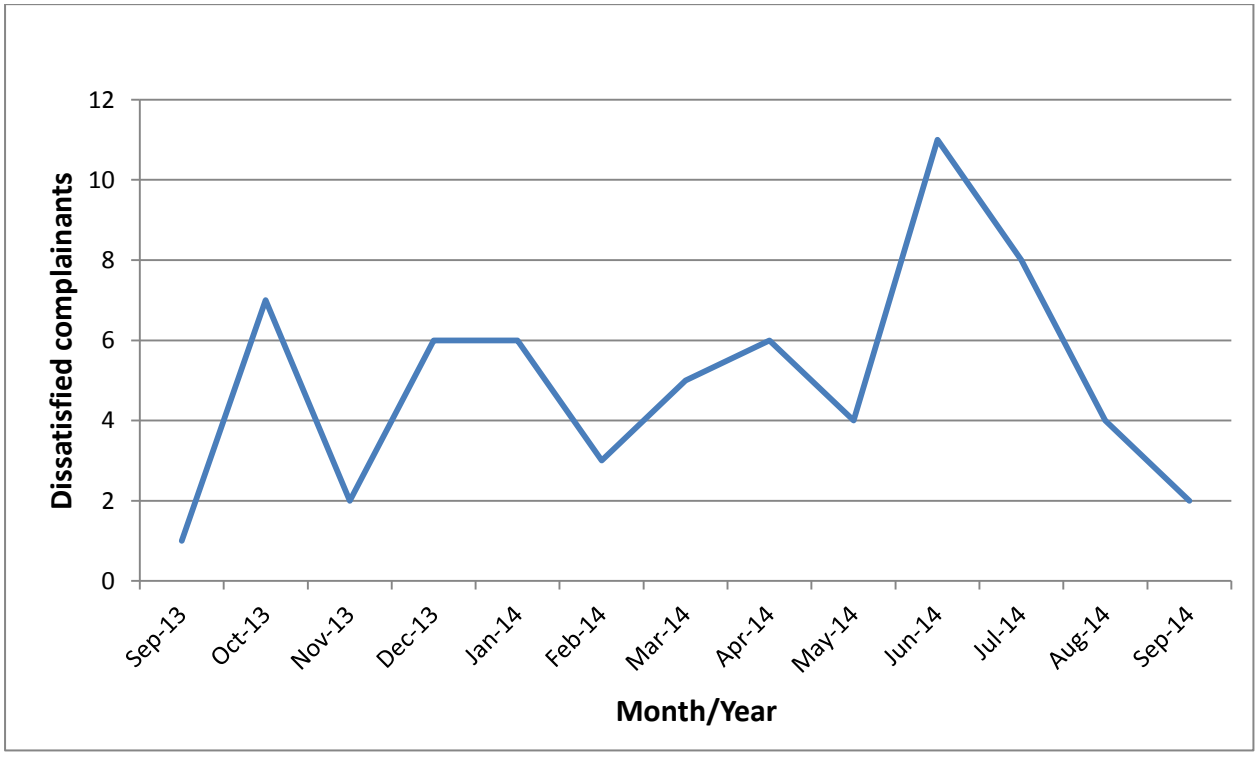
The 14 cases where the complainant was dissatisfied were associated with the following lead Divisions:

- 6 cases for the Division of Surgery, Head & Neck (compared to 8 in Q1) ↓
- 1 cases for the Division of Medicine (compared to 5 cases in Q1) ↓
- 2 cases for the Division of Women & Children (compared to 5 in Q1) ↓
- 5 cases for the Division of Specialised Services (compared to 2 in Q1) ↑
- 0 cases for the Division of Diagnostics & Therapies (compared to 1 in Q1) ↓
- 0 cases for the Division of Facilities & Estates (compared to 0 in Q1) =

A validation report is sent to the lead Division for each case where an investigation is considered to be incomplete or inaccurate. This allows the Division to confirm their agreement that a reinvestigation is necessary or to advise why they do not feel the original investigation was inadequate.

The number of dissatisfied complainants has decreased overall in Q2, with the only increase being for the Division of Specialised Services. Actions agreed to address this increase are detailed in section 3.6 of this report.

Figure 4. Number of complainants who were dissatisfied with aspects of our complaints response



2.4 Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of six major themes. The table below provides a breakdown of complaints received in Q2 compared to Q1. Complaints about all category types increased in Q2 in real terms, although 'appointments & admissions' and 'clinical care' showed a slight decrease when measured as a proportion of complaints received.

Category Type	**Number of complaints received – Q2 2014/15**	**Number of complaints received – Q1 2014/15**
Appointments & Admissions	178 ↑ (34.4% of total complaints)	152 (35.6% of total complaints)
Attitude & Communication	119 ↑ (23%)	91 (21.3%)
Clinical Care	150 ↑ (28.9%)	132 (30.9%)
Facilities & Environment	38 ↑ (7.3%)	27 (6.3%)
Access	14 ↑ (2.7%)	9 (2.2%)
Information & Support	19 ↑ (3.7%)	16 (3.7%)
Total	**518**	**427**

Each complaint is then assigned to a more specific category (of which there are 121 in total). The table below previously listed the six most consistently reported complaint categories. One complaint category that was notable in Q1: Attitude of Nursing Staff (16) was found to have increased further in Q2 and this has now been included in this quarterly report (as proposed in the Q1 report). In total, these seven categories account for 65% of the complaints received in Q2 (338/518)

Sub-category	**Number of complaints received – Q2 2014/15**	**Q1 2014/15**	**Q4 2013/14**	**Q3 2013/14**
Cancelled or delayed appointments and operations	152 ↑ **(18% increase *compared to Q1*)**	129	111	86
Clinical Care (Medical/Surgical)	62 ↑ **(15% increase)**	54	47	45
Communication with patient/relative	35 ↑ **(30% increase)**	27	32	14
Clinical Care (Nursing/Midwifery)	34 ↑ **(13% increase)**	30	26	23
Attitude of Nursing/Midwifery	22 ↑ **(37% increase)**	16		
Attitude of Medical Staff	21 ↑ **(5% increase)**	20	30	13
Failure to answer telephones	12 ↑ **(200% increase)**	4	18	16

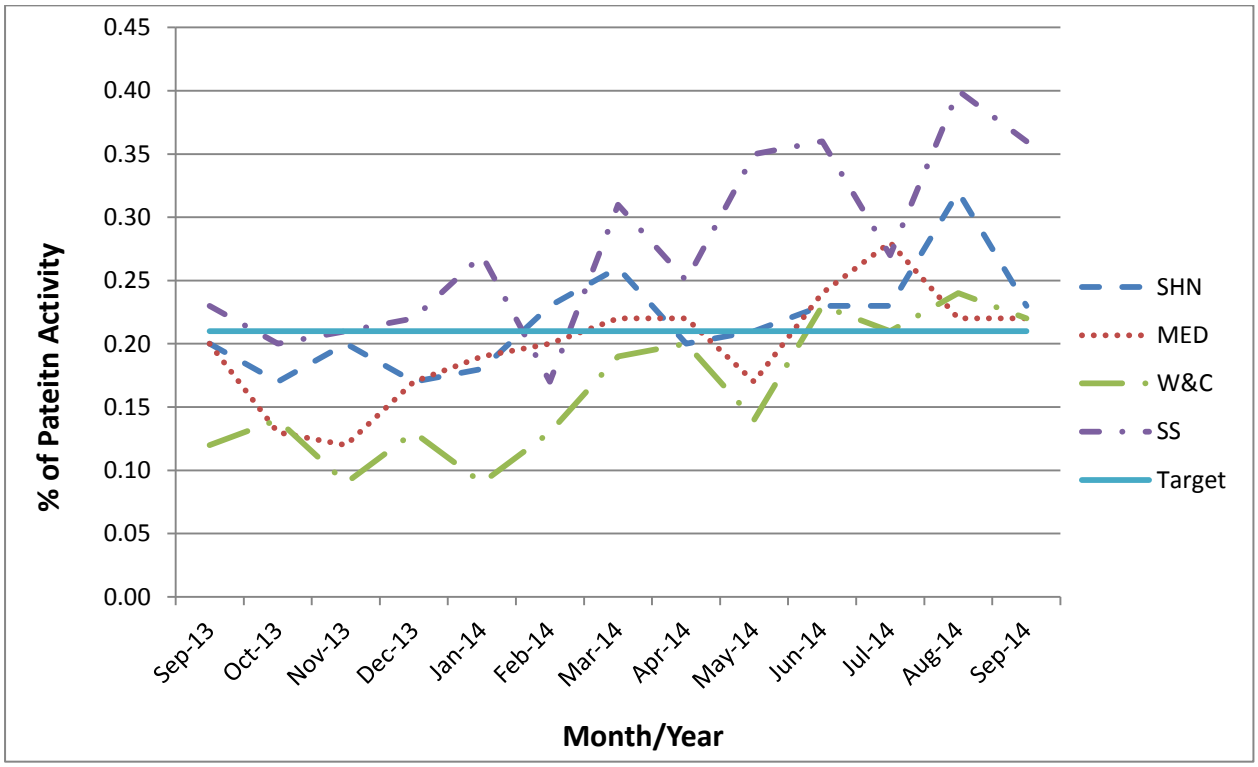
Most notably, complaints about cancelled or delayed appointments and operations continued to increase in Q2. The issue is recognised by the Trust and was highlighted in the Care Quality Commission's recent inspection report. The Trust, working in conjunction with local health and social care partners, has been tasked by the CQC and Monitor with developing a robust action plan to deliver transformational change to patient flow during the final quarter of 2014/15; the Trust's Chief Operating Officer is leading this work on behalf of the Board.

3. Divisional performance

3.1 Total complaints received

A divisional breakdown of percentage of complaints per patient attendance is provided in Figure 5. This shows a downturn in the volume of complaints received in all bed-holding Divisions at the end of Q2 following an upturn at the beginning of Q2.

Figure 5. Complaints by Division as a percentage of patient attendance



It should be noted that data for the Division of Diagnostics and Therapies has been excluded from Figure 5. This is because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Complaints are more likely to occur as elements of complaints within bed-holding Divisions. Overall reported Trust-level data includes Diagnostic and Therapy complaints, but it is not appropriate to draw comparisons with other Divisions. For reference, numbers of reported complaints for the Division of Diagnostics and Therapies since October 2013 have been as follows:

Table 2. Complaints received by Diagnostics and Therapies Division since October 2013

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Number of complaints received	12	9	11	14	11	7	9	6	8	17	6	10

3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q2 complaints performance by Division. The table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 3.

	Surgery Head and Neck	**Medicine**	**Specialised Services**	**Women and Children**	**Diagnostics and Therapies**
Total number of complaints received	193 (156) ↑	93 (81) ↑	79 (73) ↑	94 (69) ↑	33 (23) ↑
Total complaints received as a proportion of patient activity	0.26% (0.21%) ↑	0.24% (0.21%) ↑	0.34% (0.33%) ↑	0.22% (0.19%) ↑	N/A
Number of complaints about appointments and admissions	106 (80) ↑	12 (24) ↓	27 (26) ↑	34 (19) ↑	8 (6) ↑
Number of complaints about staff attitude and communication	42 (34) ↑	32 (32) =	19 (15) ↑	23 (11) ↑	10 (5) ↑
Number of complaints about clinical care	45 (44) ↑	37 (19) ↑	34 (26) ↑	43 (37) ↑	5 (10) ↑
Areas where the most complaints have been received in Q2	Bristol Eye Hospital – 41 (38) ↑ Bristol Dental Hospital – 29 (25) ↑ Ear Nose and Throat – 29 (28) ↑ Upper GI – 15 (12) ↑ Lower GI – 11 (7) ↑	A&E – 20 (15) ↑ Dermatology – 7 (8) ↓ Respiratory Department (including Sleep Unit) – 6 (10) ↓ Ward 200 (SBCH) – 5 (2) ↑ Ward 15 – 4 (2) ↑ Ward 17 (A515) – 4 (7) ↓ Ward 26 – 4 (3) ↑	Chemotherapy Day Unit and Outpatients – 16 (7) ↑ Cardiology GUCH Services – 11 (11) = Ward 52 (C708) – 8 (5) ↑ Ward 61 (D603) – 7 (5) ↑ Ward 62 & 62a (D703 & D703a) – 3 (7) ↓	Children's ED & Ward 39 – 4 (8) ↓ Paediatric Orthopaedics – 21 (7) ↑ Paediatric Neurology – 9 (4) ↑ Ward 30 – 5 (0) ↑	Radiology – 12 (12) =
Notable deteriorations compared to Q1	Trauma & Orthopaedics – 34 (29) ↑	Ward 7 – 7 (1) ↑	Bristol Heart Institute Outpatients – 25 (16) ↑	Paediatric Orthopaedics – 21 (7) ↑	BEH Pharmacy – 9 (0) ↑
Notable improvements compared to Q1	N/A	N/A	Ward 62 & 62a (D703 & D703a) – 3 (7) ↓	Ward 78 – 1 (5) ↓	N/A

3.3 Areas where the most complaints were received in Q1 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Complaints by category type[5]

Category Type	Number and % of complaints received – Q2 2014/15	Number and % of complaints received – Q1 2014/15
Access	3 (1.6% of total complaints) =	3 (1.8% of total complaints)
Appointments & Admissions	102 (52.7%) ↑	76 (48.5%)
Attitude & Communication	40 (20.7%) ↑	32 (20.6%)
Clinical Care	42 (21.8%) ↑	41 (26.7%)
Facilities & Environment	3 (1.6%) =	3 (1.8%)
Information & Support	3 (1.6%) ↑	1 (0.6%)
Total	**193**	**156**

Top sub-categories

Sub-category	Number of complaints received – Q2 2014/15	Number of complaints received – Q1 2014/15
Cancelled or delayed appointments and operations	97 ↑ (27.6% increase compared to Q1)	76 ↑ (7% increase compared to Q4)
Clinical Care (Medical/Surgical)	20 ↑ (5.3% increase)	19 =
Communication with patient/relative	11 ↑ (10% increase)	10 ↓ (37.5% decrease)
Attitude of Medical Staff	5 ↓ (44.4% decrease)	9 ↓ (18% decrease)
Attitude of Nursing/Midwifery	7 ↑ (16.7% increase)	6 (not previously reported)
Clinical Care (Nursing/Midwifery)	3 ↓ (62.5% decrease)	8 ↑ (14% increase)
Failure to answer telephones	6 ↑ (500% increase)	1 ↓ (85% decrease)

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
The Ear Nose & Throat Service continued to receive a large number of complaints (29 compared to 28 in Q1). All complaints received in Q2 again related to cancelled or delayed appointments.	Two specialty doctors started in the department in August. As a result, this has increased clinic capacity substantially, enabling patient appointments to be brought forward. Waiting times have reduced from 18 weeks in Q1 to 9 weeks in Q2.	It is anticipated that increased overall clinic capacity and reduced waiting times will lead to a reduction in the number of patients waiting an excessive length of time for their appointments.
Bristol Dental Hospital received 29 complaints in Q2; a further 16% increase compared to Q1. 15 (52%) of these complaints were for Adult Restorative Dentistry.	Ongoing complaints for Adult Restorative Dentistry relate to the problems in replacing a consultant who left the Trust approximately six months ago. With regard to appointments and failure to answer telephones, further	Several of the sessions run by the consultant who has left the Trust have now been allocated to non-consultant clinicians and the backlog is beginning to reduce. There is however still a risk relating to the lack of a consultant, as a further restorative clinician plans to retire in 2015.

[5] Arrows in Q2 column denote increase or decrease compared to Q1. Arrows in Q1 column denote increase or decrease compared to Q4. Increases and decreases refer to actual numbers rather than to proportion of total complaints received.

	recruitment has taken place in the call centre and the administrative teams, to support the volume of administrative tasks associated with a quarterly footfall of over 19,500 patient attendances.	
Bristol Eye Hospital received 41 complaints in Q2, of which 21 (51%) were in respect of Outpatients. These complaints were a mixture of cancelled/delayed appointments and communication issues.	Cancelled and delayed appointments are being addressed through the additional recruitment and outreach of glaucoma and medical retinal services. Some communication issues remain with patients not understanding treatments or procedures/likely outcomes.	There has been an increased focus on the patient experience in the Bristol Eye Hospital. As part of this, a full time Patient Support & Liaison Nurse has been employed and is available to patients who have informal concerns. Two WTE Nurse Injectors have also been employed following positive feedback from patients that these nurses have more time to talk to them and to explain procedures and outcomes than perhaps a doctor would.
Trauma & Orthopaedics received 34 complaints in Q2, an increase of 17% compared to Q1. Of these complaints, 16 (47%) were in respect of cancelled/delayed operations and appointments.	Complaints relating to cancellations and delays have often been in respect of dates for surgery at Southmead Hospital (North Bristol NHS Trust) following a complex diagnostic pathway at Bristol Royal Infirmary. NBT is currently working with commissioners and independent sector providers to address the unstable 18 week backlog for surgery. There was also a theme relating to poor or conflicting advice given to patients when they contacted the department following appointments; the administrative manager and clinic sister are working on a package of training for clerical staff to be better able to deal with these enquiries.	The Trauma & Orthopaedics Department has recently introduced a multi-disciplinary executive meeting, which will review complaint trends on a quarterly basis and oversee any action plans resulting from complaints.

3.3.2 Division of Medicine

Complaints by category type

Category Type	Number and % of complaints received – Q2 2014/15	Number and % of complaints received – Q1 2014/15
Access	2 (2.1% of total complaints) ↑	1 (1.2% of total complaints) =
Appointments & Admissions	12 (13%) ↓	22 (27.2%) ↑
Attitude & Communication	31 (33.3%) ↑	30 (37%) ↑
Clinical Care	35 (37.6%) ↑	17 (21%) ↓
Facilities & Environment	9 (9.7%) ↑	7 (8.6%) ↑
Information & Support	4 (4.3%) =	4 (5%) ↑
Total	**93**	**81**

Top sub-categories

Category	Number of complaints received – Q2 2014/15	Number of complaints received – Q1 2014/15
Cancelled or delayed appointments and operations	5 ↓ (44.4% decrease compared to Q1)	9 ↓ (40% decrease compared to Q4)
Clinical Care (Medical/Surgical)	13 ↑ (30% increase)	10 ↓ (9% decrease)
Communication with patient/relative	9 ↑ (28.6% increase)	7 ↑ (75% increase)
Attitude of Medical Staff	6 ↑ (50% increase)	4 ↓ (20% decrease)
Attitude of Nursing/Midwifery	11 ↑ (22.2% increase)	9 (not previously reported)
Clinical Care (Nursing/Midwifery)	16 ↑ (220% increase)	5 ↓ (44% decrease)
Failure to answer telephones	1 =	1 ↓ (66% decrease)

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
The Accident & Emergency Department received 20 complaints in Q2; a 33% increase on the 15 received in Q1. 10 of these complaints were about attitude and communication and 7 were in respect of clinical care.	All 20 complaints/incidents have been reviewed – 14 formal and 6 informal. No themes have been identified, although complaints included concerns about waiting times. Complaints about attitude and communication included perceived queue-jumping in radiology, treatment of patients with mental health issues and the response of security staff.	Complaints were discussed at the Emergency Department team meeting on 11th November 2014, to agree additional improvement actions.
There was a seven-fold increase in complaints received by Ward 7 (7 in Q2 compared to just 1 in Q1). The majority of these complaints (5) were in respect of clinical care.	All 7 complaints have been reviewed by the Division – 5 informal and 2 formal. The informal complaints included: lost dentures on transfer to the ward; appropriate refusal to cut toenails on a gangrenous foot; and concerns about discharge. The two formal complaints related to a disagreement about end of life care and best interests. One of the formal	The lead consultant reviewed all of the complaints to determine any additional actions that are required and emailed his findings to the wider team.

	complaints only related in part to Ward 7, with the majority of the issues being in respect of South Bristol Community Hospital.	

3.3.3 Division of Specialised Services

Complaints by category type

Category Type	Number and % of complaints received – Q2 2014/15	Number and % of complaints received – Q1 2014/15
Access	1 (1.3% of total complaints) =	1 (1.4% of total complaints) =
Appointments & Admissions	24 (30.4%) ↓	26 (35.6%) ↑
Attitude & Communication	17 (21.5%) ↑	15 (20.6%) ↑
Clinical Care	31 (39.2%) ↑	26 (35.6%) ↑
Facilities & Environment	3 (3.8%) =	3 (4.1%) =
Information & Support	3 (3.8%) ↑	2 (2.7%) ↑
Total	**79**	**73**

Top sub-categories

Category	Number of complaints received – Q2 2014/15	Number of complaints received – Q1 2014/15
Cancelled or delayed appointments and operations	24 =	24 ↑ (41% increase compared to Q4)
Clinical Care (Medical/Surgical)	10 =	10 ↑ (43% increase)
Communication with patient/relative	7 =	7 ↑ (40% increase)
Attitude of Medical Staff	3 ↑ (200% increase)	1 ↓ (50% decrease)
Attitude of Nursing/Midwifery	1 ↑	0 (not previously reported)
Clinical Care (Nursing/Midwifery)	6 ↓ (25% decrease)	8 ↑ (166% increase)
Failure to answer telephones	2 =	2 ↑ (100% increase)

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
Bristol Heart Institute outpatients received 25 complaints; an increase of 56% on the 16 received in Q1. 12 of the complaints related to problems around appointments, i.e. cancelled or delayed appointments or procedures. There were no discernible trends for the remainder of the complaints received.	The outpatient cardiology service has experienced lengthy waiting times for a number of consultants during the past year. This has led to individual patient appointments being delayed or re-booked to reflect changing clinical priorities (i.e. more urgent patients being referred).	The Division carried out a large number of additional clinics in Q2, leading to an additional 200 clinic appointments and allowing the service to reduce its backlog of long-waiting patients from 550 in July 2014 to 154 at the end of November 2014. This work will continue into the New Year.
There was a significant increase in the number of complaints received by the Bristol Haematology &	The increase in the number of complaints related to excessive heat in the BHOC outpatient environment during the	A business case has been approved to install air conditioning and this will be installed by the end of February/beginning of March 2015.

Oncology Centre's Chemotherapy Day Unit & Outpatients, with a total of 16 complaints received in Q2, a 128% increase on the 7 received in Q1.	summer months. There was a further increase in complaints related to delays in waiting for chemotherapy.	Pharmacy, medical and nursing staff are continuing to work together to reduce delays in on-day waits for chemotherapy. The Chemotherapy Group are reviewing these issues at their next meeting and the Head of Nursing has requested that the Interim General Manager takes a 'fresh look' at this issue.

3.3.4 Division of Women & Children

Complaints by category type

Category Type	Number and % of complaints received – Q2 2014/15	Number and % of complaints received – Q1 2014/15
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	30 (32%) ↑	19 (27.5%) ↑
Attitude & Communication	20 (21.3%) ↑	11 (16%) ↓
Clinical Care	40 (42.5%) ↑	36 (52.2%) ↑
Facilities & Environment	3 (3.2%) ↑	2 (2.9%) ↑
Information & Support	1 (1%) =	1 (1.4%) =
Total	**94**	**69**

Top sub-categories

Category	Number of complaints received – Q2 2014/15	Number of complaints received – Q1 2014/15
Cancelled or delayed appointments and operations	33 ↑ (120% increase compared to Q1)	15 (50% increase compared to Q4) ↑
Clinical Care (Medical/Surgical)	15 ↑ (7.1% increase)	14 (55.5% increase) ↑
Communication with patient/relative	8 ↑ (60.5% increase)	3 (40% decrease) ↓
Attitude of Medical Staff	6 =	6 (25% decrease) ↓
Attitude of Nursing/Midwifery	5 ↑	0 (not previously reported)
Clinical Care (Nursing/Midwifery)	12 ↑ (33.3% increase)	9 (50% increase) ↑
Failure to answer telephones	1 ↑	0 (100% decrease) ↓

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
There has been a significant increase in the number of complaints received by Paediatric Orthopaedics, with 21 complaints received in Q2, an increase of 200% on the 7 complaints received in Q1. Of these, 13 complaints were	The business case for the Centralisation of Specialist Paediatrics (CSP) transfer planned for an additional 19 theatre sessions with on-call arrangements to cover emergencies overnight. The additional staffing requirements	Work is taking place to address these issues and to improve capacity within the operating theatres and outpatients, including private sector provision. Post transfer, a further nine additional theatre sessions and on-site theatre night staff cover has

about cancelled or delayed appointments or operations and 5 were about attitude and communication.	were up and running at the point of transfer. However, post-transfer, is became evident that the theatre and outpatient capacity planned was insufficient to meet the needs of patients within these services and those of existing services.	been identified. Recruitment for the additional theatre staff required is being proactively managed: national adverts and open days have been placed and a Senior Nurse Lead (Matron) has been appointed to focus solely on this - with dedicated Employee Services support - for the next year. However, it is not anticipated that all of the additional staff required will be fully in place until early in the New Year (January to April). The additional capacity required in outpatients requires 'physical space' to be identified and the Division is exploring the potential use of South Bristol Community Hospital to provide the additional capacity required. The Division is working to prioritise patients based on clinical need, to ensure that those patients identified receive timely diagnosis and treatment. Families who have been delayed have been contacted to explain the current situation and to give assurance that their child will be seen and treated according to clinical priority.
Complaints received by Paediatric Neurology increased from 4 in Q1 to 9 in Q2 (a 125% increase); 5 of these complaints were about cancelled/delayed appointments.	*As above*	*As above*
The Children's Hospital received 12 complaints about clinical care in Q2. Whilst the majority of these were isolated, Ward 30 received 5 complaints in Q2 (2 related to the same patient), compared to none in Q1.	There is no obvious pattern of complaints within this category. 7 of the 12 complaints received related to clinical care provided by medical staff and 5 of the 12 complaints received related to clinical care provided by nursing staff. Of the 5 complaints received on Ward 30, 2 related to the same complainant and there were no common themes identified.	On receipt of complaints, the teams involved receive a copy and are asked to reflect on their practice, learn lessons and take action, where appropriate, to make changes.

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

Category Type	Number and % of complaints received – Q2 2014/15	Number and % of complaints received – Q1 2014/15
Access	6 (18.2% of total complaints) ↑	1 (4.4% of total complaints) ↓
Appointments & Admissions	8 (24.3 %) ↑	6 (26%) ↓
Attitude & Communication	10 (30.3%) ↑	5 (21.8%) ↓
Clinical Care	6 (18.2%) ↓	9 (39%) ↑
Facilities & Environment	2 (6%) =	2 (8.8%) ↓
Information & Support	1 (3%) ↑	0 (0%) ↓
Total	**33**	**23**

Top sub-categories

Category	Number of complaints received – Q2 2014/15	Number of complaints received – Q1 2014/15
Cancelled or delayed appointments and operations	6 ↑	5 =
Clinical Care (Medical/Surgical)	2 ↑	1 ↑
Communication with patient/relative	2 ↑	0 =
Attitude of Medical Staff	2 ↑	0 ↓
Attitude of Nursing/Midwifery	0 =	0 (not previously reported)
Clinical Care (Nursing/Midwifery)	0 =	0 =
Failure to answer telephones	3 ↑	0 ↓

Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
There was a sharp rise in the number of complaints received about the Bristol Eye Hospital Pharmacy, from none in Q1 to 9 in Q2. All 9 complaints related to the service no longer being available and patients having to collect their prescriptions from Bristol Royal Infirmary.	The BEH pharmacy dispensing service was transferred to Boots BRI, located in the Trust Welcome Centre, in June 2014. Patients now collect their eye prescriptions from this pharmacy, however other options are available: collection from another Boots branch more local to home; or home delivery. If a prescription is urgent on the day in clinic, medication could be dispensed in BEH. Unfortunately there has been insufficient communication between pharmacy/BEH clinicians and patients about the new service and the options available. A key benefits of the new Boots service was supposed to be reduced waiting times for collecting medicines; unfortunately, Boots were overwhelmed with the increase in workload and only	Improve communication about the Boots service: 1. Flow chart summary of service options to be cascaded through Ophthalmology departments in order to ensure high levels of awareness. 2. Posters for patients in reception areas. 3. Patient appointment letters to have information about new service and options for collecting medication 4. BEH lead pharmacist attending Eye Hospital strategy meetings to continue to raise awareness about the service and the options for collecting medication available to patients. 5. Information leaflet given to patients when they check in for their appointment.

	achieved a 30 minute turnaround for 64% of prescriptions in July.	Trust staff have already supported Boots to increase their staff numbers to a level that can manage the workload, and to review their systems and processes to reduce patient waiting times. (November waiting time 96% within 30 minutes).
The number of complaints received by Radiology rose from 7 in Q4 to 12 in Q1. In Q2, the number of complaints remained the same at 12. These were spread across a number of categories, with three each relating to clinical care, attitude of staff and lost or delayed test results.	Of the 12 complaints, 10 were formal and two were informal. One of the complaints about clinical care related to a historical (2006) case where the incident unfortunately could not be fully investigated as the member of staff involved is no longer in the organisation. Another case related to a patient whose MRI scan was halted because they had metal in their ear; this was picked up during the safety check. The patient subsequently had a CT scan instead. A third complaint related to an incorrect address, due to information not being updated on Medway in another department. In two cases, patients had their scans cancelled due to capacity issues, and the department has apologised for the distress caused.	Action plans are in place for those complaints where change / learning was required. In one case, a patient complained about a breach of their privacy and dignity whilst having an Ultrasound scan in St Michael's. As a result of this, screens have been ordered to ensure privacy when patients are changing. Capacity and demand issues are being taken forward via the division's Operating Plan.

Complaints by hospital site

Of those complaints with an identifiable site, the breakdown by hospital is as follows:

Hospital/Site	**Number and % of complaints received – Q2 2014/15**	**Number and % of complaints received – Q1 2014/15**
Bristol Royal Infirmary	207 (40% of total complaints) ↑	170 (39.8% of total complaints) ↓
Bristol Eye Hospital	46 (8.9%) ↑	38 (8.9%) ↓
Bristol Dental Hospital	30 (5.7%) ↑	26 (6%) ↑
St Michael's Hospital	52 (10.1%) ↓	57 (13.3%) ↑
Bristol Heart Institute	56 (10.8%) ↑	50 (11.7%) ↑
Bristol Haematology & Oncology Centre	31 (6%) ↑	25 (5.9%) ↑
Bristol Royal Hospital for Children	79 (15.3%) ↑	50 (11.7%) ↑
South Bristol Community Hospital (inc. Homeopathic Outpatients)	17 (3.2%) ↑	11 (2.7%) ↑
Total	**518**	**427**

3.5 Complaints responded to within agreed timescale

The Trust's aim is to respond to complaints within the timescale we have agreed with the complainant. All five of the clinical Divisions reported breaches in Quarter 2, totalling 19 breaches.

	Q2 2014/14	**Q1 2014/15**	**Q4 2013/14**	**Q3 2013/14**
Surgery Head and Neck	5 (7.1%)	9 (14.3%)	8 (11%)	6 (10%)
Medicine	4 (11.1%)	7 (21.2%)	7 (21.2%)	11 (25%)
Specialised Services	1 (4.3%)	2 (8.7%)	0	2 (11%)
Women and Children	8 (17%)	6 (19.4%)	9 (36%)	4 (17%)
Diagnostics & Therapies	1 (11.1%)	0 (0%)	1 (8.3%)	0
All	**19 breaches**	**24 breaches**	**25 breaches**	**23 breaches**

(So, as an example, there were seven breaches of timescale in the Division of Medicine in Q1, which constituted 21.2% *of the complaints responses that had been due in Q1*.)

Breaches of timescale were caused either by late receipt of final draft responses from Divisions which did not allow adequate time for Executive review and sign-off, delays in processing by the Patient Support and Complaints team, or by delays in during the sign-off process itself. Sources of delay are shown in the table below.

	Source of delays (Q2, 2014/2015)		
	Division	**Patient Support and Complaints Team**	**Executive sign-off**
Surgery Head and Neck	1	0	4
Medicine	3	0	1
Specialised Services	0	0	1
Women and Children	8	0	0
Diagnostics & Therapies	1	0	0
All	13 breaches	0 breaches	6 breaches

Actions agreed via Patient Experience Group:

- New KPIs have been agreed in respect of turnaround times for the Patient Support and Complaints Team and for the Executives, in addition to the four working days allowed for the Divisions. The Patient Support and Complaints Team must send the response letter to the Executives for signing within 24 hours of receipt from the Division. The Executives then have up to three working days (maximum) to review, sign and return the response to the Patient Support and Complaints Team.
- Divisions have been reminded of the importance of providing the Patient Support and Complaints Team with draft final response letters at least four working days prior to the date they are due with the complainant.
- The Patient Support and Complaints Team continue to actively follow up Divisions if responses are not received on time; Divisional staff are also reminded of the need to contact the complainant to agree an extension to the deadline if necessary.
- Longer deadlines are agreed with Divisions if the complainant requests a meeting rather than a written response. This allows for the additional time needed to co-ordinate the diaries of clinical staff required to attend these meetings. (Note that deadlines agreed with Surgery, Head and Neck, Medicine and Specialised Services are longer than for the other Divisions, to reflect the larger patient numbers and subsequent complaints received by these Divisions).
- Ongoing vigilance to avoid any delays by Patient Support and Complaints Team.

3.6 Number of dissatisfied complainants

As reported in section 1.3, there were 14 cases in Q2 where complainants were dissatisfied with the quality of our response.

At their December Divisional Board Meeting, the divisional management team for Specialised Services will review recent cases where complainants were dissatisfied, in order to rule out any common themes (in terms of how the Division responded) for future learning. Any appropriate actions that arise will be completed by the end of January 2015.

	Q2 2014/15	Q1 2014/15	Q4 2013/14	Q3 2013/14
Surgery Head and Neck	**6**	8	5	8
Medicine	**1**	5	4	4
Specialised Services	**5**	2	1	3
Women and Children	**2**	5	3	0
Diagnostics & Therapies	**0**	1	1	0
All	**14**	21	14	15

Actions agreed via Patient Experience Group:

- Divisions are notified of any case where the complainant is dissatisfied. The 14 cases recorded in Q2 have now either been responded to in full, or have had revised response deadlines agreed with the complainants.
- The Patient Support and Complaints Team continues to monitor response letters to ensure that all aspects of each complaint have been fully addressed – there has recently been an increase in the number of draft responses which the Patient Support and Complaints Team has queried with the Division prior to submitting for sign-off.
- Trust-level complaints data is replicated at divisional level to enable Divisions to monitor progress and identify areas where improvements are needed. This data will also be used for quarterly Divisional performance reviews.
- Response letter cover sheets are sent to Executive Directors with each letter to be signed off. This includes details of who investigated the complaint, who drafted the letter and who at senior divisional letter signed it off as ready to be sent. The Executive signing the responses can then make direct contact with these members of staff should they need to query any of the content of the response.
- Training on writing response letters has being delivered to key staff across all Divisions with input from the Patients Association. This training was well received and further training on this subject matter is being planned. A draft training plan has now been drafted and work is underway for the Patient Support & Complaints Team to roll out a series of focussed training sessions over the coming year.

4. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with the help and support including:

- Non-clinical information and advice;
- A contact point for patients who wish to feedback a compliment or general information about the Trust's services;
- Support for patients with additional support needs and their families/carers; and
- Signposting to other services and organisations.

In Q1, the team dealt with 132 such enquiries, compared to 174 in Q1. These enquiries can be categorised as:

- 79 requests for advice and information (104 in Q1)

- 46 compliments (60 in Q1)
- 7 requests for support (10 in Q1)

5. PHSO cases

During Q2, the Trust has been advised of new Parliamentary & Health Service Ombudsman (PHSO) interest in one complaint (compared to five in Q1 and seven in Q4). The new complaint is the first case listed (15125). The other two cases are ones where the Trust was initially notified of PHSO interest prior to Q2 but remain open/under investigation.

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
15125	NHS England	CP	24/02/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Not upheld: The PHSO requested details of this complaint on 06/08/2014 and advised on 24/10/2014 that they were taking no further action in respect of this complaint.						
10805	AJ	MM-L	17/05/2012	BRI	Ward 9	Surgery, Head & Neck
Open: Received PHSO's draft report on 30/09/2014. They are not upholding the complaint and the Trust has confirmed it has no comment to make. Awaiting receipt of final report.						
13987	AB	DJ	10/09/2013	BRI	QDU (Endoscopy)	Surgery, Head & Neck
Open: Further documentation sent to PHSO on 10/11/2014. Awaiting receipt of report.						

6. Corporate developments in Q2

Recruitment to the Patient Support & Complaints Team has been completed. The team now has a full complement of 7.6 (WTE) staff. The team's focus has continued to be to reduce and eliminate the backlog of complaints enquiries[6].

[6] The backlog was subsequently eliminated in November 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Council of Governors Meeting to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 7 – Governors' Log of Communications
Purpose
The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications added or modified since the previous Council of Governors meeting.
Abstract
The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.
Recommendations
The Council of Governors is asked to **note** the report.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Governor Log – Items since the previous meeting.

ID Governor Name

108 Pam Yabsley **Title: Provision in ED for patients experiencing mental health crisis**

Query **18/11/2014**

What provision does the Emergency Department have for a patient experiencing a mental health crisis?

Response **05/12/2014**

All patients with potential mental health issue (either presenting with symptoms suggestive of mental health illness – depression/psychosis/'requesting help' or self harm - overdose or deliberate self harm) have a mental health assessment matrix commenced at triage, this is then completed by the clinician seeing the patient.

Using the matrix we are able to assess a patient's risk into 3 categories – red, amber or green.

Patients with medical issues in addition to mental health problems – overdose or self injury – will have those conditions attended to in parallel to psychiatry assessment, this sometimes involves intravenous infusion (parvolex if serum paracetamol levels are high) and overnight stay on the ED observation ward.

Between the hours of 0800-2100 (7 days a week) we have access to the liaison psychiatry team - who will review all patients presenting with a psychiatric component. Liaison psychiatry work with the secondary mental health services to arrange follow up if needed

All patients can be given a 'services to help you' book outlining local services including social and psychological interventions

Out of hours – the patient is risk stratified using the matrix and depending on perceived risk

If the patient is high risk (red on the matrix), they are referred to the psychiatry SHO and crisis team, there is sometimes a significant delay in assessment by the AWP team

If the patient is moderate risk (amber on the matrix) they are admitted to the ED observation ward to wait for assessment by the liaison psychiatry team

If the patient is green on the matrix (low risk) the patient can be offered an outpatient appointment to see the liaison psychiatry team during the weekdays Monday to Friday.

Status *Closed*

107 Clive Hamilton **Title: Staff turnover - supplementary question to Item 104**

Query **29/10/2014**

Supplementary question to Item 104:

I appreciate that exit interview information could be key to understanding the issues precipitating a resignation but that such information is not always obtained or might conceal the real reason. Is there any merit in a follow-up contact with the ex employee say 1 to 3 months after departure to offer re-employment (if available and suitable) and/or a fuller discussion relating to comparable conditions of employment. I am particularly concerned about the increasing presence of the healthcare independent sector and the loss of staff to that employment pool and the possibility that trained clinical staff may be able to obtain better conditions of employment in that sector which, I understand, is not subject to the same pay restraint as the public sector. This is particularly relevant as a consequence of the recent non-approval of the NHS independent pay review recommendation of 1% across the board pay increase. Is there any benchmark data for independent sector remuneration and conditions of service?

Clive Hamilton 29th October 2014.

Response **28/11/2014**

1. Is there any merit in a follow-up contact with the ex employee say 1 to 3 months after departure to offer re-employment (if available and suitable) and/or a fuller discussion relating to comparable conditions of employment.

We are currently undertaking a comprehensive review of the way we collect data to better understand the key reasons for staff leaving the Trust. As part of that we will consider the helpful suggestion of contacting staff three months after they have left. At present we are focussing on contacting staff before they leave, including asking, where appropriate what might influence them to stay.

As you may be aware, we do not have the flexibility to offer comparable remuneration packages to the private sector because the Trust`s terms and conditions of employment are determined at a national level. However, we are currently reviewing how we market our terms and conditions because there are a number of benefits where we compare more favourably than the private sector. We are also ensuring that where we have some flexibility on more localised benefits, such as health and wellbeing, training, etc. we invest in areas that staff value.

2. Is there any benchmark data for independent sector remuneration and conditions of service?

There are remuneration surveys which can be purchased. Hourly pay rates can be higher in the private sector, but this is typically offset by better terms and conditions offered in the NHS. These include pensions, sick pay, maternity allowance, and annual leave. The rationale behind providing our staff with their personal "total reward statement", which is newly available to all staff in the NHS nationally, is to ensure they are aware of the total benefits package which we provide, not just the pay rate.

Status *Closed*

ID Governor Name

106 Clive Hamilton **Title: Safe Staffing Levels**

Query 17/10/2014

The Trust's expected and actual staffing levels for August are displayed on the Trust's web pages at:
http://www.uhbristol.nhs.uk/media/2234372/august_pdf.pdf
The revised format with a comments column is much appreciated as it explains maybe higher than expected shortfalls.
To what if any extent are clinicians engaged in surgical procedures, diagnostic procedures, pharmacy and outpatient clinics covered by this table?
Does the table include all Trust ward locations?
Is there merit in producing a total for all Actual Hours versus all Expected Hours to give a general assessment of safe staffing levels?

Do the Non-Executive Directors have assurance that the August shortfall of expected levels on wards 71-74 at St. Michaels Hospital amounting to a deficit of 1142 hours (22.7%) was adequately covered and the reasons fully assessed for remedial action.

Clive Hamilton 16th October 2014.

Response 24/10/2014

Response from Helen Morgan, Deputy Chief Nurse:

All Trusts were required to publish actual and planned staffing fill rates from June 2014. This requirement currently only applies to inpatient wards, it excludes day care wards, central delivery units and extra capacity wards. The data captures actual versus planned fill rates on a shift by shift basis for registered nurses, midwives, assistant practitioners, nursing and midwifery assistants. We are not currently required to capture any other groups of staff. The table includes all areas we are required publish data on.

Whilst the total actual versus planned gives a general overview of the Trust position, it is the data on a ward by ward basis which is proving of most value to Sisters and Divisional teams.

71/74 is one ward caring for both pre and post natal women. Staff work flexibly across all the maternity wards and are moved if required following a risk assessment. The acuity of the women together with the number of beds open at any one time is always considered. Capturing the change in the numbers of beds open together with the acuity of patients is one of the data capture challenges, but one which we are continuing to explore.

Status *Closed*

105 Bob Bennett **Title: Patients' problems with appointments at BRI**

Query 15/10/2014

(Reworded by Trust Secretariat by agreement with Bob Bennett) Anecdotal evidence was provided regarding negative patient experience at the Pain Clinic, BRI. Mr Bennett's query related particularly to the appointment process, including non-recording of appointments and staff attitude, resulting in distress and confusion for the patient. Mr Bennett queried whether there was an underlying issue in terms of the reliability of the appointments process, or whether there was a need to review support and training for staff.

Response 24/10/2014

The specific details were submitted to the Patient Support and Complaints Team and have been reviewed. Unfortunately, due to the lack of detail with regard to these incidents, it is not possible to investigate these issues. However, patients can be directed to the Patient Support and Complaints Team should they wish to make a formal complaint. The concerns expressed have also been forwarded to Jenny Holly, Assistant General Manager for the Pain Service.

In the meantime, following initial review, it has been confirmed that there have been no underlying issues identified with regard to the appointments process, and clarification has been provided that all appointments are booked onto the electronic booking system for the area in question. The Trust has in place a robust Induction and comprehensive mandatory training programme, which include Trust Values and Conflict Resolution training. Mandatory training for all staff is delivered every three years to ensure all staff are refreshed on the key messages on a regular basis.

Status *Closed*

ID	Governor Name		
104	**Clive Hamilton**	**Title:**	**Workforce statistics - staff turnover**

Query **14/10/2014**

Origin - page 79 of Public Trust Board pack September 2014 (Workforce Statistics report)
Rolling turnover of staff is stated as 12.9% in August compared to 12.1% in the previous month. The September Board report for 2010 indicates that staff turnover was 7.7%. Taking the data from successive board reports for September since 2010 the following trend emerges:
2010 ..... 7.7%
2011 ..... 8.5%
2012 ..... 10.8%
2013 ..... 11.6%
On page 79 of the September board report (which relates to data from August) it is noted that the staff turnover rate for University Hospitals Bristol is significantly above the national average rate of 9.5% and that the Trust has therefore set a target of reduction to 10.6% but also mentions a target of 10% by the end of 2014/15; which is correct?
Do the Non-Executive Directors accept the lack of ambition represented by this target in view of the national average and is there assurance that an improved target less than the national average should be the aim?
Clive Hamilton 14th October 2014.

Response **28/10/2014**

Response from Sue Donaldson, Director of Workforce and Organisational Development:

Firstly it might be helpful to explain how the KPI is set and why we report two figures as set out on page 79. Through the Divisional Operating plan processes, Divisions set a target for each KPI, and this is used to inform the Trust target for the year. In order to monitor the trajectory to the end point, a target is set for each month. The target for August was 10.6%, but the target to be achieved for the end of the year was 10%. This reflects the fact that turnover is a rolling cumulative figure, and therefore 11/12s of the monthly out turn have already been determined (because it is based on the previous 12 months).

We recognise historically our turnover has been increasing and appears much higher than other comparable trust. This is why we have set an ambitious target for reduction, with the full support of the Board.

We have comprehensive programmes in place to improve retention which have been described in our Board papers. These are largely in the context of improving staff experience and engagement, although considerable focus is also on developing a better understanding of why our staff are leaving . An update on this work is due in the Quarterly Workforce and OD Report coming to the board in November. Interestingly as part of this work we are refreshing our benchmarking and it looks as though other trusts are experiencing an upward trend in the number of staff leaving.

Status *Closed*

103	**Clive Hamilton**	**Title:**	**Workforce statistics - staff shortfall**

Query **14/10/2014**

Origin - pages 73-75 of Public Trust Board pack September 2014 (Workforce report)

I need some clarification and assurance regarding the figures quoted at pages 73 to 75 of the September 2014 Board Report.
1. I understand that the trust had a shortfall of 430 full time equivalent staff in August (5.56%); is this correct?
2. On page 75 the August 2013 bank and agency usage is quoted as 474.1 full time equivalents. On page 73 the number of bank and agency staff full time equivalents for August 2014 is quoted as 570.8. This is a 20.4% increase.

Have the Non-Executive Directors assurance that the Trust is sufficiently engaged in programmes to recruit replacement staff, retaining existing staff and forward planning to cope with any shortfalls due to known retirement numbers? Is there assurance that the Mutually Agreed Resignation and unpaid leave Schemes do not have an adverse effect on 1 and 2 above.
Clive Hamilton 14th October 2014.

Response **03/11/2014**

Revised response received from Director of Workforce and Organisational Development on 3/11/14:

1. I understand that the trust had a shortfall of 430 full time equivalent staff in August (5.56%); is this correct?
Response: The vacancy rate reported in August was 5.56%, 430 WTE. To qualify this, vacancies reported in our Board reports are the gap between the budgeted establishment and the substantively employed staff. This is different to a “shortfall” because where necessary, vacancies would be covered by bank and agency to ensure that there is no impact on patient care.

2. On page 75 the August 2013 bank and agency usage is quoted as 474.1 full time equivalents. On page 73 the number of bank and agency staff full time equivalents for August 2014 is quoted as 570.8. This is a 20.4% increase.
Response: We recognise that year on year, our use of temporary staff has increased. This is due to additional capacity and other factors, including higher turnover and vacancy rates. Some temporary staff usage will always be required and, when used appropriately, can be a cost effective way of flexing our workforce to cover peaks and troughs of demand. However, we are concerned about the cost of agency staff and there are plans in place to reduce this.

3. Is there assurance that the Mutually Agreed Resignation and unpaid leave Schemes do not have an adverse effect on 1 and 2 above.
Response: Any application under MARS or for unpaid leave schemes must demonstrate that they would be in the financial and operational interests of UH Bristol.

Status *Closed*

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Council of Governors Meeting to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 8 – Foundation Trust Constitution

Purpose

To receive and **approve** revisions to University Hospitals Bristol NHS Foundation Trust's Constitution, Standing Orders, Code of Conduct for Governors and Role Description for Governors.

Abstract

The Foundation Trust Constitution has been under review during 2014 and input has been received from both the Council of Governors and the Trust Board of Directors.

The suggested amendments have been reviewed and have now been incorporated into a revised version of the Foundation Trust Constitution. This revised version also includes amendments made to ensure consistency and alignment with Monitor's Model Core Constitution for NHS Foundation Trusts. They also include New Model Election Rules which allow Foundation Trusts to offer electronic voting in governor elections for the first time.

At a meeting of the Constitution Project Focus Group on 4 December 2014, governors considered and recommended the revised constitution for approval by the Council of Governors.

Recommendations

The Council of Governors is asked to consider the following for **approval**:

a) Revised Foundation Trust Constitution (including new model election rules and Standing Orders)
b) Revised Code of Conduct for Governors
c) Role Description for Governors

Report Sponsor or Other Author

Sponsor: Chairman

Author: Trust Secretary

Appendices

Appendix A - Revised Foundation Trust Constitution (including new model election rules). Also includes the Revised Code of Conduct for Governors and Role Description for Governors.

University Hospitals Bristol NHS Foundation Trust

Draft Constitution

[as at 29 January 2015]

University Hospitals Bristol NHS Foundation Trust Constitution

---

TABLE OF CONTENTS

Paragraph

1. **Interpretation and definitions**

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act.

1.2 Words importing the masculine gender only shall include the feminine gender, words importing the singular shall import the plural and vice-versa.

1.3 References to statutory provisions shall be construed as references to those provisions as subsequently amended or re-enacted (whether before or after the date of this Agreement) from time to time and shall include any provisions of which they are re-enactments (whether with or without modification).

1.4 The following expressions have the following meanings, unless the context requires otherwise—

"the 2006 Act"	is the National Health Service Act 2006 (as amended by the 2012 Act).
"the 2012 Act"	is the Health and Social Care Act 2012.
"Accounting Officer"	is 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"	means an annual meeting of the Members.
"constitution"	means this constitution and all annexes to it.
"Director"	means a member of the Board of Directors of the Trust.
"Governor"	means a member of the Council of Governors of the Trust.
"health service body"	means an NHS foundation trust or any of the bodies listed in Section 9(4) of the 2006 Act.
"Member"	means a member of the Trust.
"Monitor"	is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.
"voluntary organisation"	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2. **Name**

2.1 The name of the foundation trust is University Hospitals Bristol NHS Foundation Trust (the Trust).

3. **Principal purpose**

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

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health

service in England is greater than its total income from the provision of goods and services for any other purposes.

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

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

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph, 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,

5.1.2 the Staff Constituency, or

5.1.3 the Patients and Carers Constituency

6. **Application for Membership**

6.1 An individual who is eligible to become a Member may do so on application to the Trust or by being invited by the Trust to become a Member of the Staff Constituency in accordance with paragraph 9.

6.2 An individual shall become a Member on the date his name is added to the Trust's register of Members, and shall cease to be a Member on the date is removed from the register of Members.

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.

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

7.3 An individual who ceases to live in any area specified in Annex 1 shall cease to be a Member of any Public Constituency. A Member who moves from one area to another shall become a Member of the Public Constituency for that new area. Members should notify the Trust of any change of address.

7.4 In the case of any doubt, the Trust's decision as to whether or not an individual lives in an area will be final.

7.5 The minimum number of Members for 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 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 if they have exercised these functions continuously for a period of at least 12 months. This category includes (but is not limited to) —

8.2.1 contractors who provide services to the Trust for at least 16 hours per week or 50% of their contracted hours (whichever is the lesser),

8.2.2 registered volunteers at the Trust or individuals who work at the Trust on behalf of a voluntary organisation, and

8.2.3 academic staff who have an honorary contract with the Trust and who work at the Trust

8.3 Those individuals who are eligible for membership by reason of this paragraph 8 are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into four 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 Staff Class within the Staff Constituency.

8.5 The minimum number of Members in each Staff Class is specified in Annex 2.

9. **Automatic membership by default – staff**

9.1 An individual who is—

9.1.1 Eligible under paragraph 8.1 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 Staff Class,

shall become a Member as a Member of the Staff Constituency and appropriate Staff Class without an application being made, unless he informs the Trust that he does not wish to do so.

10. **Patients and Carers Constituency**

10.1 An individual who has, within the preceding three years, attended any of the Trust's hospitals as either a patient or as the carer of a patient may become or continue as a Member.

10.2 Those individuals who are eligible for membership by reason of paragraph 10.1 are referred to collectively as the Patients and Carers Constituency.

10.3 An individual who has not attended any of the Trust's hospitals in the preceding three years as a patient or carer may not continue as a Member of the Patients and Carers Constituency.

10.4 The Patients and Carers Constituency shall be divided into three descriptions of individuals who are eligible for membership of the Patients and Carers Constituency. Each description of individuals is specified within Annex 3 and is referred to as a class of the Patients and Carers Constituency.

10.5 An individual providing care under a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Patients and Carers Constituency.

10.6 The minimum number of Members in each class of the Patients and Carers Constituency is specified in Annex 3.

10.7 An applicant for membership who notifies the Trust of his eligibility to be a Member of either a Public Constituency or of the Patients and Carers Constituency, shall become a Member of the appropriate class of the Patients and Carers Constituency unless he has informed the Trust in writing that he wishes instead to become a Member of a Public Constituency.

11. **Restriction on membership**

11.1 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.

11.2 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.

11.3 An individual shall not be eligible for membership if he—

11.3.1 fails or ceases to fulfil the criteria for membership of any of the constituencies,

11.3.2 was formerly employed by the Trust or its predecessor applicant NHS Trust and was dismissed for gross misconduct,

11.3.3 was formerly employed by the Trust and in the preceding two years was lawfully dismissed other than by reason of redundancy,

11.3.4 has been involved as a perpetrator in a serious incident of violence or abuse in the last five years at any of the Trust's hospitals or against any of the Trust's staff members or patients,

11.3.5 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children & Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974,

11.3.6 does not agree to, or by his actions or conduct shows that he does not (in the reasonable opinion of the Trust), abide by the Trust values as set out in the Trust's Integrated Business Plan or elsewhere,

11.3.7 has been identified as a vexatious complainant by the Trust or other authority or has been excluded from treatment at any of the Trust's hospitals due to unacceptable behaviour,

11.3.8 is deemed, in the reasonable opinion of the Trust, to have acted in a manner contrary to the interests of the Trust,

11.3.9 is deemed, in the reasonable opinion of the Trust, to have failed to comply in a material way with the values and principles of the National

Health Service or the Trust, and/or this constitution, or

11.3.10 is under the age of seven (7) years.

11.4 Members should ensure their own eligibility for membership and inform the Trust if they cease to be eligible.

11.5 A Member shall cease to be a Member if—

11.5.1 he resigns by notice in writing to the Membership Manager,

11.5.2 he dies,

11.5.3 he ceases to be entitled under this constitution to be a Member,

11.5.4 he is expelled under this constitution, or

11.5.5 it appears to the Membership Manager that the Member no longer wishes to be involved in the affairs of the Trust as a Member, and after enquiries made in accordance with a process approved by the Governors, the Member does not establish that he has a continuing wish to be involved in the affairs of the Trust as a Member.

11.6 The Trust shall give any Member at least 14 days' written notice before removing him from Membership under paragraphs 11.5.3, 11.5.4, or 11.5.5. The Trust shall consider any representations made by the Member during that notice period.

12. Annual Members' Meeting

12.1 The Trust shall hold an Annual Members' Meeting no later than 30 September every year. The Annual Members' Meeting shall be open to the public.

12.2 Any Members' meetings other than the Annual Members' Meeting shall be called "Special Members' Meetings".

12.3 Special Members' Meetings shall be open to all Members, Governors and Directors, and to representatives of the Trust's financial auditors. Special Members' Meetings shall not be open to anyone else unless invited by the Trust.

12.4 All Members' meetings are to be convened by the Directors.

12.5 The Directors shall decide where any Members' meeting is to be held and may provide that the same meeting can be conducted in multiple venues.

12.6 The Directors shall set the quorum for any Members' meeting.

12.7 The Trust shall give at least 14 clear days' notice of any Members' meeting—

12.7.1 by notice in writing to all Members (by email where email addresses are held),

12.7.2 by notice prominently displayed at the Trust's main address and at all of the Trust's principal places of business,

12.7.3 by notice on the Trust's website, and

12.7.4 to the Governors and the Directors, and to the Trust's auditors,

stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting, giving the time, date and place of the meeting and indicating the business to be dealt with at the meeting.

12.8 The Directors shall present to the Members at the Annual Members' Meeting—

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

12.8.2 the progress of the membership strategy,

12.8.3 any proposed changes to the policy for the composition of the Governors and of the Non-Executive Directors,

12.8.4 the results of the election and appointment of Governors, and

12.8.5 any other reports or documentation it considers necessary or otherwise required by Monitor or the 2006 Act, including the annual accounts, any report of the auditor and the annual report.

12.9 The Chair or in his absence the Deputy Chair shall chair any Members' meetings. If neither the Chair nor the Deputy Chair is present, the Governors present shall elect one of their number to chair the meeting. If there is only one Governor present and willing to act that person shall chair the meeting. If no Governor is present and willing to chair the meeting within fifteen minutes after the notified start time of the meeting, the Members present and entitled to vote shall choose one of their number to chair the meeting.

13. Council of Governors – composition

13.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

13.2 The composition of the Council of Governors is specified in Annex 4.

13.3 The 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.

13.4 The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13.5 At all times more than half of the Governors shall be Governors who are elected by Members of the Public Constituency and the Patients and Carers Constituency.

14. Council of Governors – election of Governors

14.1 Elections for elected Governors shall be conducted in accordance with the Model Election Rules.

14.2 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 the Trust's Authorisation are attached at Annex 5.

14.3 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 45 of the constitution (amendment of the constitution).

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

14.5 A Member of a Public Constituency or the Patients and Carers Constituency standing for election as Governor must, at the time of his nomination, make a declaration for the purposes of Section 60 of the 2006 Act in the form specified by the Trust, stating the particulars of his qualification to vote as a Member and that he is not prevented from being a Governor by virtue of any provisions of this constitution.

15. **Council of Governors - tenure**

15.1 An elected Governor may hold office for a period of up to three years.

15.2 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 (except that a Public Governor who moves from one Public Constituency to another during his term of office shall continue in office as a Public Governor for the constituency which elected him for the remainder of his term).

15.3 Subject to paragraph 15.7, an elected Governor shall be eligible for re-election at the end of his term.

15.4 An appointed Governor may hold office for a period of up to three years (except for Governors appointed by the Trust's Youth Council who may hold office for a period of up to one year).

15.5 An appointed Governor shall cease to hold office if the appointing organisation withdraws his appointment.

15.6 Subject to paragraph 15.7, an appointed Governor shall be eligible for re-appointment at the end of his term.

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

16. **Council of Governors – disqualification and removal**

16.1 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

16.2 A person may not become or continue as a Governor if he—

16.2.1 has been adjudged bankrupt or his estate has been sequestrated and (in either case) has not been discharged,

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

16.2.3 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,

16.2.4 has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body,

16.2.5 was formerly employed by the Trust or its predecessor application NHS trust and was dismissed for gross misconduct,

16.2.6 is a person whose term of office as the chair or as a member or director of a Health Service Body has been terminated on the grounds that his continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest,

16.2.7 has had his name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had his name included in such a list,

16.2.8 has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which he had a direct or indirect pecuniary or

non-pecuniary interest and he is judged to have acted so by a majority of of the Council of Governors,

16.2.9 has been removed as a Governor, suspended from office or disqualified from holding office as a Governor by Monitor, or Monitor has exercised any of those powers in relation to him on any other occasion whether in relation to the Trust or some other NHS Foundation Trust,

16.2.10 has received a written warning from the Trust for verbal and/or physical abuse towards Trust staff or patients,

16.2.11 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended) and his conviction is not spent under the Rehabilitation of Offenders Act 1974,

16.2.12 is a Member of a Staff Class and any professional registration relevant to his eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six months,

16.2.13 is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs,

16.2.14 is appointed by an organisation that ceases to exist,

16.2.15 is a member of the UK Parliament,

16.2.16 is a director or a governor of another NHS Foundation Trust,

16.2.17 is a member of a health related local authority overview and scrutiny committee, or

16.2.18 information revealed by a DBS check is such that it would be inappropriate for him to become or continue as a Governor on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

16.3 A Governor who becomes disqualified must notify the Trust as soon as practicable and in any event within 14 days of first becoming aware that he is disqualified.

16.4 If the Trust becomes aware that a Governor is disqualified, the Trust will give him notice that he is disqualified as soon as practicable.

17. Council of Governors: Termination of Tenure

17.1 A Governor's term of office shall be terminated—

17.1.1 by the Governor giving notice in writing to the Trust of his resignation from office at any time during that term of office,

17.1.2 by the giving of a notice under either paragraph 16.3 or 16.4,

17.1.3 by the Council of Governors if he has failed to attend two successive meetings of the Council of Governors unless the Council of Governors is satisfied:

17.1.3.1 the absence was due to reasonable cause, and

17.1.3.2 that the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

17.1.4 if the Council of Governors resolves that—

17.1.4.1 his continuing as a Governor would or would be likely to prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this constitution or otherwise to discharge its duties and functions,

17.1.4.2 his continuing as a Governor would or would be likely to prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services,

17.1.4.3 his continuing as a Governor would or would be likely to adversely affect public confidence in the goods and services provided by the Trust,

17.1.4.4 his continuing as a Governor would or would be likely to otherwise bring the Trust into disrepute or be detrimental to the interest of the Trust,

17.1.4.5 it would not be in the best interests of the Council of Governors for him to continue in office as a Governor,

17.1.4.6 it would not be in the best interests of the Trust for him to continue in office as a Governor,

17.1.4.7 he is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and his continuance in office would not be in the best interests of the Trust,

17.1.4.8 he has failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required him to undertake in his capacity as a Governor,

17.1.4.9 he has in his conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust, and/ or this constitution, or

17.1.4.10 he has committed a material breach of any code of conduct applicable to Governors and/or the Standing Orders for Governors.

17.2 A resolution under paragraph 17.1.4 shall be proposed by the Chair (or in his absence, the Deputy Chair) and considered in a meeting of the Council of Governors convened for that purpose and to pass requires a majority of three quarters of the Governors voting at that meeting.

17.3 If the Chair is minded to propose a resolution under paragraph 17.1.4, the Chair shall first offer the Governor in question the opportunity to have the evidence reviewed by an independent assessor agreeable to that Governor and to the Chair.

17.4 The Standing Orders adopted by the Council of Governors may contain provisions governing its procedure for terminating a Governor's term of office.

17.5 A Governor whose term of office is terminated before it expires shall not be eligible to be a Governor for three years from the date of termination, except by resolution carried by a majority of the Council of Governors voting.

18. Council of Governors: vacancies

18.1 If an appointed Governor's term of office is terminated before it expires, the Trust will invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office.

18.2 If an elected Governor's term of office is terminated [more than 90 days before it] before it expires, the Trust will invite the candidate who secured the second highest number of votes in the last election for that office to assume the position for the remainder of the retiring Governor's term, provided that he achieved at least five percent (5%) of the number of votes for that constituency (or class of constituency, as the case may be). If that candidate does not accept, the vacancy will be offered to the candidate who secured the next highest number of votes (provided that he achieved at least five percent (5%) of the number of votes), and so on.

18.3 If no reserve candidate is available or willing to fill the vacancy, and an election is not due to be held within 6 months of the vacancy arising, an election will be held in accordance with the Election Scheme as soon as is reasonably practicable. If an election is due to be held within 6 months, the office will stand vacant until the next scheduled election, unless the vacancy causes the aggregate number of Public Governors and Patient and Carer Governors to be less than half the total membership of the Council of Governors. In that case an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

18.4 No defect in the election or appointment of a Governor or deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

19. Council of Governors – duties of Governors

19.1 The general duties of the Council of Governors are—

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

19.1.2 to represent the interests of the Members as a whole and the interests of the public.

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

20. Council of Governors – meetings of Governors

20.1 The Chair or, in his absence the Deputy Chair, shall preside at meetings of the Council of Governors.

20.2 Meetings of the Council of Governors shall be open to members of the public, unless members of the public are excluded for special reasons.

20.3 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 of the Council of Governors.

21. Council of Governors – standing orders

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

22. Council of Governors – referral to the Panel

22.1 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—

22.1.1 to act in accordance with its Constitution, or

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

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

23. **Council of Governors – conflicts of interest of Governors**

23.1 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 Governors as soon as he becomes aware of it.

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

24. **Council of Governors – travel expenses**

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

25. **Board of Directors – composition**

25.1 The Trust has a Board of Directors, which comprises both Executive and Non-Executive Directors.

25.2 The Board of Directors comprises—

25.2.1 a Non-Executive Chairman,

25.2.2 up to 8 other Non-Executive Directors (one of whom may be nominated as the Senior Independent Director), and

25.2.3 up to 7 Executive Directors.

25.3 One of the Executive Directors is the Chief Executive.

25.4 The Chief Executive is the Accounting Officer

25.5 One of the Executive Directors is the Finance Director

25.6 One of the Executive Directors is a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)

25.7 One of the Executive Directors is a registered nurse or a registered midwife

25.8 The Board of Directors shall at all times be constituted so that the number of Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

26. **Board of Directors – general duty**

26.1 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 as a whole and for the public.

27. **Board of Directors – qualification for appointment as a Non-Executive Director**

27.1 A person may be appointed as a Non-Executive Director only if—

27.1.1 he is a Member of a Public Constituency, or

27.1.2 he is a Member of the Patients and Carers Constituency, or

27.1.3 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

27.1.4 he is not disqualified by virtue of paragraph 31 below.

28. **Board of Directors – appointment and removal of the Chair and other Non-Executive Directors**

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors.

28.2 Removal of the Chair or another Non-Executive Director shall require the approval of at least three-quarters of the Council of Governors.

29. **Board of Directors – appointment of the Deputy Chair**

29.1 The Council of Governors at a general meeting shall appoint one of the Non-Executive Directors to be the Deputy Chair.

30. **Board of Directors - appointment and removal of the Chief Executive and other Executive Directors**

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

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

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

31. **Board of Directors – disqualification**

31.1 A person may not become or continue as a Director if he—

31.1.1 has been adjudged bankrupt or his estate has been sequestrated and (in either case) has not been discharged,

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

31.1.3 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,

31.1.4 in the case of a Non-Executive Director, no longer satisfies the relevant requirements for appointment,

31.1.5 is a person whose tenure of office as a Chair or as a member or Director of a Health Service Body has been terminated on the grounds that his appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest,

31.1.6 has within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body,

31.1.7 information revealed by a DBS check is such that it would be

inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute,

31.1.8 in the case of an Executive Director, is no longer employed by the Trust,

31.1.9 has had his name removed by a Direction under section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and has not subsequently had his name included on such a list,

31.1.10 is an Executive or Non-Executive Director of another NHS Foundation Trust, or Non-Executive Director, Chair, Chief Executive officer or equivalent of another Health Service Body or a body corporate whose business includes the provision of healthcare,

31.1.11 is a member of a patient and public involvement forum,

31.1.12 is a member of a local authority's overview and scrutiny committee,

31.1.13 is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986,

31.1.14 has failed or refused to undertake any training which the Board of Directors requires all Directors to undertake,

31.1.15 has failed to sign and deliver to the Secretary in the form required by the Board of Directors confirmation that he accepts the Code of Conduct of NHS Managers,

31.1.16 is a partner or spouse of an existing Director,

31.1.17 is an 'unfit person' as defined in the Trust's provider licence (as may be amended from time to time), or

31.1.18 does not meet any other statutory requirement for being a Director of an NHS foundation trust.

32. Board of Directors – meetings

32.1 Meetings of the Board of Directors shall be open to members of the public, unless members of the public are excluded for special reasons.

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

33. Board of Directors – standing orders

33.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 7.

34. Board of Directors - conflicts of interest of Directors

34.1 The duties that a Director has by virtue of being a Director include in particular—

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

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

34.2 The duty referred to in sub-paragraph 34.1.1 is not infringed if—

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

34.2.2 the matter has been authorised in accordance with the constitution.

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

34.4 In sub-paragraph 34.1.2, "third party" means a person other than—

34.4.1 the Trust, or

34.4.2 a person acting on its behalf.

34.5 If a Director 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.

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

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

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

34.9 A Director need not declare an interest—

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

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

34.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered—

34.9.3.1 by a meeting of the Board of Directors, or

34.9.3.2 by a committee of the Directors appointed for the purpose under the constitution.

34.10 The Standing Orders of the Board of Directors shall include provisions about the disclosure of interests and arrangements for a Director with an interest to withdraw from a meeting in relation to the matter in respect of which he has declared an interest.

35. **Board of Directors – remuneration and terms of office**

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

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

36. **Registers**

36.1 The Trust shall have—

36.1.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs,

36.1.2 a register of Governors,

36.1.3 a register of interests of Governors,

36.1.4 a register of Directors, and

36.1.5 a register of interests of Directors.

37. **Registers – inspection and copies**

37.1 The Trust shall make the registers specified in paragraph 366 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of—

37.2.1 any Member of the Public, Patients and Carers Constituency, or

37.2.2 any other Member, if he so requests.

37.3 So far as the registers are required to be made available—

37.3.1 they are to be available for inspection free of charge at all reasonable times, and

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

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

38. **Documents available for public inspection**

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

38.1.1 a copy of the current Constitution,

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 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—

38.2.1 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,

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

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

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

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

38.2.6 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,

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

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

38.2.9 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,

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

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

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

39. Auditor

39.1 The Trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor by a majority vote at a general meeting of the Council of Governors.

40. Audit committee

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

41. Accounts

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

41.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

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

41.4 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.

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

42. **Annual report, forward plans and non-NHS work**

42.1 The Trust shall prepare an annual report and send it to Monitor.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

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

42.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about—

42.5.1 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

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must—

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the Directors of its determination.

42.7 If the Trust 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, the Trust may implement the proposal only if more than half of the Governors voting approve its implementation.

43. **Presentation of the annual accounts and reports to the Governors and Members**

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors—

43.1.1 the annual accounts,

43.1.2 any report of the auditor on them, and

43.1.3 the annual report.

43.2 The documents shall also be presented to the Members at the Annual Members' Meeting by at least one Director in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. **Instruments**

44.1 The Trust shall have a seal.

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

45. **Amendment of the Constitution**

45.1 The Trust may make amendments of its Constitution only if—

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

45.1.2 more than half of the Directors voting approve the amendments.

45.2 Amendments made under paragraph 45.1 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.

45.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)—

45.3.1 at least one Governor must attend the next Annual Members' Meeting and present the amendment,

45.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment, and

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

45.4 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.

46. Mergers etc. and significant transactions

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

46.2 The Trust may enter into a significant transaction only if more than half of the Council of Governors voting approve entering into the significant transaction.

46.3 Significant transaction is defined as investments, divestments or other transactions comprising more than 25% of the assets, income or capital of the NHS Foundation Trust, in line with Monitor's Risk Assessment Framework.

47. Indemnity

47.1 Governors and Directors 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 Board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Litigation Authority to cover such costs.

ANNEX 1

THE PUBLIC CONSTITUENCIES

The Public Constituencies	**Area of each Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**
Bristol	Bristol City Council	2163
North Somerset	North Somerset District Council	1022
South Gloucestershire	South Gloucestershire Council	1331
Rest of England and Wales	Rest of England and Wales	5

The minimum number of members is based on 0.5% of the population in each Public Constituency as reported in the ONS 2012 based sub-national population data:

Rest of England and Wales – fixed value at 5 members

ANNEX 2

THE STAFF CONSTITUENCY

Classes within the Staff Constituency	**Individuals Eligible for Membership of that Staff Class**	**Minimum Number of Members in each Staff Class**
Medical and Dental Staff	Those individuals defined in paragraph 1 below.	628
Nursing and Midwifery Staff	Those individuals defined in paragraph 2 below.	2372
[Other Clinical Healthcare Staff]	Those individuals defined in paragraph 3 below.	1023
[Non-Clinical Healthcare Staff]	Those individuals defined in paragraph 4 below.	1882

The minimum number of members is based on 75% of the headcount the workforce in each Staff Constituency as at December 2014.

1. **Medical and Dental Staff**

1.1 Members of the Staff Constituency who are fully registered persons within the meaning of the Medical Act 1983 or the Dentists Act 1984 and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist.

2. **Nursing and Midwifery Staff**

2.1 Members of the Staff Constituency who are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants.

3. **Other Clinical Healthcare Staff**

3.1 Members of the Staff Constituency who do not come within paragraphs 1 or 2 above and are regulated by a regulatory body that falls within the remit of the Professional Standards Authority for Health and Social Care established by the NHS Reform Act 2002 (as amended by the 2012 Act), or who are otherwise designated by the Trust from time to time as eligible Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on such professions.

4. **Non-Clinical Staff**

4.1 Members of the Staff Constituency, who do not come within paragraphs 1, 2 or 3 above and are designated by the Trust from time to time as eligible to be a

Member of this Staff Class.

5. **Honorary contract holders**

5.1 Those individuals who are Members of the Staff Constituency pursuant to paragraph 8.2.3 of this constitution (academic staff under an honorary contract with the Trust) shall be members of a Staff Class detailed in paragraphs 1, 2 and 3 above as appropriate.

6. **Continuous Employment**

6.1 For the purposes of paragraph 8.1.2 and 8.2 of this constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

7. **Exercise of Functions**

7.1 For the purposes of paragraph 8.2 of this constitution it shall be for the Trust in its absolute discretion to determine whether an individual exercises functions for the purposes of the Trust and whether that individual has done so continuously for a period of at least twelve months.

ANNEX 3

THE PATIENTS AND CARERS CONSTITUENCY

Classes within the Patients and Carers Constituency	**Individuals eligible for Membership of each Class**	**Minimum Number of Members in each Class**
Local Patients	Patients residing in any of the Bristol, North Somerset or South Gloucestershire Public Constituencies	100
Carers of Adult Patients	Carers who provide care to patients who are 16 years of age or over	50
Carers of Child Patients	Carers who provide care to patients who are under 16 years of age	50

ANNEX 4

COMPOSITION OF COUNCIL OF GOVERNORS

	Electing/Appointing Body	**Number of Governors**	**Total**
1.	**Public Constituencies**		
	Bristol	5	
	South Gloucestershire	2	
	North Somerset	2	
	Rest of England and Wales	2	**11**
2.	**Staff Constituency**		
	Medical and Dental Staff Class	1	
	Nursing and Midwifery Staff Class	2	
	Other Clinical Healthcare Staff Class	1	
	Non-Clinical Healthcare Staff Class	2	**6**
3.	**Patients and Carers Constituency**		
	Carers of Adult Patients	2	
	Carers of Child Patients	2	
	Local Patients	6	**10**
4.	**Appointed Governors**		
	Local Authority		
	Bristol City Council	1	
	Universities		
	University of Bristol	1	
	University of West of England	1	
	Partnership Organisations		
	Avon and Wiltshire Mental Health Partnership NHS Trust	1	
	South Western Ambulance Service NHS Foundation Trust	1	

	Joint Union Committee	1	
	Community and Voluntary Sector	1	
	University Hospitals Bristol NHS Foundation Trust Youth Council	2	**9**
	Total Number of Governors		**36**

1. **Appointed Governors**

1.1 Each appointing body shall be entitled to appoint a Governor or Governors (as set out in the table above) in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not prevent an appointing body from appointing it Governor(s).

1.2 If Bristol City Council declines or fails to appoint a Governor within three months of being requested to do so by the Trust, the Trust shall consult North Somerset District Council and South Gloucestershire Council and the Trust shall invite one of those local authorities to appoint a Governor in substitution for Bristol City Council.

1.3 At the end of the term of appointment of that Governor the Trust shall in its absolute discretion decide whether to permit Bristol City Council to appoint a Governor for the next period of office (provided it remains eligible to do so) or to invite the local authority which had appointed a Governor in substitution to do so.

ANNEX 5

THE MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

PART 2: TIMETABLE FOR ELECTION

PART 3: RETURNING OFFICER

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

PART 5: CONTESTED ELECTIONS

Action to be taken before the poll

The poll

PART 12: MISCELLANEOUS

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

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

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

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

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

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

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

votes by telephone;

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

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

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

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

2. Timetable

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

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

3. Computation of time

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

(a) a Saturday or Sunday;

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

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

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

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

4. Returning Officer

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

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

5. Staff

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

6. Expenditure

6.1 The corporation is to pay the returning officer:

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

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

7. Duty of co-operation

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

8. Notice of election

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

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

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

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

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

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

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

(g) the contact details of the returning officer

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

9. Nomination of candidates

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

9.2 The returning officer:

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

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

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

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

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

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

11. Declaration of interests

11.1 The nomination form must state:

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

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

party,

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

12. Declaration of eligibility

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

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

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

13. Signature of candidate

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

(a) they wish to stand as a candidate,

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

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

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

14. Decisions as to the validity of nomination

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

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

(b) decides that the nomination form is invalid,

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

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

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

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

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

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

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

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

13.

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

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

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

15. Publication of statement of candidates

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

15.2 The statement must show:

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

(b) the declared interests of each candidate standing,

as given in their nomination form.

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

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

16. Inspection of statement of nominated candidates and nomination forms

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

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

17. Withdrawal of candidates

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

18. Method of election

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

and 6 of these rules.

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

19. Poll to be taken by ballot

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

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

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

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

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

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

(i) configured in accordance with these rules; and

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

20. The ballot paper

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

20.2 Every ballot paper must specify:

(a) the name of the corporation,

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

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

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

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

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

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

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

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

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

(a) that the voter is the person:

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

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

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

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

("declaration of identity")

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

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

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

Action to be taken before the poll

22. List of eligible voters

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

22.2 The list is to include, for each member:

(a) a postal address; and,

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

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

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

23. Notice of poll

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

(a) the name of the corporation,

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

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

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

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

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

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

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

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

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

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

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

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following

information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

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

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

(d) a covering envelope;

("postal voting information").

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

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

(b) the voter's voter ID number,

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

("e-voting information").

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

(a) only be sent postal voting information; or

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

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

for the purposes of the poll.

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

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

25. Ballot paper envelope and covering envelope

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

25.2 The covering envelope is to have:

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

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

25.3 There should be clear instructions, either printed on the covering envelope or

elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

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

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

26. E-voting systems

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

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

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

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

(a) require a voter to:

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

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

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

(vii) the contact details of the returning officer;

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

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

comprises of-

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to

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

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

(b) specify:

(i) the name of the corporation,

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

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

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

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

(vi) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

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

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

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

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

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

(i) the voter's voter ID number;

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

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

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

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

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

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been

received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the

text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

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

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

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

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone

voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

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

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been 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.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules

FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who

are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at

which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be

named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. INTERPRETATION

1.1 In these Standing Orders, the provisions relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

2. MEETINGS OF THE COUNCIL OF GOVERNORS

2.1 Calling Meetings

2.1.1 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen 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.

2.1.2 The Secretary shall ensure that within the meeting cycle of the Council of Governors, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

2.1.3 If the Chair fails to call a meeting of the Council of Governors after a requisition for that purpose, signed by at least one-third of the whole number of the Council of Governors has been presented to him at Trust Headquarters, such one third or more members of the Council of Governors may forthwith call a meeting.

2.1.4 **Admission of the Public** and the Press– The meetings of the Council of Governors shall be open to members of the public and press unless the Council of Governors decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Council of Governors following the exclusion of members of the public and/or press shall be confidential to the members of the Council of Governors. Governors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

2.1.5 In the event that the public and press are admitted to all or part of a meeting by reason of SO 2.1.4 above, the Chair (or Deputy Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Council of Governors resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

2.1.6 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Council of Governor meetings.

2.1.7 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Council of Governors. Such permission shall be granted only upon resolution of the Trust.

2.1.8 The Council of Governors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

2.1.9 **Chair of Meetings** – The Chair of the Trust, or in his absence, the Deputy Chair, is to preside at meetings of the Council of Governors.

2.1.10 The Deputy-Chair may preside at meetings of the Council of Governors in the following circumstances:

2.1.10.1 When there is a need for someone to have the authority to chair any meeting of the Council of Governors when the Chair is not present.

2.1.10.2 On those occasions when the Council of Governors is considering matters relating to Non-Executive Directors and it would be inappropriate for the Chair to preside.

2.1.10.3 When the remuneration, allowance and other terms and conditions of the Chair are being considered.

2.1.10.4 When the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

2.1.10.5 On occasions when the Chair declares a pecuniary interest that prevents him from taking part in the consideration or discussion of a matter before the Council of Governors.

2.1.11 **Setting the Agenda –** The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

2.1.12 **Agenda** – A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or Secretary at least three clear business days before Notice of the meeting is given. Requests made less than three days before the Notice is given may be included on the agenda at the discretion of the Chair.

2.1.13 **Notices of Motion** – A Governor desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair or Secretary, who shall insert in the agenda for the meeting all notices 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 in accordance with SO 2.1.13, subject to the Chair's discretion.

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

2.1.15 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be in writing, be in accordance of SO 2.1.14 and shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

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

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

2.1.17.1 An amendment to the motion.

2.1.17.2 The adjournment of the discussion or the meeting.

2.1.17.3 That the meeting proceed to the next business.

2.1.17.4 That the motion be now put.

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

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

Save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

2.1.19 **Voting** – Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

2.1.20 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

2.1.21 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

2.1.22 If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

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

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

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

2.1.26 **Suspension of Standing Orders** – Except where this would contravene any statutory provision, or any provision of the Constitution, any one or more of the SO's may be suspended at any meeting provided that at least two thirds of the Council of Governors are present, including one Public Governor, one Staff Governor and one Patients and Carers Governor, and that a majority of those present vote in favour of suspension.

2.1.27 A decision to suspend SO's shall be recorded in the minutes of the meeting.

2.1.28 A separate record of matters discussed during the suspension of SO's shall be made and shall be available to the Governors.

2.1.29 No formal business may be transacted while SO's are suspended.

2.1.30 **Record of Attendance** – the names of the Governors present at the meeting shall be recorded in the minutes.

2.1.31 **Quorum** – A meeting of the Council of Governors shall be quorate and quoracy shall require that there shall be present at the meeting not less than 50% of all Governors and of those not less than 51% shall be Elected Governors (excluding those Governors representing the Staff Constituency).

2.1.32 A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or 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.

2.1.33 Subject to SO's in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council of Governors and, subject to the overall control of the Chair, to speak to any item under consideration.

3. COMMITTEES

3.1 Except as required by paragraph 9 of this Annex 6, the Council of Governors shall exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a committee.

4. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

4.1 **Declaration of Interests** – in accordance with the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

4.2 A Governor must declare to the Secretary:

4.2.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and

4.2.2 any interests which are relevant and material to the business of the Trust.

4.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these SO's and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within three working days.

4.4 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if he has declared a pecuniary interest, he shall not take part in the consideration or discussion of the matter. The provisions of this paragraph are subject to paragraph 4.5.

4.5 "relevant and material" interests may include but may not be limited to the following:

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

4.5.2 ownership or part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

4.5.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

4.5.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

4.5.5 any connection with a voluntary or other organisation contracting for or commissioning NHS services;

4.5.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

4.5.7 research funding/grants that may be received by an individual or their department;

4.5.8 interests in pooled funds that are under separate management.

4.6 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

4.7 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

4.7.1 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

4.7.2 he is a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

4.8 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

4.8.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

4.8.1 of an interest in any company, body, or person with which he is connected as mentioned in paragraphs 4.2, 4.5 and 4.7, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

4.9 Where a Governor:

4.9.1 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

4.9.1 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

4.9.3 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;

4.10 the Governor shall not be prohibited 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 disclose his interest.

4.11 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these SO's to be also an interest of the other.

4.12 If Governors have any doubt about the relevance of an interest, this should be discussed with the Trust Secretary.

4.13 **Register of Interests** - the Trust Secretary shall record any declarations of interest made in a Register of Interests kept by him in accordance with paragraph 36 of the Constitution. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

4.14 The Register will be available for inspection by members of the public free of charge at all reasonable times. A person who requests it is to be provided with a copy or extract from the register. If the person requesting a copy or extract is not a member of the Trust then a reasonable charge may be made for doing so.

5. STANDARDS OF BUSINESS CONDUCT

5.1 **Policy –** in relation to their conduct as a Governor of the Trust, each Governor must comply with the Code of Conduct for Governors. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

5.2 **Interest of Governors in Contracts** – if it comes to the knowledge of a Governor that a contract in which he/she 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/she shall, at once, give notice in writing to the Secretary of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

5.3 A Governor shall not solicit for any person any appointment in the Trust.

6. REMUNERATION

6.1 Governors are not to receive remuneration.

7. PAYMENT OF EXPENSES TO GOVERNORS

7.1 The Trust will pay travelling expenses to Governors at the prevalent NHS Public Transport rate for attendance at General Meetings of the Governors, or any other business authorised by the Trust Secretary as being under the auspices of the Council of Governors.

7.2 Expenses will be authorised and reimbursed through the Trust Secretary's office on receipt of a completed and signed expenses form provided by the Trust Secretary.

7.3 A summary of expenses paid to Governors will be published in the Trust's Annual Report.

8. MISCELLANEOUS

8.1 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors and any requirements for amendments must be directed to the joint meeting with the Board of Directors.

8.2 **Deputy-Chair** – In relation to any matter concerning the Council of Governors or a Governor outside a meeting of the Council of Governors, which arises the Deputy-Chair may exercise such power as the Chair would have in those circumstances.

8.3 **Notice** – Any written notice required by these SO's shall be deemed to have been given on the day the notice was sent to the recipient.

8.4 **Confidentiality** – A Governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

9. COUNCIL OF GOVERNORS : NOMINATIONS AND APPOINTMENTS COMMITTEE

9.1 The Chair and other Non-Executive directors shall be appointed following a process of open competition conducted in accordance with a policy to be agreed by the Council of Governors.

9.2 The Council of Governors shall establish a committee of its members to be called the Nominations and Appointments Committee ("the Committee") to discharge those functions in relation to the selection of the Chair and Non-Executive Directors described in Terms of Reference to be approved by the Council of Governors.

ANNEX 7
STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

1. INTERPRETATIONS AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2 All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3 For convenience, and unless the context otherwise requires, the terms and expressions contained within the Interpretations and Definitions section of the Constitution at page 4 are incorporated and are deemed to have been repeated here verbatim for the purposes of interpreting words contained in this Annex 8 and in addition:

"AUDIT COMMITTEE" means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework.

"COMMITTEE" means a committee or sub-committee appointed by the Trust.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Trust to sit on or to chair specific committees.

"CONTRACTING AND PROCURING" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"FUNDS HELD ON TRUST" means 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 Schedule 6, paragraph 8 of the 2006 Act. Such funds may or may not be charitable.

"COMMISSIONING" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"NOMINATED OFFICER" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and standing financial instructions.

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

"SFIs" means standing financial instructions.

"SOs" means Standing Orders.

2. THE BOARD

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

2.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3 The power of the Trust shall be exercised in public or private session as provided for in SO 3.

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Schedule of Matters reserved to the Board and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 **Admission of the Public and the Press** – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Deputy Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

3.3 The Board of Directors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

3.4 **Observers at Board Meetings** - The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committee. Such permission shall be granted only upon resolution of the Trust.

3.6 **Calling of Meetings** – Ordinary meetings of the Board shall be held at such times and places as the Board determines.

3.7 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.8 **Notice of Meetings** – Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least three clear days before the meeting.

3.9 Want of service of the notice on any Director shall not affect the validity of a meeting.

3.10 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.21.

3.11 Agendas will normally be sent to members of the Board five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be

despatched no later than five clear days before the meeting, save in emergency. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.12 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least five clear days before the meeting.

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

3.14 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least twelve 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 twelve days before a meeting may be included on the agenda at the discretion of the Chair.

3.15 **Petitions** - Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.16 **Chair of Meeting** – At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and he/she is present, shall preside. If the Chair and Deputy-Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.17 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

3.18 **Notices of Motion** – A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least twelve clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chief Executive shall insert in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. Subject to SO 3.21.8, this paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

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

3.20 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if he/she considers it appropriate. This Standing Order 3.19 shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.21 **Motions** - A motion may be proposed by the Chair or any Director present at the meeting. Such motion shall be seconded by another Director. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Emergency Motions

3.21.1 Subject to the agreement of the Chair and SO 3.22 below, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda (by reason of SO 3.6 and SO 3.9), up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

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

3.22.1 an amendment to the motion;

3.22.2 the adjournment of the discussion or the meeting;

3.22.3 that the meeting proceed to the next business; (*)

3.22.4 the appointment of an ad hoc committee to deal with a specific item of business;

3.22.5 that the motion be now put; (*)

3.22.6 that a Director be not further heard; (*)

3.22.7 that the public be excluded pursuant to SO 3.1;

3.23 *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 and who is eligible to vote.

3.24 no amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved;

3.25 the Chair may (at his/her discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.16, other than a motion relating to:

(a) the reception of a report;

(b) consideration of any item of business before the Trust Board;

(c) the accuracy of minutes;

(d) that the Board proceed to next business;

(e) that the Board adjourn;

(f) that the question be now put.

3.26 **Chair's Ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matter shall be final.

3.27 **Voting** - Save as provided in SO 3.32 every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.28 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.29 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.

3.30 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

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

3.32 An Officer who has been appointed formally by the Board 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 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.

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

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

3.35 Minutes shall be circulated in accordance with Director' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.36 **Joint Directors** – Where the Office of a Director is shared jointly by more than one person:

3.36.1 either or both of those persons may attend or take part in meetings of the Board:

3.36.2 if both are present at a meeting they should cast one vote if they agree:

3.36.3 in the case of disagreements no vote should be cast:

3.36.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.38 (Quorum).

3.37 **Suspension of Standing Orders** – Except where it 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 are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present vote in favour of suspension.

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

3.39 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.40 No formal business may be transacted while Standing Orders are suspended.

3.41 The Audit and Assurance Committee shall review every decision to suspend Standing Orders.

3.42 **Record of Attendance** – The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.43 **Quorum** – No business shall be transacted at a meeting unless at least one half of the whole number of the voting Chair and Directors appointed are present (including at least one Non-Executive Director and one Executive Director).

3.44 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.45 If the Chair or 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 Standing Order 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 one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Nominations Committee).

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders (Standing Order 2.4) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 **Delegation to Officers** – Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain an accountability to the Trust.

4.6 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the

Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or Monitor requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by the Monitor), the Trust may appoint committees of the Trust, or together with one or more Health Authorities or other Trusts, appoint joint committees, consisting wholly or partly of the Chair and members of the Trust or other health service bodies or wholly of persons who are not members of the Trust or other health service bodies in question.

5.2 A committee or joint committee appointed under SO 5.1 may, subject to such directions as may be given by the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute, or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.6 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.7 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.8 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.9 The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of Interests** - The Constitution, the 2006 Act and the Code of Conduct and Accountability requires Board Directors to declare interests which are relevant and material to the NHS board of which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.4 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a Board 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.

6.6 There is no requirement in the Code of Conduct and Accountability for the interests of Board Directors' spouses or partners to be declared. However SO 7 requires that the interest of Directors' spouses, if living together, in contracts should be declared. Therefore

the interests of Board Directors' spouses and cohabiting partners should also be regarded as relevant.

6.7 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.8 **Register of Interests** - The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.9 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.

6.10 The Register will be available to the public in accordance with paragraph 36 and 37 of the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.11 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their respective Directors for clarification.

7 DISABILITY OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chair or a Director 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 The Board may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

7.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 7.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.4.1 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

7.4.2 he is a partner / associate 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;

7.4.3 and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.5.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

7.5.2 of an interest in any company, body or person with which he is connected as mentioned in SO 7.4 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.

7.6 Where the Chair or a Director 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 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and 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/her 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/her duty to disclose his/her interest.

7.7 This SO 7 applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a director 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 POLICY

8.1 Staff should comply with the national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”. This section of Standing Orders should be read in conjunction with this document.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of 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 or the Secretary of the fact that he is interested therein. In the case of 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 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

8.4 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

8.5 **Canvassing of and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or 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 Standing Order 8 shall be included in application forms or otherwise brought to the attention of candidates.

8.6 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 8 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

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

8.8 **Relatives of Directors or Officers** – Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust 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.

8.9 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

8.10 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8.11 Where the relationship to a Director of the Trust is disclosed, the Standing Order headed `Disability of Chair and Directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer 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 or of a committee, thereof or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors, one Director and the Secretary or two senior managers (not being from the originating department) duly authorised by the Chief Executive and shall be attested by them.

9.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an Officer nominated by him/her 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. A report of all applications of the Trust seal shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

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, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

11 MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** – 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 be informed in writing and shall receive copies where appropriate in Standing Orders.

11.2 **Documents having the standing of Standing Orders** – standing financial instructions (including provisions as to tendering and contract procedures, disposals and in-house services), Schedule of Matters reserved to the Board and Scheme of Delegation, the Policy on the Register of Interests and Hospitality and the Staff Disciplinary and Appeals Procedures document shall be read in conjunction with the Standing Orders. The Board may also, from time to time, agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by the Trust. The decision to approve such policies and procedures shall be recorded in an appropriate Trust Board minute to be read in conjunction with these Standing Orders.

11.3 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Board and any requirements for amendments must be directed to the joint meeting with the Council of Governors unless paragraph 8.3.1 of Annex 9 applies. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

11.4 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using appropriate powers under the 2006 Act and shall comply with procedures laid down by the Finance Director which shall be in accordance with this Act.

ANNEX 8
COUNCIL OF GOVERNORS CODE OF CONDUCT

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

1. Introduction

1.1 As defined by legislation, the Trust's Council of Governors have a formal role in the governance of the Trust, working with the Board of Directors to promote the success of the organisation for its members and the public. To support the proper discharge of the Council of Governors' statutory duties and to promote the success of the relationship between the Council of Governors and the Board of Directors, it is essential that Governors adopt high standards of personal conduct. Recognising this, this document sets out the Council's expectations for the way in which Governors will conduct themselves in all aspects of their role within the Trust.

2. Framework for Council of Governors

2.1 The Trust operates within a legal, regulatory and governance framework which includes the NHS Act 2006, the Health and Social Care Act 2012, the Foundation Trust Code of Governance and the Trust's Constitution. The Constitution defines the composition of the Council of Governors and the arrangements for appointing (and, where necessary, removing) Governors. The Constitution's annexes include the Standing Orders for the Council of Governors and Board of Directors.

2.2 The regulatory and governance framework is supplemented by the Terms of Reference for the Council of Governors, the Role Description for Governors and this Code of Conduct. This Code of Conduct, the Terms of Reference and the Role Description are subject to the Constitution; nothing within them shall take precedence over or in any way amend the Constitution or any legal or regulatory requirements. This Code of Conduct is to be read in the context of that legal and regulatory framework.

3. Role of the Council of Governors

3.1 The role of the Council of Governors is defined in law and in Monitor's regulatory and governance framework. Although the role definition is not repeated here it is important as context for this Code of Conduct to recognise that good governance in the Trust depends upon active and constructive engagement between the Board of Directors and the Council of Governors. Adopting this approach will ensure that the Council of Governors is able to discharge its statutory duties, particularly in relation to:

3.1.1 Holding the Non-Executive Directors individually and collectively to account for the performance of the Board; and

3.1.2 Representing the interests of the members as a whole and of the public

4. Board of Directors/Council of Governors Engagement

4.1 The Constitution and supporting guidance commit the Board of Directors and the Council of Governors (as a whole and Governors individually) to engaging proactively and constructively with the Board of Directors, acting through the Chairman, Senior Independent Director and the Lead Governor where appropriate according to their roles.

4.2 The Council of Governors will work with the Board of Directors for the best interests of the Trust as a whole, taking into account all relevant advice and information presented to, or requested by, the Council of Governors. The Council of Governors will not unduly delay responses to proposals or other reports from the Board of Directors, acting proactively to

agree with the Board of Directors the information which the Council of Governors will need in order properly to discharge its statutory duties.

5. Conduct of Governors

5.1 This section of the Code sets out the conduct which all Governors agree to abide by. These commitments are in addition to compliance with Monitor's requirements, the Code of Governance, the Constitution, and Terms of Reference for the Council of Governors and Role Description for Governors.

5.1.1 **Personal Conduct**

Governors agree that they will:

a) Act in the best interests of patients and the Trust as a whole in the delivery of services within relevant financial and operational parameters, seeking at all times to properly discharge their statutory duties;
b) Comply at all times with legal and regulatory requirements and with the Constitution, Standing Orders, relevant Terms of Reference, Role Descriptions, policies and guidance;
c) Be honest and act with integrity and probity at all times;
d) Respect and treat with dignity and fairness, the public; patients; relatives; carers; NHS staff and partners in other agencies;
e) Respect and value all Governors and Directors as colleagues;
f) Not seek to profit from their position as a Governor or in any way use their position to gain advantage for any person;
g) Accept responsibility for their actions and generally take seriously the responsibilities which are commensurate with the decision-making rights assigned to the Council of Governors through the legal and regulatory framework;
h) Ensure that the interests of the members as a whole and the public are represented and upheld in decision making such that in accordance with the requirements of the Constitution and relevant policies, those decisions are not influenced by gifts or inducements or any interests outside the Trust;
i) Not be influenced in any way and not represent any outside interests which they may hold, including any membership of trade unions or political organisations;
j) Ensure that no person is discriminated against on grounds of religion or belief; ethnic origin; gender; marital status; age; disability; sexual orientation or socio-economic status;
k) Show their commitment to team working by working constructively with their fellow Governors and the Board of Directors as well as with their colleagues in the NHS and the wider community;
l) Not make, permit or knowingly allow to be made, any untrue; misleading or misrepresentative statement either relating to their own role or to the functions or business of the Trust;
m) At all times, uphold the values and core principles of the NHS and the Trust as set out in its Constitution;
n) Conduct themselves in a manner which reflects positively on the Trust and not in any manner which could be regarded as bringing it into disrepute;
o) Seek to ensure that the membership of the constituency from which they are elected/their appointing organisation is both properly informed and represented
p) At all times, uphold the seven principles of public life as set out by the Committee on Standards in Public Life (also known as the Nolan Principles) as below:
    (i) 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 friends or other interested parties.
    (ii) 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.
    (iii) Objectivity: In carrying out public business, including making public

appointments; awarding contracts or recommending individuals for awards or benefits, holders of public office should make choices on merit.

(iv) 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.

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

(vi) 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.

(vii) Leadership: Holders of public office shall promote and support these principles by leadership and example.

q) seek advice from the Chairman or the Trust Secretary on matters relating the Constitution, governance requirements or conduct, and have regard to the advice given to them.

5.1.2 **Confidentiality**

Governors agree that they will:

r) Respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors, except where information is made available in the public domain.

s) Understand, endorse and promote the Trust's Confidentiality and Data Protection Policy in every aspect of their work. A copy of this policy will be provided to each Governor and training will be provided where necessary.

t) Make no public statements on behalf of the Trust or communicate in any way with the media without the prior consent of the Chairman or a designated officer from the Trust's Communications Department.

5.1.3 **Declaration of Interests**

Governors agree that:

u) It is essential for good corporate governance and to maintain public confidence in the Trust that all decision making is robust and transparent. To support this, the Constitution and the Trust's Policy on Declaration of Interests set out requirements for Governors to declare relevant interests (as defined in the Constitution).

v) Governors will declare interests on request from the Trust Secretary or, as required by the Constitution, whenever they become aware of a potential conflict of interest in respect of a matter being considered by the Council of Governors. Governors should seek advice from the Trust Secretary or the Chairman where they are unsure as to whether an interest needs to be declared. Declared interests will be included in a Register of Interests, which will be published

6. Participation in Meetings and in Training and Development

6.1 The Council of Governors will hold a number of meetings per year, the number to be determined by the Chairman. The schedule for these meetings and for other activities will be proposed by the Trust Secretary and is subject to approval by the Council of Governors.

6.2 It is expected that Governors will attend meetings of the Council of Governors and of any committees or working groups (including Project Working Focus Groups) to which they are

appointed but it is accepted that there will be occasions on which Governors cannot attend, in which case they will give apologies for absence.

6.3 The Constitution provides for the Council of Governors to remove any Governor from office where he/she fails to attend two consecutive Council of Governor meetings and where the Council is not satisfied that the absence was due to a reasonable cause and that the attendance record will be rectified.

6.4 The Board of Directors has a statutory duty to take steps to ensure that the Governors are equipped with the skills and knowledge they need to discharge their responsibilities appropriately. A programme of training and development will be agreed with the Council of Governors and it is expected that Governors will participate in such activities unless, in reasonable circumstances, this is not possible.

7. Upholding this Code of Conduct

7.1 Following approval of this Code of Conduct by the Council of Governors, individual Governors agree to comply with all of its content.

7.2 Where possible or appropriate, any concerns about the conduct or performance of a Governor will be addressed under the leadership of the Chairman through training, development or other means which are considered appropriate. Where such concerns exist the Chairman will write to the Governor concerned to set out the concerns and the action agreed to rectify or otherwise address them.

7.3 The Constitution provides for the circumstances in which a Governor can be removed from office, including where any Governor fails to comply with this Code of Conduct. It is for the Chairman to propose removal from office if this is necessary after all other course of action, including training and development where relevant, have been exhausted. The Constitution provides for an independent review of evidence associated with such a proposal, reflecting the Foundation Trust Code of Governance. As required by the Constitution, it is for the Council of Governors to determine (in accordance with rules set out in the Constitution) whether any Governor should be removed from office following a proposal from the Chairman and an independent review if one is commissioned.

Approved by the Council of Governors on 29th January 2015

To be reviewed not later than January 2017

ANNEX 9
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

DECLARATION OF ACCEPTANCE

I confirm that I have received, read and understood the Code of Conduct for Governors (the Code).

I further confirm that I will comply with the provisions of the Code.

……
Signature of Governor

……
Name of Governor

……
……
……
……
……
Address for Governor

……
Date of signature

Please return the completed form to:

The Trust Secretariat
Trust Headquarters
University Hospitals Bristol NHS Foundation Trust

ANNEX 9
ROLE DESCRIPTION FOR THE COUNCIL OF GOVERNORS

1. Introduction

As members of the Trust's Council of Governors, our Governors play an important role in making the Trust publicly accountable for the services we provide and bring valuable perspectives and contributions to our activities.

In summary, they reflect the views of the Trust's Members, promote and support the Trust's strategy, hold the Board's Non-Executive Directors to account, and help the Trust to decide its future direction.

Our Public, Patient and Carer and Staff Governors are elected by our Foundation Trust's public and staff Members. We also have Appointed Governors who are nominated by stakeholders such as the local authority, commissioning groups, and our partner provider organisations.

Governors are not paid for the work they do, but can claim reasonable expenses incurred in connection with their duties in accordance with the Trust's expenses scheme.

2. Who can be a Governor?

In line with the Trust's Constitution, to be a Public, Patient, Carer or Staff Governor, Governors need to be:

- a member of the Trust
- at least 16 years old

You cannot be a Governor if you:

- are an Executive or Non-Executive Director of the Trust
- have been sentenced to 3 months imprisonment or more within the last five years
- are a bankrupt
- have been dismissed from an NHS job within the last two years
- have been disqualified from a health related professional body

3. What does a Governor do?

Governors of NHS Foundation Trusts have two main roles:

3.1 Acting as a link to the community

Governors form an important link to the community that the Trust serves. They are responsible for promoting and supporting the Trust's strategy, acting as a 'critical friend' to the Trust to help plan and steer its direction. They feed back information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.

Governors are responsible for feeding back to the Trust, via the Council of Governors, the views and ideas of the members or organisations they represent. By doing this, they help the Board to make sure that the views of local communities and people who use the Trust's services are taken into account when plans for services are being developed.

They also help to develop the Membership of the Trust in two main ways by:

- overseeing the development and implementation of the Membership Strategy
- direct engagement with Members at Constituency meetings and other Trust events

3.2 Holding the Non-Executive Directors to account for the performance of the Board

The Board of Directors has overall responsibility for running the Trust. A number of Non-Executive Directors sit on the Board to make sure that the Trust meets its performance targets, and acts in accordance with the Trust's Constitution. The Council of Governors is expected to hold the Non-Executive Directors to account for the performance of the Board of Directors. The National Health Service Act 2006 (as revised by the Health & Social Care Act 2012) gives Governors several powers to help them do this. These powers enable Governors to:

- appoint or remove the Chairman and Non-Executive Directors
- decide the remuneration and allowances, and other terms and conditions of office, of the Chairman and other Non-Executive Directors
- approve the appointment of the Chief Executive
- appoint or remove the Trust's Auditor
- receive the annual report and accounts
- advise the Board of Directors and be consulted on proposed strategic decisions and forward plans

Performing these functions means that Governors can be confident in the skills and abilities of the Non-Executive Directors to hold the organisation to account. Governors can also be sure that the Auditor will give an independent and reliable view of the Trust's accounts. Taken together, these functions help to demonstrate to Members of the Trust, the public, and stakeholders that the Trust is well-led.

4. What can't a Governor do?

It is important to remember that the powers of Governors rest with them in Council as a collective, not as individuals. Overall responsibility for running the Trust lies with the Board of Directors. There are therefore some things that they cannot do as a Governor:

- they will not be involved in the day to day running of the Trust, setting budgets, staff pay or any other operational matters
- they cannot veto or over-rule decisions made by the Board of Directors
- they do not play a part in considering the appointment or dismissal, appraisal, pay levels or conditions of service of Executive Directors
- they should not raise complaints on behalf of individuals, or act as advocates, but should represent a broad range of interests in your constituency

5. What responsibilities does the Council of Governors have?

5.1 Statutory Responsibilities

The Council of Governors has some responsibilities that are set out in Acts of Parliament such as the National Health Service Act 2006 and more recently new powers within the Health and Social Care Act 2012. These statutory responsibilities are to:

- represent the interests of the Members of the Trust as a whole and the interests of the public
- hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- give a response when consulted by the Board of Directors on the Trust's Annual Plan
- appoint and (if necessary) remove the Trust Chairman and Non-Executive Directors
- receive performance appraisal information regarding the Trust Chairman and Non-Executive Directors
- set the pay and terms & conditions of appointment for the Trust Chairman and Non-Executive Directors
- approve the appointment of the Chief Executive - however, the Council of Governors will not appoint the Chief Executive

- appoint or (if necessary) remove the Trust's external auditors
- receive the Trust's Annual Report and Accounts, and the Auditor's report
- inform Monitor, via the Lead Governor, if there are any 'material concerns' about the actions of the Board of Directors which cannot be resolved locally
- satisfy itself that proposals in the Annual Plan (other than those relating to the provision of health services in England) will not significantly interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions
- approve any proposal to increase by 5% or more the proportion of the Trust's total annual income from activities other than the provision of health services in England
- approve any applications for significant transactions
- approve any applications for mergers, acquisitions, separation or dissolution of the Trust
- agree, in conjunction with the Board of Directors, changes to the Trust's Constitution

5.2 Other responsibilities

The Council of Governors has other responsibilities which are not set out in law. These include:

- supporting the Board of Directors in setting the long-term strategic direction for the Trust
- being assured that that the Non-Executive Directors act so that the Trust does not breach the conditions of its NHS Provider Licence
- developing the membership by overseeing the implementation of the Trust's Membership Strategy and by direct engagement with members at events and meetings
- providing a Governor perspective on the efficacy of staff engagement mechanisms

6. What other duties does an individual Governor have?

As a Governor they are expected to:

- promote and support the organisation's strategy
- feedback information about the Trust, its vision and its performance to your Members or stakeholder organisation
- attend meetings of the Council of Governors
- abide by the Governors Code of Conduct and uphold the Trust's values
- act in the best interests of the Trust and preserve the Trust's standing and reputation
- comply with the policies and procedures of the Trust, including its Authorisation and Constitution
- serve on at least one Governor Project Focus Group
- maintain an appropriate level of confidentiality in respect of information provided to the Council of Governors and its working groups
- attend such training events as may be necessary in order to fulfil the role
- represent the interests of the community, including service users and carers, by ensuring effective communication with Members, feeding back information to the Trust as necessary
- if invited, to advise on staff appointments

7. What skills will a Governor need?

The Governor's role is an important one. As well as representing their own views, they must be able to represent the views of people in their community.

They will also need the time to communicate with their constituents and to prepare for and attend several meetings each year, including some Governor Committee and Project Focus Group meetings and be able to absorb high level information.

8. What support will a Governor get to do the job?

To help them to perform this important role, the Trust will provide training and support. This will include:

- an induction session to familiarise them with the Trust and the services it provides, any relevant policies and legislation, and the role of the Governor within the Trust
- an opportunity to attend relevant parts of the Trust's corporate induction training
- training relevant to specific Governor roles such as recruitment of Non-Executive Directors, appointment of auditors, or approval of significant transactions
- assignment of an experienced Governor to act as a 'Buddy' in their first year
- an opportunity for Governors to engage in Patient-Led Assessments of the Care Environment (PLACE) assessments
- participation in joint events with other partner organisations
- access to training sessions and materials from the Foundation Trust Governors Network
- participation in engagement and community events

9. How much time will it take up?

There are four formal Council of Governor meetings, eight informal meetings (which include a Counsel meeting with the Chairman) each year. Each of the three Governor Project Focus Working Groups meets four times each year.

As a minimum, Governors should attend all the formal Council of Governor meetings and there is an expectation that individual Governors be a regular attender of at least one of the Governor Project Focus Groups – Quality Project Focus Group; Constitution Project Focus Group or Annual Plan Project Focus Group.

In addition, Governors are expected if possible to attend the training/ education seminars that are organised four times per year. These Governor Development Seminars provide briefings on current topics and developments being considered by the Board as well as formal training on skills and tools relevant to their role as Governor.

Most Governors find that they get more satisfaction from the role if they attend other activities as well as the formal Council of Governor and Governor Project Focus Group meetings. There are a number of Trust events throughout the year that Governors can take part in. Governors also sit on working groups from time to time, and are often involved in the interview process for new members of the Board.

In accordance with The Trust's Constitution, the Trust also holds an Annual Members Meeting which takes place in September and all Governors are expected to attend.

There are a range of other events that Governors are encouraged to attend if available, including:

- Chairman and Chief Executive walkabouts, PLACE assessments and other similar events to observe first-hand how the hospital is running
- Board of Directors meetings - all Governors should attend at least one Board meeting in each year, to see the Board 'in action'
- staff achievement and long-service awards
- events supporting the Trust's associated Charity – 'Above and Beyond'
- Ad-hoc presentations, celebrations and other events

All events are notified to Governors in advance by the Trust Secretariat, with as much notice as possible. The Trust Secretariat is available to discuss with individual Governors possible external events to attend if they feel they would be of benefit to support their Governor role.

10. How long does a Governor serve for?

- Public and Staff Governors are elected for a period of up to three years at a time
- Appointed Governors other than Local Authority Governors and Youth Governors (see below) may serve for up to three years at a time. They will cease to hold office if the appointing organisation withdraws their appointment.
- Governors appointed by the Youth Council may hold office of up to one year

- Local Authority Governors serve until they stand for re-election as a local councillor. They cannot be a Governor for more than two terms of office as a local councillor
- No Governors can serve for more than a total of nine years

11. Specific Governor Roles

11.1 The role of Lead Governor

Monitor did not intend the person holding this role to 'lead' the Council of Governors or assume greater power or responsibility than other Governors. However it is recognised that University Hospitals Bristol like many NHS Foundation Trusts have broadened the original intention of this role and given greater responsibility to their Lead Governor. The role of lead Governor for University Hospitals Bristol is described below and includes:

- acting as the point of contact between the Governors and Monitor
- ensuring a continuing good relationship between Governors and Directors
- bringing to the Trust Chair's notice any issues from the Governors
- working towards the effectiveness of the Council of Governors and its Project Focus Groups
- chairing meetings of the Council of Governors which cannot be chaired by the Trust Chair, Vice-Chair or other Non-Executive due to a conflict of interest (these occasions are likely to be infrequent)
- deputising for the Chairman/Vice Chairman at Members' events
- chairing the quarterly Informal Governors' meetings
- presenting the Membership report to the Annual Members' Meeting and lead the Governors in issues related to Membership
- presenting reports to the Board of Directors as Lead Governor
- being available to provide or approve quotes for press releases
- providing leadership & guidance; mentor new or less experienced Governors
- meeting regularly with the Chair and Chief Executive; be a point of contact through which channels of communication flow between Chair/Board of Directors and Council of Governors so as to foster good relations and openness
- providing a sounding board for the Chair and members of the Executive.
- liaising regularly with the Trust Secretary in relation to meetings, minutes, follow up action, progress chasing etc.
- ensuring that Governors, individually and as a body, maintain a good standard of conduct

11.2 What the Lead Governor cannot do

The Lead Governor is not a shadow or vice chair in the same way that the Council of Governors is not a shadow Board of Directors.

11.3 Conditions of appointment and Term of Office for the Lead Governor

The Lead Governor:

- should be a Governor of at least one year's standing but ideally 2 years
- should be appointed by the Council of Governors
- may hold the position of Lead Governor until the end of their term of office
- if they are reappointed they may be reappointed as Lead Governor by the Council of Governors - the reappointment may be delayed for 6 months to allow new Governors to get to know the incumbent
- removal of the Lead Governor will require the approval of three-quarters of the members of the whole membership of the Council of Governors
- understand the Trust's Constitution and how the Trust is influenced by other organisations
- represent the position and wishes of Governors and be able to commit the time necessary
- be IT literate and have the ability to influence and negotiate; and be able to present a well-reasoned argument

11.4 Process for appointment

The Trust Secretary will organise the process as follows:

- any Governor may nominate another Governor with the agreement of the nominee
- any Governor may nominate themselves with the support of one seconder
- each candidate, even if unopposed, will provide a one page statement setting out what they would bring to the role
- if there is more than one nomination there will be an election conducted by email – a simple majority will win
- if there is a tie the Trust Chair has a casting vote in consultation with the Nominations & Appointment Committee
- if there is a single nomination the Governors will be asked to endorse (or not) that nomination by voting for that person or abstaining
- if there are no nominations the Trust Chair in consultation with Nominations & Appointment Committee will nominate a Lead Governor for approval by the Council of Governors, for one year initially

11.5 Staff Governors

Staff Governors have a responsibility to the people who elect them. The role involves talking and listening to staff about issues and concerns, about what's working well and what could be improved, and feeding those views into the work of the Council. As ambassadors, Staff Governors should seek to engage with staff as much as possible about the work of the Council and the Trust and encourage staff to remain part of the FT membership so they can influence the formal governance structures of the Trust.

The role of Staff Governors at UHB includes:

- communicating with staff in their constituency and feeding the views of staff back to the Council of Governors and into any working groups they are part of
- advising the Council of the impact of decisions on staff and advise on how staff can contribute to improving services for patients
- regularly advising staff of work undertaken by the Council of Governors and seeking their views. The Trust will work with the staff governors to develop effective ways to make sure this happens
- being very clear about what information can be reported back to colleagues/staff members

All Governors are expected to sign-up to the Governors Code of Conduct. If it is believed a Staff Governor has failed to observe this Code of Conduct, the Trust Chair will deal with the case according to the procedure set out in the Code. However, the Trust's normal disciplinary procedures will be followed in the case of misconduct in a Staff Governors' substantive role.

11.6 What Staff Governors should not do

Staff Governors are not expected to always agree with other Staff Governors or other Governors in general but are expected to be professional if and when disagreement occurs. Staff Governors who disagree with or question the Board of Directors will not find their professional standing within the Trust affected in any way as long as the Code of Conduct is complied with. Staff Governors should not:

- pursue a personal agenda at the expense of others' or participate in discussions where they have a personal interest in the outcome
- get personally involved in staff members' individual problems or issues and never promise to solve someone's problem themselves
- deal with disciplinary or grievance issues which are dealt with by formal staff representatives

The role of Staff Governor is significantly different from that of a Trades Union or staff side representative. Formal staff representation and negotiation through the Joint Union Committee remains in place. It is intended that the work of these groups run alongside and where appropriate complements the Staff Governor role and vice versa. However, Staff Governors do have a responsibility for reporting staff views in the Council and other meetings and working groups where there may not be a staff-side representative.

Staff Governors should be able to advise Trust staff members on appropriate routes of action, keeping in mind the role of the individual's line Manager and/or Staff representative. If the individual staff member has not approached their Line Manager or staff representative first, then the Staff Governor should direct the individual back to these sources. If there is any concern on the part of the Staff Governor that this is not the appropriate course of action (and it is likely to be only in exceptional circumstances that it is not) then the Staff Governor should refer to the Line Manager's Line Manager and/or the Human Resources Department. The Staff Governor may also sign-post the availability of Trust policies and procedures, clinical standards etc.

11.7 Public, Patient and Carer Governors

Our Public Governors represent the local constituencies of Bristol, North Somerset, and South Gloucestershire and our diverse local community. As Bristol University Hospitals is a major tertiary centre for a range of specialist services, there is also Public Governor representation nationally from the rest of England and Wales.

Public Governors provide the Trust with a greater understanding of the issues affecting patients and visitors as well as representing our diverse local community and national populations who use our specialist services.

Patient and Carer Governors provide valid insight in the patient experience of our services at UHB and are supported to ensure they can fully interact with the Council should they require special arrangements such as transport or communication materials.

11.8 Appointed Governors

Appointed Governors are appointed by organisations that the Trust has identified as partner organisations. For University Hospitals Bristol these partners are considered to be:

- Bristol City Council
- University of Bristol
- University of West of England
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South Western Ambulance Service NHS Trust
- Joint Union Committee
- University Hospitals Bristol NHS Foundation Trust Youth Council
- Community and Voluntary Sector representative

These partner organisations have the ability to nominate whomever it feels is appropriate to represent it on the Council of Governors and understands the time commitment and what will be involved in the role of being a Foundation Trust Governor.

It is recognised that sometimes an Appointed Governor may sometimes experience a conflict of interest between their duties to their primary organisation and duties as a Foundation Trust Governor. Appointed Governors should be asked to declare an interest in discussing matters such as contracts or significant transactions; and be allowed to voluntarily leave the meeting if they consider this the appropriate action in the interest of probity.

12. Summary

Ultimately Governors are accountable to the Membership of the Trust (with the exception of Appointed Governors, who are accountable to their own organisation) and shall demonstrate this by their communication with their electorate in order to best understand their views.

Nominations and Appointments Committee Report for a Council of Governors Meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 9 - Nominations and Appointments Committee Report

Purpose

The purpose of this report is to provide the Council of Governors with an update on the activities of the Governors' Nominations and Appointments Committee.

Abstract

The Nominations and Appointments Committee is a formal Committee of the Council of Governors established for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment, removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

Recommendations

The Council of Governors is asked to **note** the report and:

- To **approve** the formal appointment of Jill Youds as Non-executive Director.

Report Sponsor or Other Author

Sponsor: Trust Secretary

The Nominations and Appointments Committee has held **one** meeting since the last Council of Governors meeting.

Nominations and Appointments Committee: 19 December 2014

Governors present: Sue Silvey, Mo Schiller, John Steeds, Pam Yabsley, Wendy Gregory, Philip Mackie, Florene Jordan, and Jeanette Jones.

Others present or in attendance: John Savage – Chairman and Sarah Murch – Membership & Governance Administrator.

Non-executive Director Activity Reports

The Committee noted the activity reports of Non-executive Directors and Non-executive Observers from June-December 2014.

Non-executive Director Terms of Office

- It was noted that Lisa Gardner's term of office was due to end in May 2015. The committee agreed that, subject to discussion between John Savage and Lisa Gardner, a recommendation be submitted to the Council of Governors to re-appoint Lisa for a further 3-year term of office as Non-executive Director.
- John Savage noted that following Kelvin Blake's end of term of office on 31 October 2014, Kelvin's duties had been re-allocated to the other Non-executive Directors and he agreed to circulate these to governors.

The next meeting of the Nominations and Appointments Committee will take place on Wednesday 25 February 2015 at 13:30-14:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

A Governor Development Seminar Report for a Council of Governors Meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – Governor Development Seminar Report

Purpose

To provide the Council of Governors with an update on the governor development programme.

Abstract

The governor development programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively. The programme was co-created with governors using self-assessment and short-life task and finish groups.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Report

There has been **one** Governor Development Seminar since the last Council of Governors meeting.

Governor Development Seminar: 14 January 2015

Governors attending: Sue Silvey (Lead Governor), Clive Hamilton, Brenda Rowe, Mo Schiller, Tony Tanner, Angelo Micciche, Anne Skinner, John Steeds, Pam Yabsley, Wendy Gregory, Karen Stevens, Thomas Davies, Florene Jordan, Ben Trumper, Jeanette Jones, Tim Peters, Bill Payne.

Others in attendance: Magnus Carter, Principal Consultant, Mentor Communications Consultancy Ltd, Fiona Reid, Head of Communications, James Rimmer, Chief Operating Officer, Tony Watkin, Patient Experience Lead (Engagement and Involvement), Debbie Henderson, Trust Secretary, Debbie Marks, Membership Support Assistant and Sarah Murch, Membership & Governance Administrator.

Topics discussed:

- **Public Relations and Communications for Foundation Trusts** – Governors received a presentation by Magnus Carter (Principal Consultant, Mentor Communications Consultancy Ltd) on how the media works. Fiona Reid, Head of Communications, was also in attendance to explain how the Trust responds to negative media coverage and how positive stories are promoted.
- **Access Recovery Plan** – briefing from James Rimmer, the Chief Operating Officer on the latest position regarding access standards and the work to update the recovery plan and trajectories for the key performance targets.
- **Workshop session: Public and Patient Involvement / Membership engagement** – Governors explored the meaning of involvement and discussed ways to develop patient and

public involvement in the Trust.

- **Performance Effectiveness Evaluation of the Council of Governors** – Governors discussed a self-assessment questionnaire to review their effectiveness and assess their performance as a governing body. Individual members of the Council of Governors were sent a copy of the questionnaire and asked to complete and return their response by 29 January. It is important that the Trust Secretariat receive a 100% response as the outcome will inform a Governor Development plan going forward.

Suggestions of topics for future seminars include:

- Making the best use of performance and finance metrics.
- Governor communications – how can governors communicate more effectively?
- NED Appraisals and re-appointment process
- Changing healthcare landscape – explanation of different organisations now involved in healthcare provision locally and nationally.

The next Governor Development Seminar will be held on 10 June 2015 from 10:00-15:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Annual Plan Project Focus Group Meeting Account for a Council of Governors Meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11a - Annual Plan Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on meetings of the Annual Plan Project Focus Group.

Abstract

The Annual Plan Project Focus Group provides an opportunity for engagement with governors to develop the Monitor Annual Plan and to contribute to the Trust's strategic objectives.

Aidan Fowler is the Executive Lead for the Annual Plan Project Focus Group and it is chaired by David Relph. The Lead Governor for the group is Wendy Gregory. There are usually 6 meetings a year, and they are open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Trust Secretary/ Governor Lead for Annual Plan Project Focus Group

The Annual Plan Project Focus Group has held **one** meeting since the last Council of Governors meeting.

Annual Plan Project Focus Group: 4 December 2014

Governors attending: Wendy Gregory *(Lead Governor for the Focus Group)*, Sue Silvey, Pam Yabsley, Bob Bennett, Angelo Micciche, Graham Briscoe, Clive Hamilton, Florene Jordan, Mo Schiller, John Steeds and Ben Trumper.

Others present or in attendance: David Relph – Head of Strategy and Business Planning *(Focus Group Chair)*, Paul Tanner – Head of Finance, Alex Crawford – Deputy Head of Commissioning and Planning, Angela Martin – Membership Administrator.

Topics discussed:

- **Monitor Annual Plan:** David Relph, Head of Strategy and Business Planning, discussed the Annual Plan. The Trust was still awaiting feedback from Monitor on its strategic plan.
- **Update on Operating Plan Development***:* David Relph briefed the meeting on the proposed work plan. The Trust was awaiting further guidance from Monitor – a clearer report would be available in March 2015.
- **Review of Capital Prioritisation Work**: Alex Crawford explained the Trust's proposals for capital prioritisation work for presentation to the commissioners.
- **Review of Monitor Plan Template and Plan Development:** David discussed the implications of the NHS England Five-year vision in relation to the Monitor Plan development.
- **Care Quality Commission Inspection Update:** David updated governors on ongoing discussions with other providers about working together to develop new models of care as recommended by the CQC.
- The group also discussed emerging issues and priorities.

The next meeting of the Annual Plan Project Focus Group will be on **Thursday 5 February 2015 at 10:00-12:00** in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Quality Project Focus Group Meeting Account for a Council of Governors Meeting, to be held at 14:00 on 29 January 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11b - Quality Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Quality Project Focus Group.

Abstract

The objectives of the Quality Project Focus Group are to provide:

a) engagement with governors to develop the Board's Annual Quality Report;
b) regular support to enable governors to understand and interpret the Board Quality and Performance Report;
c) regular support to enable governors to understand and interpret reported progress on the Board's Quality Objectives; and,
d) opportunities for input from governors on quality matters.

The group is jointly chaired by Sean O'Kelly and Carolyn Mills (previously Deborah Lee), and its Lead Governor is Clive Hamilton. Meetings are held bi-monthly and open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Trust Secretary/ Governor Lead for the Quality Project Focus Group

The Quality Project Focus Group has held **two** meetings since the last Council of Governors meeting.

Quality Project Focus Group Meeting: 13 November 2014

Governors attending: Clive Hamilton (Lead governor for the group), Sue Silvey, Bob Bennett, Graham Briscoe, John Steeds, Mo Schiller, Wendy Gregory, Florene Jordan, Sue Milestone, Karen Stevens and Nick Marsh.

Others present or in attendance:, Sean O'Kelly – Medical Director, Carolyn Mills – Chief Nurse, Anne Reader – Head of Quality (Patient Safety), Steve Brown – Director of Pharmacy, Sarah Murch – Membership PA/Administrator

Topics discussed:

- **Medicines Safety:** Steve Brown, Director of Pharmacy, gave a presentation to governors on Medicines Safety, including the work that the Trust had done to reduce medication errors.
- **Trust Board Quality and Performance Report:** Governors received the Quality & Performance report. Clive provided a governors' summary of the performance of the Trust and sought assurance on the following key areas: emergency re-admissions, fractured neck of

femur, stroke care, dementia and cancelled operations.

- **Care Quality Commission Inspection Update:** The Trust had received a draft CQC Inspection report to check for factual accuracy. Headlines had been shared with the governors, who were aware of the Trust's overall rating of 'Requires Improvement'. The full report would be available at the end of the month and would be shared with governors at this point.
- **Cardiac Outcomes Data from National Institute of Cardiovascular Outcomes Research:** Governors received an explanation of the NICOR Cardiac Outcomes data from Sean O'Kelly, Medical Director.
- **National Cancer Patient Experience Programme Survey 2014 results:** Governors discussed these results and asked for an update on the action plan at a future meeting.
- **Governors' Log of Communications** – current items were noted.
- **Staff Morale at Bristol Royal Hospital for Children Theatres**: Governors asked the Chief Nurse to look into this issue.
- **Histopathology update:** The Medical Director reported that UH Bristol was still waiting for a business case paper from North Bristol Trust regarding integration of the histopathology service.

Quality Project Focus Group Meeting: 13 January 2015

Governors attending: Clive Hamilton (Lead governor for the group), Brenda Rowe, Sue Silvey, Mo Schiller, Angelo Micciche, Wendy Gregory, Lorna Watson, Sue Milestone, Florene Jordan, Ian Davies, Thomas Davies, John Steeds, and Bill Payne.

Others present or in attendance:, Sean O'Kelly – Medical Director, Carolyn Mills – Chief Nurse, Anne Reader – Head of Quality (Patient Safety), Chris Swonnell – Head of Quality (Patient Experience and Clinical Effectiveness), Alex Nestor, Deputy Director of Workforce, Aidan Fowler, Fast-Track Executive, Debbie Marks – Membership Support Assistant, Rachel Bush – Lead Dementia Practitioner, Julie Dovey – Care of the Elderly Consultant & Consultant Lead for Dementia for UH Bristol and Cathy Edwards – Dementia Project Nurse.

Topics discussed:

- **Histopathology Update –** The Medical Director reported to governors that both Trusts had approved the business case for service integration, and that UH Bristol had appointed two cellular pathologists.
- **Dementia Update –** Governors received a presentation about the Trust's work in Dementia and asked questions.
- **Improving Staff Experience update –** The Deputy Director of Workforce updated governors on how staff experience data is captured and on the Trust's action plans to improve staff experience.
- **Trust Board Quality and Performance Report:** Governors received the Quality & Performance report. Clive provided a governors' summary of the performance of the Trust, noting in particular that the Trust's performance in October and November had deteriorated, with access standards still below the planned trajectory. Governors sought assurance on the Trust's action plans for recovery, particularly in relation to the A&E 4-hour maximum wait, the 62-day GP referral-to-treatment cancer standard and the 18-week referral-to-treatment time standards.

- **Quality Impact Assessments -** Governors discussed quality impact assessments carried out during Service/ Provider changes.
- **Learning from Complaints–** Governors received this Patients' Association report.

The next meeting of the Quality Project Focus Group will be held on Tuesday 3 March 2015, 10:00 – 12:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**.**

University Hospitals Bristol NHS
NHS Foundation Trust

Constitution Project Focus Group Meeting Account for a Council of Governors Meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11c – Constitution Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Constitution Project Focus Group.

Abstract

The objectives of the Constitution Project Focus Group are to provide:

(i) engagement with governors in drafting Constitutional changes;

(ii) assessing the membership profile; and,

(iii) advice from governors on communications and engagement activities for Foundation Trust members.

The group meets quarterly and is open to all governors. The Chair of the Group is Sue Silvey, Lead Governor, and the executive lead for the Group is Debbie Henderson, Trust Secretary.

Recommendations

The Council of Governors is asked to **note** the update.

Report Sponsor or Other Author

Sponsor: Trust Secretary/Lead Governor for the Constitution Project Focus Group

The Constitution Project Focus Group has held **one** meeting since the last Council of Governors meeting.

Constitution Project Focus Group Meeting: 4 December 2014

Governors attending: Sue Silvey (Lead governor for the group and meeting Chair), Clive Hamilton, Bob Bennett, Graham Briscoe, John Steeds, Mo Schiller, Pam Yabsley, Angelo Micciche, Wendy Gregory, Florene Jordan.

Others present or in attendance: Emma Woollett – Non-executive Director, Debbie Henderson - Trust Secretary, Tony Watkin – Patient Experience Lead (Engagement and Involvement), Sarah Murch – Membership PA/Administrator, Debbie Marks – Membership Administrator.

Topics discussed:

- **Action Log and Attendance at meetings:** It was agreed that an action log should be re-instated for all meetings of the group. It was suggested that governors' attendance at meetings be reported to this group, and it was agreed that a questionnaire regarding appropriateness of meeting arrangements would be circulated to governors and responses reported back to the March 2015 meeting.
- **Constitutional Review:** Governors reviewed the proposed changes to the constitution, and received a presentation on the New Model Election Rules. The revised constitution will go to the Council of Governors meeting for approval.
- **Revised Code of Conduct for Governors:** Governors discussed the revised new code of conduct for governors. The revised Code of Conduct will now go to the Council of Governors meeting for approval.

- **Public & Patient Involvement Strategy – proposed alignment with Membership Strategy:** Tony Watkin, Patient Experience Lead (Engagement and Involvement), was in attendance to speak to governors on how the Trust involved patients and the public in its work, and the proposal to align this more closely with membership engagement. Tony Watkin also briefed the group on a recent visit to the Heart of England NHS Foundation Trust in Birmingham to explore their model of a 'Citizen's Assembly' as a way of engaging membership as part of a wider PPI strategy.
- **Process for Governors' Log of Communications/Raising Concerns**: Governors discussed the review of the process for the Governors' Log of Communications.
- **Role Description for Governors**: No amendments were suggested. To go to the Council of Governors for approval and then to be uploaded to the Trust's website.
- **Process for Annual Effectiveness Reviews for Council of Governors meetings and Project Focus Groups** – this item was deferred until the next meeting.

The next meeting of the Constitution Project Focus Group will be held on Tuesday 10 March 2015 from 13:00-15:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Membership Activity Report for a Council of Governors Meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 12a - Membership Activity Report

Purpose

To provide the Council of Governors with current membership details, a summary of membership engagement since the last Council of Governors meeting on 30 October 2014 and an update on the review of the membership strategy.

Abstract

The Trust has a formal requirement to maintain a Foundation Trust membership and a responsibility to engage with its membership. Membership statistics and recent engagement, recruitment and involvement opportunities for members are listed below.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Report

As of 20 January 2015, Foundation Trust membership stands at 21,109 (6,498 public members, 4,808 patient members and 9,803 staff members).

This compares with membership of 20,974 (6,550 public members, 4,870 patient members and 9,554 staff members) on 14 October 2014.

Membership can be broken down as follows:

Member Type Breakdown	Total
Public Constituencies	**6,498(714)**
Out of Trust Area	5(3)
Bristol	3,163(167)
North Somerset	1,282(80)
South Gloucester	1,254(62)
Rest of England and Wales	794(402)
Patient Constituencies	**4,808(2408)**
Unspecified	29(4)
Carer of patients 16 years and over	209(120)
Carer of patients 15 years and under	543(311)

Patient - Local	4,027(1973)
Staff Classes	**9,803(0)**
Unspecified	0(0)
Medical and Dental	1,201(0)
Nursing and Midwifery	2,823(0)
Other clinical healthcare professionals	1,946(0)

Engagement

9 Dec 2014	Health Matters Event – Rheumatology • Talk from Rheumatology Consultant Robert Marshall on rheumatoid arthritis. • Talk from Carolyn Mills on Quality of Care at UH Bristol. *Hosted by governors and attended by around 70 people.*
19 January 2015	Quality Counts – Members' Event Opportunity for Foundation Trust members to consider and influence the Trust's priorities for improving the quality of services. *Hosted by the UH Bristol Quality Team and attended by around 35 members.*
30 October 2014 – Jan 2015	Youth Council activities (open to our young members): • 11 November – Session with Clinical Commissioning Group about experiences of community healthcare. • 15 January – Session with artist Dave Bain to look at designs for the new corridors in Bristol Royal Hospital for Children.

Recruitment

18/9/2014-20/01/2015	17 people joined as Public or Patient Foundation Trust members in this period.
	There have been no specific recruitment activities in this period.

Other communications with members

21/01/2015	Members' feedback sought about Trust website.

Forthcoming engagement with members:

Health Matters Events

Health Matters Events is a series of free talks organised by the Trust's governors. They are open to Foundation Trust members, staff, patients, carers and members of the public.

- **Thursday 5 March 2015: 5.30-7.00pm – Health Matters: Dermatology**

Dr David de Berker, Consultant Dermatologist and Honorary Clinical Senior Lecturer, will give a talk on skin conditions: chronic, moles and melanomas. We will also have a talk from Sean O'Kelly, Medical Director, on plans to bring together the Cellular Pathology services currently provided by UH Bristol NHS Foundation Trust and North Bristol NHS Trust into a single, combined service for Bristol.

- **Thursday 7 May 2015: 5.30-7.00pm – Health Matters: Diabetes**

Children's focus on diabetes/nutrition and transition to adulthood – Speaker tbc. Also speaking will be James Rimmer, Chief Operating Officer, on the re-organisation of outpatients departments.

- **Thursday 2 July 2015: 5.30-7.00pm – Health Matters: Chronic Kidney Disease.**
- **November 2015: Health Matters - Osteoporosis**

Members are also welcome to attend our quarterly **Council of Governors meetings** and our **Annual Members Meeting/AGM – 15/09/2015.**

Voices magazine

Voices, the magazine for the UH Bristol community, is sent to Foundation Trust members 3 times a year. The schedule for 2015 is as follows:

Jan/Feb issue – publication date 29 Jan 2015

May/June issue – publication date 28 May 2015

Sept/Oct issue – publication date 1 Oct 2015

Membership Engagement and Governor Development Strategy

Work is ongoing on the development of a new membership strategy, led by the Trust Secretariat with a view to submitting proposals to the Council of Governors meeting scheduled to take place on 30 April 2015. The strategy will focus on:

- How the strategy will underpin delivery of the mission, values and strategy intent of 'Rising to the Challenge',
- Building a representative membership,
- Developing a meaningful membership engagement programme.

University Hospitals Bristol NHS
NHS Foundation Trust

Governor Activity Report for a Council of Governors Meeting, to be held on 29 January 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 12b - Governor Activity Report

Purpose

To provide the Council of Governors with a summary of governor activity since the last Council of Governors meeting on 30 October 2014.

Abstract

Governors fulfil their statutory responsibilities through involvement in various meetings and other activities. The Trust also has a responsibility to consult with governors on key issues. A summary of recent activities is below.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Report

Date	Event	Governors attending
30/10/2014	Council of Governors meeting	Sue Silvey, Pauline Beddoes, Bob Bennett, Clive Hamilton, Tony Rance, Brenda Rowe, Tony Tanner, Edmund Brooks, Angelo Micciche, John Steeds, Pam Yabsley, Wendy Gregory, Philip Mackie, Thomas Davies, Nick Marsh, Karen Stevens, Ben Trumper, Marc Griffiths, Jeanette Jones, Bill Payne, Tim Peters, Sue Hall, Jim Petter.
10/11/2014	Chair & Chief Executive Walkround (Diagnostic and Therapies)	Angelo Micciche and Bill Payne
12/11/2014	South West Governor Exchange Network meeting, Taunton.	Edmund Brooks, Graham Briscoe, Pam Yabsley, Sue Milestone.
13/11/2014	Quality Project Focus Group meeting	Clive Hamilton , Sue Silvey, Bob Bennett, Graham Briscoe, John Steeds, Mo Schiller, Wendy Gregory, Florene Jordan, Sue Milestone, Karen Stevens and Nick Marsh.
14/11/2014	Voices Editorial Group meeting	Wendy Gregory and Flo Jordan.

21/11/2014	Recognising Success Staff Awards	Sue Silvey, Flo Jordan, Mo Schiller, John Steeds, Marc Griffiths, Jeanette Jones, Angelo Micciche, Karen Stevens, Elliott Westhoff, Phil Mackie, Ian Davies, Wendy Gregory.
25/11/2014	Governors' Informal Meeting (including presentation by Maria Fox, Project Manager, Facilities, on Patient-Led Assessments of the Care Environment) Chairman's Counsel	Clive Hamilton, Sue Silvey, Mo Schiller, Brenda Rowe, Tony Rance, Elliott Westhoff, Pam Yabsley, Angelo Micciche, John Steeds, Wendy Gregory, Philip Mackie, Sue Milestone, Karen Stevens, Florene Jordan, Ben Trumper, Jeanette Jones.
27/11/2014	Trust Board Meeting	Sue Silvey, Bob Bennett, Clive Hamilton, Karen Stevens, Jeanette Jones, John Steeds, Sue Milestone –Governor, Marc Griffiths, Wendy Gregory, Florence Jordan, Brenda Rowe and Jim Petter.
Nov 2014	NHS England consultative event on planned elective care, London.	Edmund Brooks.
2/12/2014	Chair and Chief Executive Walkround- Women's and Children's.	Karen Stevens and Sue Milestone
4/12/2014	Annual Plan Project Focus Group	Wendy Gregory, Sue Silvey, Pam Yabsley, Bob Bennett, Angelo Micciche, Graham Briscoe, Clive Hamilton, Florene Jordan, Mo Schiller, John Steeds and Ben Trumper.
4/12/2014	Constitution Project Focus Group	Sue Silvey, Clive Hamilton, Bob Bennett, Graham Briscoe, John Steeds, Mo Schiller, Pam Yabsley, Angelo Micciche, Wendy Gregory, Florene Jordan.
9/12/2014	Health Matters Event - Rheumatology	Karen Stevens, Clive Hamilton, John Steeds, Wendy Gregory, Sue Silvey, Mo Schiller, Sue Milestone, Tony Rance
19/12/2014	Governors' Informal Meeting/ Chairman's Counsel meeting (including talk about impact assessments from Alison Grooms - BRI Redevelopment Implementation Manager and Rebecca Ridsdale - Assistant Director of	Pauline Beddoes, Bob Bennett, Graham Briscoe, Ian Davies, Thomas Davies, Wendy Gregory, Clive Hamilton, Philip Mackie, Sue Milestone, Sue Silvey, John Steeds, Karen Stevens, Tony Tanner, Ben Trumper, Pam Yabsley, Mo Schiller, Angelo Micciche, and Jeanette Jones.

	Human Resources.)	
19/12/2014	Nominations and Appointments Committee	*Open to Committee members only:* Mo Schiller, Sue Silvey, John Steeds, Pam Yabsley, Philip Mackie, Wendy Gregory, Florene Jordan, Jeanette Jones.
22/12/2014	Extra-ordinary Public Trust Board meeting	John Steeds, Angelo Micciche, Clive Hamilton, Pam Yabsley, Thomas Davies, Graham Briscoe, Jeanette Jones, Pauline Beddoes, Florene Jordan.
13/01/2015	Quality Project Focus Group	Clive Hamilton, Brenda Rowe, Sue Silvey, Mo Schiller, Angelo Micciche, Wendy Gregory, Lorna Watson, Sue Milestone, Florene Jordan, Ian Davies, Thomas Davies, Bill Payne and John Steeds.
14/01/2015	Governor Development Seminar	Sue Silvey (Lead Governor), Clive Hamilton, Brenda Rowe, Mo Schiller, Tony Tanner, Angelo Micciche, Anne Skinner, John Steeds, Pam Yabsley, Wendy Gregory, Karen Stevens, Thomas Davies, Florene Jordan, Ben Trumper, Jeanette Jones, Tim Peters, Bill Payne.
15/01/2015	Carer Strategy Group	*Lorna Watson (unconfirmed)*
19/01/2015	Quality Counts Members' Event	Clive Hamilton, Sue Silvey, John Steeds, Sue Milestone, Bob Bennett.
28/01/2015	*Workshop for PLACE (Patient-Led Assessment of the Care Environment)*	*At the time of writing, Graham Briscoe, Bob Bennett, Anne Skinner, Sue Milestone, and possibly Brenda Rowe had booked to attend workshop.* *Mo Schiller, Pam Yabsley and Angelo Micciche taking part in PLACE but not workshop.*