University Hospitals Dorset
NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust

Board of Directors Part 1

Wednesday 31 March 2021

13:15 – 15:15

Via Microsoft Teams

(Link to join meeting can be found in Outlook Diary Appointment)

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1
HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors held in public will commence at 13:15 on Wednesday 31 March 2021 via Microsoft Teams.

If you are unable to attend please notify the Company Secretary's Team, telephone 0300 019 2980

David Moss
Chairman

Please note that mobile devices and laptops may be in use during the meeting to access papers, record actions and notes as appropriate

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AGENDA – PUBLIC MEETING

13:15	1	Apologies for Absence:		
	2	Declarations of Interest		
	3	Patient Story		CNO
	4	For Accuracy and to Agree: Minutes of the Interim Boards of Directors Meeting held on 27 January 2021		Chairman
	5	Matters Arising – Action List		Chairman
13:35	6	Chief Executive's Report		CE
	7	**RISK**		
	7.1	Update on Covid-19 (inc. recovery of diagnostic and elective work) *(presentation)*		CNO/COO
13:55	**8**	**QUALITY AND PERFORMANCE**		
	8.1	For discussion	Integrated Quality, Performance, Workforce and Finance Report	Chief Officers
	8.2	For information	Chief Medical Officer - Mortality Report	CMO
14:25	**9**	**STRATEGY AND TRANSFORMATION**		
	9.1	For approval	Equality, Diversity and Inclusion Strategy	CPO
14:40	**10**	**GOVERNANCE**		
	10.1	For approval	Anti-Slavery Statement and Public Sector Equality Duty	CPO
	10.2	For approval	Charitable Funds Expenditure over £250k (verbal)	CFO

	10.3	For approval	Appointment of Senior Independent Director	Chairman
	10.4	For approval	Independence of Non-Executive Directors	Chairman
	10.5	For approval	Register of Compliance of Licence Conditions	CEO/Co Sec
	10.6	For approval	Register of Compliance with Code of Governance	CEO/Co Sec
	10.7	For discussion	Annual Review of effectiveness of third-party processes and relationships	CEO/Assoc. Director Comms

14:55	**11**	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 28 March 2021 to fiona.ritchie@uhd.nhs.uk	
15:05	**12**	Any Other Business	Chairman
	13	Key points of communication	Chairman
	14	Date and Time of Next Meeting: Wednesday 26 May 2021 at 13:15 via Microsoft Teams	
	15	2021 Meeting Dates: 26 May 2021; 28 July 2021; 29 September 2021; 24 November 2021.	
	16	RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.	
15:15	**17**	NB: A glossary of abbreviations that may be used in the Board of Directors papers will be found at the back of the Part 1 papers.	

AGENDA – PRIVATE MEETING

15:30	**18**	Welcome & Apologies for Absence:	Chairman
	19	Declarations of Interest	Chairman
	20	**APPROVAL OF MINUTES AND ACTIONS:**	
	20.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 27 January 2021	Chairman
	20.2	For Accuracy and to Agree: Part 2 Minutes of meeting held on 24 February 2021	Chairman
	20.3	Matters Arising – Action List	Chairman

15:40	**21**	**QUALITY, PERFORMANCE & RISK**		
	21.1	For information	Serious Incident Report	CMO
	21.2	For information	Risk Registers: New Red Risks	CNO
	22	**STRATEGY AND TRANSFORMATION**		
	22.1	For approval	Acute Reconfiguration – Final Business Case	CSTO
	22.2	For information	Wessex Fields Update (verbal)	CSTO
	23	**GOVERNANCE**		
	23.1	For approval	Annual Going Concern Statement	CFO
	23.2	For noting	Derwent Theatre Expansion	CSTO
	23.3	For noting	Informatics Capital Programme	CIO
	23.4	For approval	Flexible Cystoscopes and Stacks	CFO
	23.5	For information	Update on Operational Planning (verbal)	CFO/CSTO
	23.5.1	For approval	Opening Interim Budget 2021/22	CFO
	23.6	For information	Board Committees: Exception Reports (verbal)	Non-Exec Chairs
	24	Any other business		Chairman
	24.1	EVOLVE Cloud Service and Scanning Services.		CFO
	24.2	Key points of communication to staff		Chairman
	25	Board Reflection on the Current Meeting: • What has gone well; • What do we need to do more of; • What do we need to do less of.		Chairman
	26	Date and Time of Next Private Board Meeting: Interim Board of Directors Part 2 Meeting on Wednesday 28 April 2021 at 11 am via Microsoft Teams.		
17:00	**27**	Close of meeting.		

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

INTERIM BOARD OF DIRECTORS PART 1 – PUBLIC MEETING

Minutes of the meeting of the Interim Board of Directors held on Wednesday 27 January 2020 at 13:15 hours via Microsoft Teams.

Present:	Mr David Moss	Chairman
	Mr Pankaj Dave	Non-Executive Director
	Mr Philip Green	Non-Executive Director
	Mr Stephen Mount	Non-Executive Director
	Prof Christine Hallett	Non-Executive Director
	Prof Cliff Shearman	Non-Executive Director
	Mr John Lelliott	Non-Executive Director
	Mrs Caroline Tapster	Non-Executive Director
	Mrs Debbie Fleming	Chief Executive
	Dr Alyson O'Donnell	Chief Medical Officer
	Mrs Paula Shobbrook	Chief Nursing Officer
	Mr Peter Gill	Chief Informatics and IT Officer
	Mr Peter Papworth	Chief Finance Officer
	Ms Karen Allman	Chief People Officer
	Mr Richard Renaut	Chief Strategy and Transformation Officer
	Mr Mark Mould	Chief Operating Officer
In attendance:	Prof John Vinney	Associate Non-Executive Director
	Mr James Donald	Interim Associate Director of Communications
	Ms Lorraine Tonge	Group Director of Midwifery
	Mr Stephen Killen	Transformation Director
	Ms Zoe Jones	Corporate Governance Manager
	Mrs Carrie Stone	Company Secretary
	Mr Mike Weaver	Interim Assistant Company Secretary (minute taker)

BoD 001/21 Welcome and Apologies for Absence

Mr Moss welcomed everyone to the first Board of Directors meeting held in public in 2021. Mr Moss welcomed Prof John Vinney who had been appointed to the Board as an Associate Non-Executive Director. Mr Moss noted that Prof Vinney is Vice Chancellor of Bournemouth University and his appointment to the Board is an important part of the developing partnership between University Hospitals Dorset NHS FT and Bournemouth University. Mr Moss welcomed newly appointed Governors to the meeting, noting the first meeting of the Council of Governors would be held tomorrow. Mr Moss welcomed Ms Fiona Ritchie to the meeting, who would be joining the Trust as Company Secretary when Mrs Carrie Stone retires in March. Ms Ritchie is attending today's meeting as part of her induction. Mr Moss welcomed Mr Jim Durkin who was attending from the Bournemouth Echo and Mr James Donald the Trust's Interim Associate Director of Communications.

There were no apologies for absence.

BoD 002/21 Declarations of Interest

There were no declarations of interest noted.

BoD 003/21 Patient Story

Mrs Shobbrook presented a video that outlined feedback received from the wife of patient who was diagnosed with Alzheimer's Disease in January 2019, following his admission to Poole Hospital ED after a fall at home in November 2020 and the subsequent care he received both in the hospital and following his discharge, in the community.

Mrs Shobbrook asked the Board to note it was very pertinent to receive this patient story today as it provided a very clear understanding of the pressures that patients and visitors felt in the environment that staff were currently working in. The story identified lessons to be learnt in terms of communication e.g. answering telephones and patient moves at night, all of which would be discussed during the course of today's meeting. Mrs Shobbrook asked the Board to note the work of the Trust's PALs team and in particular Ms Underhill in this case, who help and support patients and carers to navigate the healthcare system particularly when patients are moving from hospital into a care home.

BoD 004/21 For Accuracy and to Agree: Minutes of the Interim Boards of Directors Meeting held on 25 November 2020.

The minutes were APPROVED as a correct record of the meeting.

BoD 005/21 Matters Arising – Action List

170/20: Mr Mould reported that health inequalities were a really important topic, not least as a result of the impact Covid-19 had on health inequalities across the organisation and the Dorset system. The Trust had added a section on health inequalities to the elective escalation sheet in the IPR this month and work had started to reflect performance linked to health inequalities in future IPRs. The phase 3 planning letter linked health inequalities to Trusts' performance on recovery of referral rates and activity levels; reducing variation in access across geographies in the system, regionally or nationally; and the use of digitally enabled pathways e.g. attend anywhere. The Trust took part in a South West Regional session on 14 December on Health Inequalities & Elective Care Recovery to look at best practice in this area. The Clinical Commissioning Group (CCG) had been asked to support a conversation between the Trust and the Population Health Implementation Team. It was agreed that the Trust's approach to Health Inequalities would be reported to the Board in March. **Action: MM**

It was noted and AGREED that all matters arising had been executed unless subject to this or future meetings.

BoD 006/21 Chief Executive's Report

- With high staff sickness rates during the pandemic it had proved challenging at times to maintain appropriate staffing levels due to the number of staff absent through illness or isolation. All staff had done the very best they could in very difficult circumstances and that was reflected in feedback from patients and their families.
- Mrs Fleming was delighted with the progress made in rolling out the Covid-19 vaccine locally and nationally. The vast majority of Trust staff had received the Covid-19 vaccination.

- Mrs Fleming welcomed the establishment of the Council of Governors, noting the first meeting would be held on 28 January. Mrs Fleming noted the Trust arranged a very informative and useful induction for Governors and a very useful Board and Council of Governors Development session. The Trust was very fortunate with the calibre and commitment of the Governors who had been appointed and looked forward to a very constructive and productive relationship that did the very best for the patients and people served by the Trust.
- The Trust was looking forward to formally launching its newly adopted set of values for University Hospitals Dorset in February 2021.
- Mrs Fleming noted progress with the Trust's Capital Programme particularly plans for the creation of the emergency and planned care sites. Further details on what would be happening at all Trust sites would be shared over the next few weeks. Work had already started on the Theatres at Poole Hospital and work was expected to start on the Bournemouth site within the next few weeks.
- Discussion with partners in regard to the Dorset Integrated Care System (ICS) would be taken forward over the coming weeks.
- The Trust was very proud that Minnie Klepacz (Ophthalmology Matron & BAME Lead) had been recognised in the Covid Kindness UK:2020 book for her incredible efforts to support others and her founding of the Filipino Nurses Association UK, going over and beyond her daily matron duties.

The report was NOTED.

BoD 007/21 Update on Covid-19

Mrs Shobbrook introduced an update on COVID-19. Key points were noted as follows:

- The infection rate and local circumstances continued to vary across the country. Incidence was rising in Dorset and in UHD. Rates were up to 891 per 100k population for the BCP area, much higher than wave one of the Covid-19 Pandemic. Responding to that increase in Covid-19 demand had been the workload and absolute focus of the team over the last month.
- Supporting all staff was an absolute priority. Staffing levels had been impacted. Infection Prevention and Control measures were very robust. The Trust had seen an increase in the number of staff off sick with the latest wave of Covid-19.
- The number of patients admitted with Covid-19 correlated with the number of cases in the community. The Trust had worked with Public Health Dorset to understand the impact of rates in the community on the Trust. More patients were admitted in the second phase and there was a significant increase in patients admitted in phase three that reflected the increase in cases in the community.
- Mrs Shobbrook chaired the outbreak control meetings every day in her role as Director of Infection Prevention and Control (DIPC). Attendees included Public Health Dorset and NHS Dorset who provide a very helpful external view of what was happening and therefore ensured the Trust was able to understand and react to what was happening in the community. The organisation was linked up with the tactical approach set up by Dorset.

- The Trust closely followed advice from Public Health England in terms of action to reduce nosocomial spread that included allocating pathways for patients and ensuring reductions in the movements of staff. Within the organisation the Trust provided training, support and equipment to enable staff and patients to be as safe as they possibly could. The Trust had a continuous regime of testing patients. Staff had access to an IPC training programme across Poole, Bournemouth and Christchurch Hospitals. Staff could therefore complete their training online.
- This was a very challenging time for staff and the patient story today illustrated the impact this could have on patients, noting that staff were wearing PPE in ward areas. Answering phones in a ward area could be more difficult when wearing PPE. In addition, staff were focusing on the care of patients and PPE had to be put on and taken off in the right order. The Trust was being assisted by volunteers to help improve communication. The major incident system included a nurse commander and a medical commander, and they were working tirelessly every shift to ensure there were sufficient staff across the organisation. This sometimes involved moving staff across wards and sometimes wards were changed from a green to blue. The Trust was starting to see a reduction in the numbers of patients admitted into the hospital with Covid-19.

Mr Mould presented an update on Covid-19. Key points were noted as follows:

- The Trust planned out a number of scenarios around admissions and discharges across the organisation on a daily and weekly basis. This included work to understand what capacity the Trust needed to safely care for patients should there continue to be a rise in the number of Covid-19 patients.
- The Trust worked on a scenario that predicted a peak of 479 beds being occupied by Covid-19 positive patients.
- As reported by Mrs Shobbrook, the Trust was starting to see a slight reduction in admissions of Covid-19 patients and therefore it was hoped the Trust would have sufficient capacity for admissions and discharges. The Trust had also worked on scenarios for Critical Care. Normally there would be 22 critical care beds in UHD. On the basis of physical space the Trust could increase critical care capacity to 60 beds. That would be 50 beds for patients that were Covid-19 positive and 10 beds for patients who were Covid-19 negative. The Trust had not needed to surge into that number of beds.
- The Trust had sought mutual aid as part of working with the Dorset ICS where each partner helped and supported each other around demand that was coming through the front door or the stepping down of patients in a safe and timely way. Working with local authorities the Trust had commissioned additional residential, nursing home and domiciliary care capacity. Community health providers had used community bed capacity to discharge medically ready to leave Covid-19 positive patients to support patient flow outside the hospital. The Trust had worked very closely with the independent sector to maintain cancer operations where it was safe to do so. The Trust had worked with the Nightingale hospital in Exeter to safely transfer a very small number of patients which had allowed the Trust to free up bed capacity on a number of the Covid-19 positive wards. As part of the critical care network, the Trust had sought mutual aid from other organisations around critical care transfers to other organisations to allow the Trust to be able to operate within its critical care footprint. A number of military medics had also been working alongside Trust's teams across the organisation

Ms Allman presented an update on Covid-19 in relation to support for staff. Key points were noted as follows:

- From the offset the Trust had worked to ensure it was providing the right support to staff and this was reviewed with staff on a regular basis. The Trust sought to learn from other organisations as well and offered enhanced wellbeing and there was also a system offer. Members of the Board were asked to note that staff would require support for a significant length of time. With the roll out of the vaccination programme Ms Allman noted it was hoped the situation would improve by the summer. However, support for staff would need to be in place for a much longer period of time and the level would depend on their level of need. The Trust was utilising resources through its charitable funds and any other funds that were available.

Mr Gill provided an update on the Trust's Covid Vaccination programme. Key points were noted as follows:

- The Trust started its vaccination programme on 28 December and had come to the end of dose one for all UHD staff and was coming to the end of all frontline health and care staff in East Dorset.
- The Trust was not permitted to disclose the exact number of staff vaccinated. The national expectation was that 80% of all people offered a vaccination would take up the opportunity and that was consistent with UHD staff. The interval between the first and second dose was a matter of debate. Current advice was that it would be 12 weeks and therefore the second dose was expected to be offered around the middle of March. The Trust would like to start at 10 weeks in order to provide a buffer should there be any interruption to the supply of vaccine or some other operational problem.

Mr Moss paid tribute to the enormous effort from staff in their support of the vaccine programme. It was understood that 300 members of staff helped to set up and run the vaccination programme. An extraordinary achievement in a very constrained delivery situation. The support of circa 40 to 50 military personnel was making a real impact on what the Trust was able to do.

Dr O'Donnell noted it had been a real team effort, advising that staff were finding it very difficult not being able to provide the pastoral support to families that they would like, particularly for example, towards the end of life. That was potentially contributing to the moral injury that people were feeling, and the Trust would need to pay particular attention to some of the senior leaders in the organisation and the burden they carried.

Mr Papworth provided an update on the Trust's Financial Position. Key points were noted as follows:

- The Trust was in a very volatile situation in relation to the operational challenges that it faced and that made predicting the forecast and end of year position very difficult.
- The Trust was in favourable position at the moment: £1m favourable against the deficit plan to date. However, there were a number of issues that would happen between now and the end of the year. The elective incentive scheme was expected to be void due to the bed occupancy related to Covid-19 patients so there won't be a reduction in income linked to that. The Trust was expecting some additional income to come through in March linked to the continued loss of non-NHS income and there would be some allocation in March that was yet to be confirmed. There would be an increase in costs in March as the Trust made provision for untaken annual leave.

- There would not be any additional funding linked to the current peak and that was the national approach because currently the general position across the NHS was an underspend against planned Covid costs. The expectation and therefore the request was that the Trust managed the surge within its current budget profile.

The report was NOTED.

BoD 008/21 Integrated Quality, Performance, Workforce and Finance Report

Mr Mould presented a report on the operational performance of the Trust during December 2020. Key points were noted as follows:

- The organisation was making good progress on its elective, diagnostic and cancer recovery returning a considerable percentage of previous work back to normal. However, in the middle of December the Trust started to experience the impact of Covid-19. The Trust had to move its resources to be able to respond to the numbers including staffing and bed capacity. The Trust had to support its critical care unit with its theatre staff and therefore between the middle of December and all through January there had been a reduction in activity across the organisation.
- The total number of people waiting in the organisation for elective treatment had not changed remarkably. There were 45k people on the waiting list in January this year compared to 45k on the waiting list this time last year. However, when looking at the profile of how long people had waited, there were currently 3,705 waiting over 52 weeks for treatment compared to 60 people waiting over 52 weeks at the same time last year. With regard to the number of people waiting over 40 weeks for treatment, there were nearly 8,000 people waiting for treatment compared with 786 last year. Mr Mould advised that the Trust had clinically prioritised the waiting list into P2, P3, P4 and P5.
- Patients clinically prioritised as P2 were those patients who absolutely needed to have their elective operations within a time period that was very clearly defined, noting that P3 and P4 had different time periods.
- Specialities with significant waiting times included ENT, Oral Surgery, Trauma and Orthopaedics, General Surgery and Urology.
- There were clear governance procedures in place around recovery plans across the Medical, Surgical and Specialist Care Groups.
- Diagnostics Waiting Times and Activity (DM01): the Trust had achieved 97.3% of patients within 6 weeks, a tremendous achievement for the organisation. Performance had slightly deteriorated in January. UHD stood out nationally as one the organisations that had recovered remarkably well. This performance informed cancer and diagnostic pathways for elective surgery.
- Urgent and Emergency Care: there has been a reported fall in patients attending urgent and emergency care. All patients were required to be tested for Covid-19 on admission after which they were admitted through a green or blue pathway. This had resulted in delays at the front door. However, the Trust had seen a significant increase in testing capacity in its Emergency Departments across the Poole and Bournemouth sites in the last 10 days.
- Medically ready to leave patients: at present there are 87 medically ready to leave patients in UHD. 24 patients are waiting for their Covid-19 swab results before they can be discharged into an appropriate setting. For the other 63 patients the Trust was working with local commissioners to agree transfers of care.
- Cancer: the Trust's cancer position had improved. The Trust was starting to see a reduction in the numbers of people waiting. The number of people waiting over 104 days for their final treatment had significantly reduced.

Mrs Shobbrook provided an update on the key performance indicators relating to quality, safety and patient experience. The following key points were highlighted:

- The Quality Committee reviewed the quality metrics in detail at its meeting on 25 January.
- The rates of patient falls and pressure damage which are monitored very closely remained stable. This was an absolute testament to the work teams were doing on the wards.
- As referenced in the patient story earlier, there had been an increase in the number of patient moves, particularly out of hours in order to assist with supporting Covid-19 pathways.
- The criteria for escalating concerns in relation to staffing levels i.e. red flags for Poole and Bournemouth Hospitals were different when they were separate organisations. The Trust had undertaken work to align criteria for red flags across the Trust and this was discussed in detail at the Quality Committee meeting held on 25 January and would be reported to the Workforce Strategy Committee.
- Despite the number of patient moves the Trust had maintained single sex accommodation. The Trust was constantly working to maintain the privacy and dignity of patients whilst undertaking patient moves.
- There were two national surveys running: the Inpatient Survey and the Urgent, Emergency Care Survey.

Dr O'Donnell provided an update on the key performance indicators relating to quality, safety and patient experience. The following key points were highlighted:

- The Trust had successfully merged the learning from deaths and mortality surveillance groups across UHD.
- There was very good collaborative work with some themed reviews being undertaken with teams from the historic organisations to look at how the Trust may bring the learning together.
- Mortality metrics remained a good story. The Trust had a robust process for reviewing any death associated with Covid-19. A consolidated report would be brought to the Board at a later date.
- The Trust had completed work to bring together the end-of-life care teams and was looking to see how it may contribute to national studies around care at the end of life and any other audits. It was expected there would be many lessons learnt from how organisations have had to work differently during the pandemic.

Mr Papworth presented a report on financial performance. The following key points were highlighted:

- The report was for the six-month period rather than the full financial year i.e. from the date of merger until the end of March.
- The revenue position was volatile at the moment, but the Trust was expecting to be favourable at the year end.
- The current Covid-19 situation had had a significant impact on the Trust's capital outturn. The Trust had a capital programme in excess of £80m and there had been material slippage as a result of limited access to operational areas as a consequence of operational challenges. There had also been supply chain issues and delays linked to the third lockdown. The Trust was trying to offset significant estate slippage by bring forward medical and IT equipment from next year's capital programme, but even with these measures in place it was likely there would be a significant underspend. The Trust had previously forecast an underspend of £6m and that had been formalised with the Trust's regulators. The Finance and Performance Committee agreed to increase the forecast capital underspend to £11m at its meeting on 25 January and this had been agreed with the Trust's regulators.

- The current interim arrangements would be rolled over into Quarter One of 2021/2022 and this reflected the current operational and clinical challenges faced by the Trust and the need to prioritise the safety of patients. Confirmation of these arrangements was not expected until mid to late March. Discussion between NHSE/I and the Treasury to agree allocations for the first quarter of next year was continuing. The expectation was the Trust would roll over current budgets and bring a report back to the Board in April that was reflective of the continuation of the interim arrangements. In quarter one of next year the Trust was expecting to go through a detailed operational planning process. Further guidance for quarters two to three next year was expected in early April. The Trust expected to submit detailed operational plans by the end of June 2021.

Ms Allman provided an update on the key performance indicators relating to Workforce. The following key points were highlighted:

- As reported in the IPR, the Trust continued to be very busy in its HR and OD functions and its support for staff across the Trust. Ms Allman noted her huge pride in her team and the way that all staff across the Trust were working to support each other.

The report was NOTED.

BoD 009/21 Update on recovery of diagnostic and elective work.

Members of the Board noted this item was reported by Mr Mould under item 008/21 as part of his operational performance update.

BoD 010/21 Ockenden Report: assurance framework and safety action plan

Mrs Shobbrook introduced a report on the Trust's position in relation to the NHSE Self-assessment tool following the Ockenden Report issued on the 14 December 2020 and welcomed Ms Tonge, Group Director of Midwifery to the meeting. The following key points were highlighted:

- The purpose of today's presentation was to report the UHD position in relation to the NHSE Self-assessment tool which would include the action plan to address the gaps identified and in doing so, provide assurance to the Board.
- The Board was asked to approve the Trust's action plan prior to submission to the Local Maternity System (LMS), Regional Chief Midwife and NHSE/NHSI.
- The Ockenden report was an independent maternity review into The Shrewsbury and Telford NHS Trust and the maternity service which showed many failings in maternity safety.
- To provide initial assurance of maternity safety, all Trusts were asked to implement 12 immediate clinical priorities in December and report back to the national team.
- In December 2020 UHD was able to report that 10 of the standards were already fully met and the further 2 standards were in progress to achieve full compliance.
- To provide further assurance to NHSE/I, the regulator had asked all Trusts to complete a deeper analysis of the 7 key essential actions.
- Analysis showed 60 to 70% of each of the standards were fully achieved by UHD. To achieve full compliance the Trust had developed an action plan.
- The Trust would work with the regional and national team to strengthen maternity governance and provide evidence and assurance of maternity safety.
- The assessment was completed with the maternity Non-Executive Maternity Safety Champion, Mrs Tapster, Executive leads Mrs Shobbrook and Dr O Donnell, the Clinical Director and the Director of Midwifery, the LMS

partnership and the Maternity Voices Partnership (MVP). This analysis and action plan was approved at the Quality Committee on the 25 January.

- The Maternity Safety Champions would commence the action plan and report progress to the Board through the Quality Committee with oversight from the Non-Executive Maternity Safety Champion.
- Further work had commenced through the LMS in establishing maternity safety reporting and the UHD Maternity team were fully engaged in this new LMS governance structures.
- Regional and National reporting of quality and governance mechanisms were also underway.
- Trust Boards had been asked to review their own processes to be confident that they know that mothers and babies are really safe.
- The Board would be provided with a report each month using the data set criteria as outlined by in the perinatal quality surveillance model. The maternity safety champions would analyse this data with the Non-Executive board member and executive board member prior to submission of the report and the Board would be altered to any concerns raised.
- The Quality Committee discussed the action plan and the assessment that had been completed in detail at its meeting on 25 January. The recommendation from the Quality Committee, Mrs Shobbrook and Dr O'Donnell was to recommend to the Board that it approved the NHSE Self-assessment tool following the Ockenden report and the action plan to address the gaps identified from the self-assessment.

Mrs Tapster expressed her thanks to Ms Tonge and her team for completing the assessment whilst managing the current operational pressures in a very short space of time. The Quality Committee received assurance that the action plan was developing as it should be and it would be monitored by the Quality Committee on a monthly basis. Mrs Tapster advised she would keep the Board updated.
The Board NOTED and APPROVED the Trust's position in relation to the NHSE Self-assessment tool following the Ockenden report issued on the 14 December 2020 and the Trust's action plan that would be submitted to the LMS, Regional Chief Midwife and NHSE/NHSI.

BoD 011/21 Quality Impact Assessment (QIA) Overview Report

Mrs Shobbrook introduced the Quality Impact Assessment (QIA) Overview Report produced by the Head of Productivity and Efficiency. The following key points were highlighted:

- The Trust agreed to provide the Board with a quarterly summary report on the QIA Overview Report, noting the Board had previously approved the QIA process for the Trust. This was a process in place that included the Finance and Performance Committee and all operational teams.
- The purpose of the process was to ensure that as operational leaders the Trust was clear that in line with its Risk Appetite, any Cost Improvement Schemes do not have a negative impact on the quality of care provided and that the organisation remained safe.
- Circa £4.1m schemes had been fully agreed or agreed in principle. 106 schemes required a QIA. This was reviewed at the Finance and Performance Committee. If there were any schemes that were thought to have a negative impact on the quality of services these schemes were then reported by exception to the Quality Committee.
- This paper was presented for information, noting the QIA process agreed by the Board was embedded and underway.
- Dr O'Donnell and Mrs Shobbrook provided oversight in order to give assurance around the additive effects of cost improvement programmes, not the individual

cost improvements themselves and the Board could be assured that the process was working well.

Mr Moss noted the importance of taking into account the impact of Covid-19 on the pace of the cost improvement programme.

The report was NOTED.

BoD 012/21 Six Month Safe Staffing Review (Q1 & Q2) 2020

Mrs Shobbrook presented the Six-Month Safe Staffing Review (Q1 & Q2) 2020 report. The following key points were highlighted:

- The Chief Nursing Officer had a statutory responsibility to provide the Board with assurance that the Trust had controls in place to oversee safe staffing.
- This was in line with NHSI/E and CQC requirements and it was a process the Board was very used to receiving.
- This report had been presented to the Workforce Strategy Committee
- The Trust had the metrics in place to review its staffing e.g. red flags and care hours per patient day. Operationally there were daily staffing meetings and detail was worked through with Directors of Nursing, Matrons and the operational teams. This operated 24 hours per day across all sites.
- The report encapsulated a great deal of learning. Mrs Shobbrook assured the Board there were no unmitigated red flags reported during wave one of the pandemic. This served to demonstrate the level of achievement within teams supported by colleagues within the HR team and staff bank.
- Detail was contained within the Care Group reports. The template review was used to assess ward staffing levels in order to ensure they were safe, there was professional judgement, that there were quality metrics for patients and staff in place and that it aligned with Trust budgets and the electronic roster.
- The Care Group reports included details of proactive changes to care pathways in the light of Covid-19. Pathways continued to change as the pandemic continued. Lessons learnt from the movement of staff within the Emergency Department and the Surgical Care Group for Intensive Care in order to support patients was being applied to other areas in the Trust during the pandemic.
- The Specialist Care Group had not got as many 'frontline wards' compared with other Care Groups. However, the support received from staff working in the Specialist Care Group to other Gare groups in the Trust had been absolutely remarkable.

Mr Moss noted colleagues that had offered to work outside their specialty in order to support areas under pressure and also noted the contribution from aspirant nurses i.e. student nurses from the university. Mrs Shobbrook noted the temporary register of the Nursing and Midwifery Council (NMC) was opened in wave one of the pandemic and this enabled third year students to work under supervision on hospital wards as Band 5 Nurses. This was supported by the Trust's education and training teams linking with the universities and these nurses provided great support. The NMC had again opened up the register for students to be able to work under supervision in the Trust. Members of Ms Allman's team, the Bournemouth University Team and Mrs Shobbrook had worked very closely together. This has been a great example of partnership working. Mr Moss asked Prof Vinney to pass on the Board's thanks and best wishes to university colleagues in the Faculty of Health Sciences for their support during this time.

On behalf of the Board, Mr Moss expressed his thanks to Ms Allman and members of her team, noting that the support of student nurses, nurses returning to the register, medical students and doctors had been remarkable and it was very much appreciated. Of note was the work of Ms Allman's team supporting recently retired staff to return to the Trust in liaison with the nurse commander.

The report was NOTED.

BoD 013/21 Update on Transformation (to include Estates)

Mr Renaut provided an update to the Board of Directors on Transformation, including changes to the Trust Estate and welcomed Mr Killen to the meeting. The following key points were noted as follows:

- There would be three main site changes between February and October 2021.
- This included changes to the West (Eye Unit) Entrance and construction for the Maternity, Childrens', Emergency and Critical Care Centre at the Royal Bournemouth Hospital site.
- From February to August 2021 there would be changes to access for staff and patients around the West (Eye Unit) Entrance in order to protect patients, staff and visitors to the hospital. A tunnel would be created in order to enable pedestrian access to the West Wing and there would be signposting to the main entrance. Access to the existing car park would be maintained and staff would still be able to exit right from the multistorey car park. Disabled parking would be moved to facilitate pedestrian access.
- From March 2021 onwards, Car Park A and what was currently the consultants' car park would be closed. Anyone arriving at the bus interchange would still be able to access the front of the site. Following the closure of Car Park A, people would be directed down to Car Parks B and C.
- A site compound would be created around the front of the Bournemouth site from October 2021 onwards. Access into the Emergency Department would be maintained at all times. Access into the Bournemouth site would be one way from bus interchange to the car park and then around and exiting the estate.

Mr Moss noted there were two very informative videos that showed the changes that would be made at Royal Bournemouth and Poole Hospitals and these had been shown to a wide range of stakeholders. Mr Killen confirmed the videos were available to view on YouTube.

The report was NOTED.

BoD 014/21 National Zero Carbon Strategy

Mr Renaut updated the Board on the National Zero Carbon Strategy, with the key points noted as follows:

- The National Zero Carbon Strategy was reported for information for all those in attendance at today's meeting.
- The Board held a seminar on this matter in November 2020. A sustainability strategy, known as the "Green Plan" would be developed in draft for the Board in March 2021 for approval as part of the Annual Plan by April 2021.
- Whilst the Trust responded to the Covid-19 pandemic it must also be noted the climate crisis was also a health crisis, particularly in the way it affected the health and wellbeing of the population.
- There were many practical actions the Trust could take, many of which were beneficial to staff and patients as well as the environment.

- The wedge diagram on page 16 of the strategy set out the pathway to net zero for the NHS Carbon Footprint. Aside from national schemes from which the Trust would benefit e.g. electricity decarbonisation there had been a huge carbon reduction with the introduction of virtual consultations. The Trust would look to further action to become carbon sustainable as part of its capital programme. The biggest opportunities from carbon reduction would be in relation to how the Trust delivered its care. Both BCP Council and Bournemouth University were vital members of the Trust's Sustainability Committee.

Prof Hallett noted the National Zero Carbon Strategy mentioned the link between sustainability and inclusion and highlighted the importance of the Sustainability Committee in tackling inclusion as part of its plan for the Trust. Prof Hallett suggested it would be helpful for the Equality, Diversity and Inclusion Group to be briefed on sustainability dimensions of its activities so that they were aware of the work that was taking place elsewhere in the organisation. Prof Hallett asked Mr Papworth to draft a two-page briefing for the Equality, Diversity and Inclusion Group.

Mr Lelliott reported on work by Mr Renaut and his team to produce a "Green Plan" which was based on the National Zero Carbon Strategy. Sustainability was cross cutting and touched on many other areas such as Equality, Diversity and Inclusion. Key areas for the Trust included Estates, Clinical Pathways, Pharmaceuticals and Procurement. The three key areas to be considered in terms of carbon reduction were "avoid, reduce and substitute" and that would be the basis of the Trust's "Green Plan" going forward.

Prof Vinney noted it was to good the Trust and the University working on sustainability together. Sustainability was absolutely central to the strategy for the University. The University looked forward to working with the Trust to achieve net zero as soon as possible.

The Sustainability Strategy would be presented to the Board in April 2021.

Action: RR

It was agreed that a briefing on the aspects of sustainability linked to inclusion would be provided to the Equality, Diversity and Inclusion Group. **Action: RR/PP**

The report was NOTED.

BoD 015/21 Charitable Funds Expenditure over £250k

The Board NOTED there were no items to approve.

BoD 016/21 Board of Directors Governance Cycle

Mrs Stone presented the draft Governance Cycle for the Board of Directors, with the key points noted as follows:

- Mrs Stone asked the Board to note items 10.2 to 10.6 were linked to the approved Constitution or were contained within the NHS Code of Governance, a comply or explain document that the Trust was required to report against at each year's annual report.
- The purpose of the paper was to inform the Board of the proposed governance cycle and to seek approval subject to any further comments or amendments from members of the Board.

The Board APPROVED the governance cycle for the Board of Directors.

BoD 017/21 Chairman v Chief Executive Responsibilities Statement

Mrs Stone presented the responsibilities statement for the Chairman and Chief Executive, with the key points noted as follows:

- In Monitor's Code of Governance for NHS Foundation Trusts, one of their main principles (A.2 Division of Responsibilities) is that there should be a clear division of responsibilities at the head of the NHS Foundation Trust between the Chairing of the Board of Directors and the Council of Governors and the Executive responsibility for the running of the NHS Foundation Trust business. No one individual should have unfettered powers of decision.
- The purpose of the paper was to inform the Board of the proposed statement and to seek approval subject to any further comments or amendments from members of the Board.
- If approved, the statement would be placed on the Trust's website.

The Board APPROVED the Chairman v Chief Executive Responsibilities Statement

BoD 018/21 Statement on the Composition of the Non-Executive Directors

Mrs Stone presented the Statement on the Composition of the Non-Executive Directors, with the key points noted as follows:

- The statement had been reviewed by the Chairman and Chief Executive.
- The purpose of the paper was to inform the Board of the proposed statement and to seek approval subject to any further comments or amendments from members of the Board.
- The Board was asked, if so minded, to recommend approval of the statement by the Council of Governors.
- The Council of Governors would be receiving the statement on 28 January.
- If the statement was approved by the Council of Governors on 28 January then it would be added to the Trust's website.
- Work was underway to consider the principles of succession planning for the Board of Directors. There was a draft process researched and drafted by the Interim Assistant Company Secretary, Mr Weaver. This draft document was with the Chairman and Chief Executive with the proposal that it would be discussed at a future Board Development session.

Mr Moss noted the Non-Executive Director Skill Matrix key areas of performance included in the report. Mrs Fleming welcomed this document as a very useful position statement. Over the coming months and years as the focus for the Board turns to strategy, the Board would need to review the composition of the Board and consider whether it was truly representative of the communities that it was serving.

Ms Allman stated the skills matrix would need to be reviewed to reflect a more generic understanding of what was required for Non-Executive Directors. The age profile of Non-Executive Directors should reflect what was required by the Board. Mrs Stone agreed, the current skills matrix for Non-Executive Directors would need to be reviewed in light of what was required by the Board of Directors.

The Board AGREED the Statement and recommended its approval to the Council of Governors.

BoD 019/21 Board Policy for Engagement with the Council of Governors

Mrs Stone presented the Policy for Engagement with the Council of Governors, with the key points noted as follows:

- The paper fulfilled the requirement of Monitor's Code of Governance (provision A.5.6) and reflected Annex 6, Section 6: Governors and Directors: Communication and Conflict of the Trust's Constitution, previously approved.
- Mrs Stone asked to note key points as set out in the supporting paper.
- The purpose of the paper was to seek approval of the Policy for Engagement from the Board of Directors.

Mr Moss noted the policy reflected the statutory framework and the Council of Governors would receive the policy for information tomorrow. What really mattered was how the Board and Council of Governors worked together. The recent joint development event between Directors and Governors went very well.

The Board APPROVED the Board Policy for Engagement with the Council of Governors and recommended it for information to the Council of Governors.

BoD 020/21 UHD Declaration of Directors' Interests and Fit and Proper Persons Declarations

Mrs Stone presented the most recent register of interests and confirmation of compliance with the Fit and Proper person requirements. Key points were noted as follows:

- All Directors had been asked to sign individual Fit and Proper Person Declarations.
- Checks against the Insolvency Register and the Disqualified Directors list had been conducted.
- No concerns about Directors' fitness or ability to carry out their duties or information about a Director not being of good character had been identified or brought to the attention of the Chairman.
- The Chairman could therefore provide the Board with assurance that all Directors continued to meet the Fit and Proper Person requirements.
- DBS checks for each Director had been undertaken.
- Mrs Stone asked the Board to note one verbal update to the register of interests for Mr Pankaj Dave, Non-Executive Director who had confirmed he was a Board Lay Trustee, member and Chair of the Audit and Risk Committee of the Royal College of Surgeons. This update would be included in the register of interests before it was uploaded to the Trust website.
- Mr Renaut asked the Board to note his wife was a pharmacist undertaking shifts via the UHD staff bank and in a local Primary Care Network.

The Board NOTED the register of interests and accepted the assurance that all Board members met the Fit and Proper Persons requirements.

BoD 021/21 Questions from Governors and Public arising from the agenda

Question

I understand that a national investigation has been launched by the Healthcare Safety Investigation Branch into the provision of piped oxygen gas supplies and the robustness of hospital oxygen supply systems, after the need to care for a rapidly increasing number of Covid-19 cases caused problems which saw one trust struggling to treat critically ill patients.

Can the Board please provide an update on the current position with regard to the supply and availability of oxygen within their hospitals and give an assurance that no patients have been adversely affected by the lack of it during the current pandemic.

Answer

We have carefully followed the national guidance including very detailed reporting on oxygen usage and supplies at both Poole and RBH. This is in addition to the alarm systems installed to alert where localised usage is high. The other actions taken including pre-agreed mitigations if usage is likely to rise to levels that require closer monitoring or actions.

Despite the much heavier draw on oxygen supplies as result of the number of covid patients, currently the system has not risen above “Green” (50% of total system capacity). Therefore patient care has not been affected by oxygen supply issues. This is a dynamic situation and will remain closely monitored.”

Mr Renaut added the Trust has an alarm system for levels of oxygen and undertakes manual testing in order to identify areas where there has bee an increase in oxygen use. Even at the peak of oxygen use a week or so ago the Trust was at slightly less than half its capacity. The Trust continues to monitor the situation very closely. The Trust invested in expanding its oxygen capacity at the Bournemouth Hospital site in wave one.

Question

Is the Trust planning to install electrical charging points as part of its estate redevelopment plans.

Answer

The NHS has a salary sacrifice scheme to support staff who may wish to purchase electric cars. There are some public and staff electrical charging points on site however not enough. As part of the Trust capital programme particularly around car parking, more charging points will be installed. With battery life extending the Trust is looking to install top-up charging points.

Question

My son is a paramedic with Southwestern Ambulance, and he is concerned with vehicular access to Bournemouth Hospital during rush hour when roads can become gridlocked. There was no mention of this issue under item 9.1 on the agenda. It is understood there was going to be a flyover built over the Cooper Dean roundabout.

Answer

Papers published for the Bournemouth, Poole, Christchurch Council Cabinet meeting includes a proposal to sell land to the Trust in order to connect the road junction from Wessex Way to the hospital site which will provide a second road in and out. It's not the full fly over junction but it is an additional junction that will partly reduce the traffic at peak hours. It is understood there has been less gridlock in the last few years as a result of action taken in relation to the road junctions and reducing overall traffic volumes on site. Ambulances have been able to get in and out throughout this however we are conscious of the risk of delays in and off site. That is why as part of the zero-carbon strategy the Trust is working to reduce traffic on and off site that includes taking high volume traffic generating services off site such as GP blood tests, Sexual Health Clinic, Outpatient Physiotherapy and moving to more community-based services. That would take circa 200k annual trips off the Bournemouth Hospital site. This is part of a whole range of actions the Trust is taking to reduce congestion around the Bournemouth site.

Mr Renaut agreed to brief the Governors on the position regarding the BCP position on the fly-over over the Wessex Way. **Action: RR**

Question

With regards to the performance report would someone please comment on the quite big rise in medication incidents. Particularly in December and the increase in MSSA in November. Is this linked to the current pressure that staff are under. On a positive note there has been a reported decrease in pressure ulcers. Is that linked in with a different patient cohort or is there something else.

Answer

The Trust is not concerned by the slight spike in MSSA cases in November. The Trust review any case where there has been infection in order to understand if there is anything the Trust should be concerned with. Cases of Clostridium difficile have reduced. All of the practices the Trust has for infection prevention and control are important for all the other infections. With regards to pressure damage, teams are prioritising fundamentals of care and ensuring that patients are moved, repositioned and have the right bed and pressure relieving surface. All of these measures have remained an absolute focus. Whilst staff are incredibly busy they are wearing PPE and not able to answer the phone in perhaps as timely a way as they would usually be able to. Staff are alongside patients providing that fundamental care. In terms of the medication incidents Dr O'Donnell chairs the Medicines Governance Group. Dr O'Donnell reported on discussion at the December Medicines Governance Group that included the rise in medication incidents. Historically if you look at the pattern of medication incidents they appear to rise over the second half of the year. It is not certain whether this rise is related to how busy the Trust is or whether it is related to the intake of junior doctors in August however the pattern is seen to be repeating. Most of incidents reported have not been associated with any patient harm. There was only one incident related to insulin that was classified as a Serious Incident and that incident was subject to a full Root Cause Analysis Investigation which included the CCG. That investigation resulted in important lessons being spread throughout the organisation. There are no particular themes or areas of the organisation that would explain what is happening. There is often an increase in medication error reporting with the introduction of electronic reporting.

Question

Given that the Care Quality Commission (CQC) sometimes make unannounced visits what processes does the Trust have in place to monitor staff dissatisfaction and concerns. It is pleasing to see the Trust has put in place health and wellbeing support for staff. How to you monitor any dissatisfaction?

Answer

The Trust aims to have an open and supportive culture in the organisation. The CQC are not undertaking inspections at this present time. Mrs Shobbrook works very closely with the CQC as do other members of her team. Because of the current situation the CQC have confirmed they have no plans to inspect UHD. Mrs Shobbrook participates in engagement meetings with the CQC and Mrs Shobbrook has a call with the CQC on Friday 29 January. The Trust maintains a strong relationship with the CQC. Staff have many ways in which they may raise concerns that include their line managers, their directors, Freedom to Speak Up Guardian. Ms Allman and her team have put in place a raft of wraparounds for staff. The Trust makes every effort to pick up on matters as quickly as possible. Ms Allman noted the Trust is acutely aware of the need to have more than one route through which staff may access someone to talk to. There are well laid out policies and guidance that encourage staff to raise their concerns before they become a problem that results in a grievance. One of the huge success the Trust has had as an organisation is offering support for staff. The Trust receives regular reports from the Freedom to Speak Up Team and the ambassadors. Any member of staff can attend the Chief Executive Briefing and raise concerns or ask questions. Up to 500 members of staff have attended a Chief Executive Briefing. The Schwartz Rounds provide a opportunity for staff to reflect on and review practice.

If staff get to a more formal process there is the offer of mediation. Networks within the Trust assist with feedback from staff groups and help to alert the Trust to potential concerns before they become a problem.

Mr Moss thanked Governors for their questions. There would be another opportunity for Governors to raise questions when they meet with Directors at the Council of Governors meeting tomorrow.

BoD 022/21 Any Other Business

Mr Moss reported that Mrs Stone, the Trust's Company Secretary would be retiring in March. There would be an opportunity in March to say farewell. However, as it would be Mrs Stone's last Board of Directors Meeting in Public Mr Moss wanted to put on record his thanks to Mrs Stone. Mr Moss paid tribute to Mrs Stone for the astonishing work she had undertaken on behalf of the Trust over many years. Mrs Stone had completed 38 years' service in the NHS, all of it at Poole Hospital in a variety of roles including Medical Secretary, Patient Complaints, Litigation, Patient Liaison, Risks and Claims. More recently she was the Company Secretary of the former Poole Hospital NHS FT and at present she was Company Secretary of UHD. As evidenced earlier in the meeting today, Mrs Stone had assisted in the setting up of the new organisation and provided invaluable support and advice to Mr Moss and Mrs Fleming. On behalf of the Board of Directors Mr Moss expressed his personal thanks and appreciation for the work Mrs Stone had undertaken over the years. The Board wishes you well for the future.

BoD 023/21 Key Points of Communication to staff

Mr Moss noted there were a number of important key points of communication to staff through the website in conjunction with Trust partners. Matters to be reported included an update on Covid-19 as discussed at today's meeting, the recovery plans, staffing issues and other matters discussed at today's meeting. These key points will be reported by the Trust Communications Team inside and outside the organisation. Mr Donald expressed his thanks to clinical staff for helping to get the voice of the organisation across in newspaper interviews, TV etc. It was important the public heard from our clinical colleagues about what's going on in the organisation. There was so much misinformation at this present time and therefore Mr Donald wanted to put on record his thanks to clinical colleagues. Mr Moss noted the Trust had received amazing coverage in the national and local news about what is going on, what the Trust is doing and what it is up against. Mr Moss expressed his thanks to Mr Donald and his team.

Mr Green asked whether it was appropriate for the Board to send a formal message of appreciation to all staff who are performing heroically at the moment. Mr Moss agreed with the proposal put forward by Mr Green and seconded by Mr Mount. Mr Moss thanked attendees and the Governors for their contribution to todays meeting.

A formal letter of thanks to all UHD staff from the Board would be drafted by Mr Donald to be agreed by Mr Moss and Mrs Fleming. **Action: JD**

BoD 024/21 Date and Time of the Next Meeting

Wednesday 31 March 2021 at 13:15 via Microsoft Teams

Agreed as a correct record of the meeting:

*Chairman*_____ *Date* _____

University Hospitals Dorset
NHS Foundation Trust

MATTERS ARISING: ACTION TRACKER MARCH 2021

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Update
27/01/21	005/21	It was agreed that the Trust's approach to Health Inequalities would be reported to the Board in March	MM	31/03/21	Closed: On March 2021 agenda
27/01/21	014/21	It was agreed that a briefing on the aspects of sustainability linked to inclusion would be provided to the Equality, Diversity and Inclusion Group	RR/PP	31/01/21	Closed: update to be provided at March 2021 Board
27/01/21	021/21	Mr Renaut agreed to brief the Governors on the position regarding the BCP position on the fly-over over the Wessex Way	RR	31/01/21	Closed: CoG updated on the 4 March 2021
27/01/21	023/21	A formal letter of thanks to all UHD staff from the Board would be drafted by Mr Donald to be agreed by Mr Moss and Mrs Fleming	JD	31/01/21	Closed: Letter sent to staff

FUTURE ACTIONS: NONE

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Update
27/01/21	014/21	The Sustainability Strategy would be presented to the Board in April 2021.	RR	28/04/21	Agreed to move to May 2021 agenda

Key:	Outstanding	In Progress	Complete	Future Action

BOARD OF DIRECTORS MEETING
31 March 2021
CHIEF EXECUTIVE REPORT

1. Update on Covid-19

Over the past few weeks, as the rate of infection within the community has reduced dramatically, we have continued to see less pressures in our hospitals relating to Covid-19. There have been far fewer patients admitted with Covid-19, a significant reduction in the number of outbreaks, and fewer staff away from work for Covid-19 related reasons.

At the time of writing, there are 9 Covid-19 inpatients receiving care within our hospitals, compared to 435 in January, and only 1 of these is within intensive care. Since the pandemic began, we have provided treatment to over 3000 inpatients with Covid-19.

A year on from the first national lockdown, the 23 March 2021 was designated as a National Day of Reflection. Within the Trust, this anniversary was noted on all three of our sites with a service of remembrance led by our chaplains, and a minute's silence at noon. Staff were invited to tie a ribbon on a tree or railing in memory of our patients, and their own family members or friends who have sadly lost their lives to the virus.

Looking forwards, we all continue to be hugely encouraged by the success of the national vaccination programme – to date, more than 25 million people have received their first dose of a Covid-19 vaccination, in line with the JCVI guidance. Our internal vaccination programme has also been a huge success, with more than 80% of UHD staff having received the first dose of the vaccination. Clinics providing the second doses of the vaccine have now commenced on both sites, and we have also started providing an inpatient vaccination service for appropriate patients that wish to receive it.

Earlier this month, we held events at both the RBH and Poole Hospital sites to thank the service personnel who have been working alongside us within UHD since January 2021. Teams from the army, navy, RAF and Royal Marines joined us on a temporary basis, undertaking a wide range of activities to support hospital staff. We are enormously grateful to all service personnel for the support that they provided at this time of unprecedented challenge, which enabled us to maintain essential services.

2. Developing our Plan for Recovery

As the number of patients with Covid-19 within our Trust reduces, and as more staff are able to be released back to their normal ward/department, our thoughts are now turning to restarting our services, and returning to some form of "business as usual". However, it is recognised that this will be dependent on a number of factors – not least the availability of staff, and the ability of our different teams to revert back to their normal duties. Over the past year, the Trust has cared for more than 3,000 cases of COVID-19, with our experience of the pandemic being characterised by a series of peaks and troughs of demand. It is important to note that staff are exhausted emotionally and physically as they worked hard to care for so many COVID positive patients, whilst at the same time, maintaining essential services such as cancer or urgent/emergency treatments, with very high rates of sickness absence. With this in mind, we are clear that the wellbeing of our staff must be "front and centre" of all our recovery plans.

Overall, the Trust has done extremely well, in maintaining emergency and urgent care, working in close collaboration with our Dorset partners and colleagues in the private sector. This will continue to be a priority going forwards as we focus with partners on avoiding unnecessary admissions, achieving swift discharge for those patients who no longer require acute hospital care, and maintaining effective flow through our hospitals.

We are particularly proud of our achievements throughout the COVID-19 pandemic in maintaining cancer treatments. Through close collaboration with the independent sector, we have been able to maintain treatment for the most clinically urgent patients. Maintaining short waiting times across the cancer pathway is always a priority, and whilst we are not currently achieving the key cancer waiting times standards, the situation is improving and we expect this to continue over the next few weeks and months.

Unfortunately, the pandemic required us to halt our routine elective work, which means that in line with other Trusts across the country, our waiting times are longer than ever before. Therefore, one of our top priorities, working with partners across Dorset, will be to do everything possible to reduce these in 2021/22 - recognising that the pace at which we can do this will be resource dependent.

It is also important to note that the pandemic has changed the way in which we deliver services very dramatically, with many teams now working in very different ways. A key feature of our recovery plans will therefore be to hold on to these innovations moving forwards, so as to maximise our productivity and make best use of all our resources.

3. Developing our organisation

Values

Members will be aware that in February 2021, we formally launched the values for UHD. This has been an extremely important piece of work in developing our new organisation, given that these values will be used in all our recruitment and appraisal processes going forwards, and as such, will shape the way in which we behave towards our patients and each other for many years to come.

During the course of this week, the Chairman and I sent out a joint letter to staff, expressing our heartfelt gratitude for each individual's contribution throughout the Covid-19 pandemic. As a gesture of our appreciation, staff have been given an extra day of special paid leave as a 'Wellbeing Day'.

I would like to take this opportunity to thank our Director of Organisational Development, Deb Matthews, the OD team and our Culture Champions for all their hard work in listening to staff, analysing the results, and shaping these into our core values. They are now playing an important role in supporting our work to embed these across the organisation.

Tier 3 consultation

On 23 February, we launched the consultation process for staff working at "Tier 3" within our organisation. This involves around 120 staff, including the majority of senior leaders working within our clinical directorates and operations teams. The consultation is expected to run until 8th April, which allows time for staff affected to feedback their views on the proposed roles and structure. Once this feedback has been considered, the final plans/structures will be published, and we shall begin the process of appointing to these new roles. Completion of these Tier 3 appointments will be another important milestone in the development of our organisation.

Formalising the UHD Board

I am delighted to confirm that at an extraordinary meeting held on 4 March 2021, the Council of Governors for University Hospitals Dorset unanimously endorsed the appointment of our Chair (David Moss), the Non-Executive Directors and myself as Chief Executive. This means that the UHD Board of Directors is now formally established and need no longer be referred to as being in "interim" form.

The NHS Staff Survey 2020

The NHS Staff Survey 2020 results have now been published, and whilst these have been recorded separately for our two predecessor organisations, we have obtained a combined UHD report for our internal use, that provides us with a clear baseline for our new organisation. Overall, UHD has scored significantly better than our comparator group of other acute trusts in England in seven of the 10 themes.

I am particularly pleased that despite working through an organisational merger, and of course, providing services in the midst of the pandemic, 76% of those taking part in the survey would recommend our Trust as a place to work, whilst 84% would recommend our Trust to friends and family as a place for treatment. Both of these scores represent an improvement compared to the previous year.

These reports provide us with the views of our staff at a time of unprecedented change, and a strong foundation upon which to focus on our ambitions and organisation development plans for the future. We shall be working on more detailed analysis within our care groups and corporate functions, so as to enable the development of targeted action plans where further improvement is needed.

This work will continue to be overseen by our Workforce Committee.

4. Estates and transformation

Our Estates Department continues to be extremely busy taking forwards our complex capital programme. There are now numerous schemes being progressed as a consequence of (a) the significant, multi-year plans to transform our sites, and (b) the additional funds that have been made available this year to address backlog maintenance and Covid-19. The Estates team is therefore focusing on completing a number of projects before the end of the current financial year, whilst at the same time, preparing for 2021/22 and planning for the next 5-10 years.

Members will be aware that the Outline Business Case (OBC) for the redevelopment of our sites was approved by the Joint Investment Committee on the 1 December 2020, and we are awaiting formal Treasury approval. In the meantime, work continues to finalise the Final Business Case (FBC) ready for submission on 1 April 2021.

Linked to this, the Trust has been working very closely with BCP Council to achieve full planning permission on the Royal Bournemouth Hospital (RBH) site and to agree the Reserved Matters. Outline Planning permission was formally approved on the 14 January 2021 with the Reserved Matters relating to the new road alignment confirmed on 11 March 2021.

Work on the Poole theatres has had to be temporarily paused as a consequence of asbestos being discovered in the existing building. Unfortunately, removing the asbestos will result in a delay of 9 weeks to the overall theatres programme. On the Royal Bournemouth site, the enabling works has commenced in preparation for our new Maternity, Children's and Emergency Care development.

Finally, work continues with our partners across the Dorset Integrated Care System (ICS) on the New Hospital Programme (NHP), formerly known as the Health Infrastructure Programme - HIP2. The Dorset system includes 12 of the original HIP2 hospitals, and 5 of the 40 hospitals prioritised by the government for upgrade/improvement in the New Hospital Programme. All three of the UHD hospitals are within the 5 that have been prioritised to receive investment.

5. Operational planning 2021/22

The Trust continues to await the final operational planning guidance and financial allocations for the coming year, which are expected to be published following the NHSEI board meeting on 25th March. In the meantime, a tremendous amount of work has been undertaken to understand the underlying cost base and priority investments for 2021/22, inclusive of ongoing COVID costs and the costs of recovering our services.

An interim budget is being recommended to the Board providing an overarching financial framework effective from 1 April, including detailed expenditure budgets at service level and centrally held income budgets. This will be revisited following receipt of the updated guidance and allocations, with a final budget expected to be brought back to the Board for approval in April or May.

Meanwhile, work is underway to firm up our corporate objectives for 2021/22. These will build upon our vision and values, and our 5 strategic objectives which are not changing. The process includes assessing what we need to do in the year ahead, taking into account national and local priorities - in particular, the Dorset ICS plan. The draft objectives will be discussed and agreed at our Trust Management Group before being formally approved by the Board.

6. Integrated Care System (ICS) Development

Members will be aware that the NHS Long Term Plan stated that Integrated Care Systems would be central to its delivery by bringing together local organisations to redesign care and improve population health, creating shared leadership and action. ICSs exist to improve the health of all residents and better support people living with multiple and long term conditions - preventing illness, tackling variation in care and delivering seamless services, whilst at the same time achieving maximum benefit from all resources.

Earlier this year, NHS England & NHS Improvement published a consultation document detailing the vision for a more effective and responsive care system across England. The document set out the ambition for NHS organisations, local councils, frontline professionals and others joining forces in an integrated care system (ICS) in every part of England from April 2021.

Following on from this consultation, the Government has now published a White Paper setting out plans to remove current legislative barriers to integration across health and social care bodies, and foster collaboration between NHS and local government organisations. This means that from April 2022, ICSs will be further strengthened and established on a statutory footing.

The Dorset ICS was one of the first to be established in the country, as local partners were very clearly sighted on the benefits that could be delivered for patients and local people through more integrated joint work and collaboration. Whilst much of the past year has been focused on managing the Covid-19 pandemic, we are now working together to further strengthen our governance arrangements in line with the White Paper, whilst awaiting the publication of further national guidance. It is important to note that as part of this change, the Dorset Clinical Commissioning Group will no longer exist in its current form, with its functions transferring to the new ICS and/or to other partners within the Dorset system.

Members of the UHD Board receive regular updates on progress in developing the Dorset ICS, and all partners are actively involved in this work. A more detailed briefing on the anticipated changes will be provided at a future meeting.

7. Health inequalities

Members will be aware that tackling health inequalities is already a priority the NHS. Health inequalities can be defined as the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

The Covid-19 pandemic has brought to the fore the fact that for some people in England there are still unfair and avoidable inequalities in their health and in their access to and experiences of NHS services.

Within the Dorset Integrated Care System (ICS), tackling health inequalities was agreed as a priority for all partners some time ago, and this work is already a key responsibility for each of the two Health and Well-being Boards, led by BCP Council and Dorset Council respectively. A new Dorset Health Inequalities Group (HIG) supported by all partners has now been established within the ICS to develop a Dorset-wide strategy and maintain an oversight of this work. The group is chaired by Patricia Miller, Chief Executive for Dorset County Hospital NHS Foundation Trust, supported by Paul Iggulden (Public Health Consultant, Public Health Dorset) who has taken on the role of Programme Director. The HIG has met twice and will be meeting every other month going forwards.

As Chief Executive for UHD, I am a member of the BCP Health and Well-being Board, which is the means by which the Trust connects directly with the local programmes aimed at tackling health inequalities. In addition, we have identified a named Executive (Pete Papworth, Chief Financial Officer) and a named Non-Executive (Christine Hallett) to champion equality and inclusion on the Board. These individuals will be representing the Trust at the new HIG as the representatives for UHD.

8. Good news

International nurses joined the Trust

I am delighted to report that earlier this month, we welcomed seven international nurses from the Philippines, India and Ghana to University Hospitals Dorset. These nurses will be working across a variety of wards, including our Emergency Departments and our Theatres. This is excellent news for these areas, and for the Trust as a whole.

I should like to take this opportunity to thank our recruitment and training teams for their ongoing hard work that brings new people into our organisation, and ensures that they receive the necessary training.

HSJ Awards

The HSJ Awards took place on Wednesday 17 March, hosted by Sir Lenny Henry, to acknowledge and celebrate projects and teams across the country who have championed quality improvement and resilience. This year, there were over 1000 applications across the categories. I am delighted to inform members that UHD was shortlisted for *'FTSU Organisation of the Year'* and whilst we did not win this accolade, we were one of eight finalists, which in itself is a fantastic achievement. I should like to take this opportunity to thank our colleagues Helen Martin, Freedom to Speak Up Guardian, Professor Mike Vassallo, consultant, and Dr Mohammed Elmasry, Internal Medicine Trainee and lead for our International Doctor Support Initiative (IDSI) network, for their leadership in this area which has achieved such positive results and led to such positive publicity for the Trust.

Hepatology/Liver Nurse of the Year

I am delighted to announce that our hepatology consultant Hazel Allen and the Liver Nursing Team at RBH were recently recognised in the *Hepatology/Liver Nurse of the Year* category at the British Journal of Nursing (BJN) Awards. The team's accolade was announced in the national award ceremony earlier this month. Working with local partners including 'Hep C U Later' and Avon & Wiltshire Mental Health NHS Trust, the team are part of the wider Dorset Hepatitis C Elimination Programme, which aims to eliminate Hepatitis C in the community by 2023. Following receipt of additional funding, the project has been running 'pop up' clinics over the past year, offering testing in the community and anti-viral treatments that give 95% cure rates through a course of daily tablets. These pop-up clinics have improved delivery of care for hard-to-reach groups, including the homeless

Treating Tobacco Dependency

Members will be aware that on 10 March, we celebrated National No Smoking Day. As part of this event, the Acute Medical Unit (AMU) at Poole Hospital became the first site in the county to launch the 'treating tobacco dependency' in secondary care pathway. This means that all patients will be offered a carbon monoxide test and nicotine replacement therapy, for example gum or patches, to treat nicotine withdrawal while in hospital. Our staff have and continue to receive special smokefree champion training as part of this work, which incorporates motivational and behavioural support.

The new programme is supported by Public Health Dorset and aims to reduce smoking rates in the county from 136% of the adult population now, to 5% by 2030.

I would like to take this opportunity to say a big thank you to Heidi Croucher (specialist midwife for smoking cessation & lead for the pan-Dorset work), Harriet Mulcahy (staff nurse, AMU) and Geoffrey Walker (matron) for all their hard work in making this possible.

Contribution of Dr Kat Dixon to the Administration of Radioactive Substances Advisory Committee

I would like to take this opportunity to acknowledge the work of Dr Kat Dixon (consultant physicist & head of nuclear medicine) and thank her for her valuable contribution to the Administration of Radioactive Substances Advisory Committee (ARSAC). ARSAC is an expert advisory committee sponsored by the Department of Health and Social Care (DHSC) that advises DHSC on applications for employers and practitioner licences for the administration of radioactive substances under the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017, as well as applications for research study proposals.

I recently received a letter from the committee highlighting the high calibre of the contribution from Dr Dixon. Given the important role of this committee in safeguarding services for patients, I thought it important to bring this to the attention of the Board, and formally thank Dr Dixon for her dedication and on-going commitment to the delivery of safe, high quality care.

Mrs Debbie Fleming
Chief Executive

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 8.1

Subject:	University Hospitals Dorset (UHD) NHS Foundation Trust Integrated Performance Report (IPR) February 2021

Prepared by:	Executive Directors, Donna Parker, Jackie Coles, David Mills, Fiona Hoskins, Louise Hamilton-Welsh, Andrew Goodwin
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the Board of Directors and Sub Committees members on the performance of the Trust during February 2021 and consider the content of recovery plans
Background:	Our integrated performance report (IPR) will be published monthly and includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It gives the public and staff better quality information about the performance of our hospital in the areas that matter to them. It shows the indicators that are used to measure performance for each of the Trust's operational areas and how well key services are delivering. The IPR is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. The document provides a single 'shared truth' of performance across the organisation. All NHS organisations received a letter from Amanda Pritchard (Chief Operating Officer NHSE/I) and Julian Kelly (NHS Chief Financial Officer) on 23 December 2020 detailing the ongoing Operational priorities for winter and 2021/22 recognising the extraordinary challenge of Covid-19 wave 3. **Key priorities for the rest of 2020/21:** A. Responding to Covid-19 demand B. Pulling out all the stops to implement the Covid-19 vaccination programme C. Maximising capacity in all settings to treat non-Covid-19 patients D. Responding to other emergency demand and managing winter pressures E. Supporting the health and wellbeing of our workforce F. Recover non-covid services

Key points for Board members:

Areas of Board Focus

1. A reducing number of Covid inpatients and lowering acuity during February has contributed to an improving bed occupancy position. This reduction correlates with reducing prevalence of Covid in the community and the number of staff absences.
2. Attendances to ED and emergency admissions for non-Covid reasons started to increase during February.
3. Focus has remained on urgent and cancer care during February with elective routine activity plans being developed to address the growing number of patients on routine waiting lists and in particular the high number of 5325 patients waiting over 52 weeks for treatment. Recovery to pre-Covid levels will require investment and take some time to deliver due to workforce and capacity limitations, there could be an impact on hospital reputation in the South West region as Dorset was hit harder during response to wave 3 of Covid than other systems.
4. The current number of patients who are medically ready to leave and not meeting Criteria to reside remains and this puts additional pressure on workforce to staff escalated bed capacity, driving increased agency costs and has a potential impact on quality.

Operational Performance

Emergency Care

UHD is one of 14 trusts across England to test the proposed new urgent and emergency care standards. Following the national consultation, we await confirmation of the Urgent & Emergency Care standards going forward.

Operational (Field testing standards) and Internal Care Standards

(colours based on change from last month)

		Feb-21		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	235	222	228
Time to assessment	15 mins	3	7	5
Internal Care Standards				
Time to triage (*RBCH: to assessment*)	15 mins	3	7	5
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	54	88	73
Time waited for a bed (*RBCH: DTA to left dept*)	60 mins	172	85	121

The other key emergency care related standards/metrics are:

- 12 hours from Decision to Admit (DTA)
- Ambulance handover delays:
  - 30+ min delays
  - 60+ min delays
- Occupancy, flow and criteria to reside (*long waits for medically optimised for discharge patients*) – Occupancy and bed days attributable to long waiting patients.

Emergency Departments

Both departments saw lower levels of attendances and emergency admissions in February compared to January and levels remained below last year's. Ambulance conveyances were below last year at the PH site, though remained similar to last year's levels at RBH site.

Both sites saw a significant improvement in Type 1 mean time in February and across all of the metrics, excepting 'wait to see a clinician' at the RBH site. This increased by 3 mins from 85 mins in January. However, both sites continued to be challenged above 200 mins mean time. Positively, mean bed

	wait also improved significantly, noting the reducing number of Covid patients and lower bed occupancy. Though again, this remained above the aspirational target of 60 mins. Despite the lower number of Covid patients in the community and presenting to the hospitals, blue/green (Covid/Non Covid) testing and pathways need to be maintained in line with IPC guidance. Testing capacity remains a challenge. No patients waited in either department for more than 12 hours after a decision to admit, an improvement over the 2 previous months. It is anticipated that when the new UEC standards are introduced (following the recently closed national consultation) the new standard will be 12 hours from arrival, and UHD is updating escalation policies ahead of this change. Alongside better flow through our Emergency Departments and hospitals, both Departments made significant improvements in Ambulance Handover times. 36 ambulances waited over 60 minutes compared to 205 in January and 173 exceeded 30 minutes, compared to 304 in January. Average daily Ambulance conveyances were consistent at 135 per day for both January and February, noting RBH site seeing higher conveyances and levels consistent with last year. Poole site saw 120 less per week than last year. We are closely monitoring demand trends together with system partners, with the aim of ensuring patients access the right services through primary and community care, NHS111, acute hospitals and Local Authorities. **Progress and ongoing improvement work includes:** • Development of cross site live and reporting dashboards and integration into the Departments to facilitate patient management as well as benchmarking and shared learning between sites. • Covid/non covid pathways reviewed and reconfiguration of wards/admission units in response. • Re-establishment of the Frailty Assessment Units and estates works to establish refurbished Frailty Same Day Emergency Care Units. • Focus on 'wait to be seen' within the 60 mins internal care standard, as a significant factor in achieving the 200mins meantime. • Focus on action around the first 60 mins of care delivered in the department and management of the rapid assessment (RAT) process. • Finalising UHD-wide escalation pathways and undertaking staff engagement across the Trust to support avoidance of 60 min ambulance waits and 12 Hour waits in the EDs. • Quality and Safety review by Dorset CCG provided positive feedback and opportunity for shared learning around ambulance waits. • NHS111 First pilots continued booking into AEC and Frailty Same Day Emergency Care (SDEC) – work underway to optimise the model further. • NHS111 First booking into ED continues. ***Occupancy, Flow and Discharge*** (***See exception report in IPR pack***). A stabilised discharge to admission ratio and improvement against our length of stay metrics resulted in a favourable occupancy rate of 84.6% in February (87.4% in January), and this remains below the 90.8% observed in February last year. An average of 383 beds a day were consumed by patients in hospital for over 7 days in February compared to 442 in January (and compared to 491 in February 2020).

A reducing number of Covid inpatients and lowering acuity also contributed to an improving occupancy position and positive impact on our mean bed waits later in the month. It should be noted however, that a lower occupancy is required to manage covid/non covid pathway flow and cohorting through the admission units and wards. Our Operational Flow and Safety meetings, supported by Inpatient Capacity, Infection Control and Tactical groups continue to have oversight of the complexities related to our bed configuration, as well as our flow and swabbing processes and pathways.

The increase in the number of patients no longer meeting the 'Criteria to Reside' during the first part of February prompted a risk assessment to be presented to the Dorset system in relation to potential impact on patients, services and elective care recovery. An action plan has been developed and aligned alongside the broader Dorset Home First programme plans and the system 100 day plan, supported by ECIST. Some overall improvement in external delays has been seen late Feb/early Mar however, this ongoing work is key to maintaining a sustained improvement trajectory that minimises the number of patients who no longer need acute care in our hospitals.

A great deal of work is ongoing both internally and externally in relation to Criteria to Reside and Home First, albeit with a number of challenges, please refer to the escalation report in the pack for further detail.

Surge and Escalation Planning

We are currently reviewing recent demand trends and formulating plans for the coming months including Easter. It is expected that capacity implemented over the winter period and particularly in response to the recent Covid surge, will need to be maintained. This is given the growing level of non covid admissions as well as the need to increase elective care for patients. We also await the outputs of national and local modeling and the impact of vaccines to further inform our onward planning, noting we will be reviewing our response to Covid Wave 3 and considering our plans should there be any further waves.

Internally, we continue to support urgent and emergency care though our Operational Flow & Safety, Inpatient Capacity, IPC and Tactical meetings; as well as through our UEC Quality & Performance Improvement Programme.

At system level, Bronze and Silver arrangements remain, noting these will be moving towards 'business as usual' arrangements as determined by national incident levels. Regional winter sitrep and trigger exception reporting is ongoing and we continue to submit exception reports as required, noting a reduction in these in recent weeks due to the more positive picture.

Referral to Treatment (RTT)
92% of all patients should wait no more than 18 weeks for treatment

	Mar 19	**Jan21**	**Feb 21**	
Waiting List Size	42,587	44615	45524	**+2937 v March 19**
Referral to treatment 18 week performance		63.0%	**59.3%**	**-3.7% v Jan 21**
RTT incomplete pathways >52+ weeks		4273	5325	**+1052 v Jan 21**

Providers and commissioners are required to plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2021 than in March 2019. At the end of February '21 there were 45,524 patients on the waiting list, more than the combined March 2019 position of 42,587, this is a worsened position from January 2021.

The overall waiting list is still at a higher level than last year with a corresponding increase in backlog of patients waiting over 18 weeks, this has resulted in a reduction in performance from 63% to 59.3%. Whilst the number of patients waiting over 40 weeks has reduced slightly, there has been a rise in patients waiting over 52 and 78 weeks.

There are 5,325 patients waiting over 52 weeks, an increase of 1052 patients from last month, this is higher than the trajectory submitted to the South West region which was 4223 for February 2021.

Factors impacting on the RTT standard

Clinical Capacity & Response to COVID-19	The reduction in RTT performance and rising number of patients waiting > 52 weeks is a cumulative problem due to ceasing routine elective activity in Q1, restoring routine activity within new Infection Control guidance during Q2 & Q3 followed by the need to pause routine elective activity during the first two months of Q4. Clinical staff have been redeployed from theatres, endoscopy, outpatient services and other areas to support the wards and critical care in the Trust response to COVID-19, this has resulted in lost clinical capacity to run routine elective services. Many patients are choosing not to attend hospital for consultation, diagnostic test or treatment until they have had their vaccination and/or the pandemic is over. In recovering routine elective activity, specialties productivity will remain lower than previous years due to restoring services safely in line with national and clinical infection control guidance which make each outpatient attendance, diagnostic test and procedure / treatment take much longer. There is regional recognition of the challenging position of elective care performance in Dorset prior to COVID-19 and this has resulted in many patient waiting > 52 weeks for treatment. The growing number of 52 weeks is mainly due to lack of theatre / treatment capacity however due to lost capacity during Q1 and Q4, there are now patients waiting over 52 weeks for an outpatient appointment. The waiting list for patients waiting to be admitted for treatment is clinically reviewed and prioritised to reduce any potential harm for those patients waiting longer than expected for their procedure.

The main focus is to increase activity by the following **High-Level Actions:**

- Clinical Validation of the RTT PTL will commence in April 21, this programme of work is aimed at clinically prioritising patients and ensuring that they still require to be seen or have treatment. It is expected that there will be considerable attrition from the wait list allowing clinicians to allocate capacity to see the patients who still need care or treatment
- Creating additional capacity to see and treat our longest waiting patients, this includes use of the national contract to use the independent sector, using other NHs and private providers, insourcing using a partner organisation and running wait list initiatives where possible
- Think Big is a project being considered to enable high volumes of outpatients to be seen safely
- Use of digital technology to support non face to face outpatient activity.

DM01 (Diagnostics report)
1% of patients should wait more than 6 weeks for a diagnostic test

February	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	6609	6222	387	**5.9%**

The DM01 standard has achieved 94.1% of all patients being seen within 6 weeks of referral, 5.9% of diagnostic patients have waited > 6 weeks. Radiology have achieved > 99% of all patients being seen < 6 weeks from referral. This is a remarkable achievement and testament to all the previously reported plans delivering during Q3 and continued in Q4.

This is a good position to be in at the end of February, noting endoscopy activity has been considerably reduced as the service has deployed staff to wards and critical care whilst keeping urgent endoscopy services open.

High level actions include:

- Continuation of additional temporary endoscopy capacity on the RBH site and reviewing all endoscopy activity in the Dorset system to reduce waiting times
- Working collaboratively across both sites to standardise and reduce waiting times for cardiology, ultrasound, MRI and CT
- Insourcing radiological reporting to provide additional capacity.
- Sharing capacity across sites to reduce the waiting times in endoscopy and echo cardiology.

Cancer Standards

	Measure	Target	Quarter 1 2020/21	Q2 20/21 FINAL	Q3 2020/21 - FINAL	Jan 21 - FINAL	Feb 2021 - Predicted
UHD	Cancer Two Week Wait	93%	96.7%	97.3%	N/A	N/A	N/A
	Cancer Plan 62 Day Standard (Tumour)	85%	79.3%	80.0%	78.6%	78.5%	69.5%
	62 Day Screening Standard (Tumour)	90%	73.3%	73.3%	94.1%	86.7%	78.8%
	31 Day First Treatment (Tumour)	96%	96.2%	94.4%	97.0%	96.6%	95.0%
	Subsequent Treatment - Surgery	94%	89.4%	86.7%	95.4%	83.9%	85.0%
	Subsequent Treatment - Radiotherapy	94%	98.8%	100.0%	98.7%	100.0%	100.0%
	Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	100.0%	100.0%	99.1%	100.0%
	Faster Diagnosis	75%	76.3%	77.4%	80.7%	72.5%	80.6%
	Over 104 days (treated in month)	N/A	18	23.5	26	5	

The number of fast-track referrals have reduced since January and during wave 3 of the COVID-19 pandemic.

Whilst performance remains below the standard for some of the KPI's, this position is reflected Nationally. February is seeing improvement in the Faster Diagnosis standard and a reduction in the backlog and backstop position, the Trust is now back at pre-COVID level with only 0.8% of the PTL being over 104 day

Factors impacting on standard

Demand	• Referral numbers continue to exceed previous years putting additional pressure of several services at all stages of the pathway
Clinical Processing Capacity	• Patient choice continues to impact all pathways • Capacity not able to cope with current demand especially for some diagnostic tests impacting pathways • Specific challenges in some pathways- due to capacity to manage the increased demand- especially head and neck and gynaecology.

High Level Actions ongoing

- Clinical teams continue to explore opportunities to work across sites to maximise capacity and improve flexibility
- One stop opportunities at the start of the pathway to improve time to diagnosis.
- Exploring opportunities for robotic assistance at referral/triage stage to improve efficiency of current process and expedite the process
- Escalating any potential opportunities to improve pathway management across the care groups – especially for diagnostics
- Weekly backlog/backstop meeting to manage patients who have already breached 62 days to ensure appropriate actions and clinical safety
- Pursuing the opportunity to introduce LA template biopsies as part of Adapt and Adopt to improve efficacy of the pathway, this would decrease the use of TRUS biopsy (as per National guidance) and free up essential theatre space –moving GA to LA .
- Working with Primary care to improve quality of referral information

Health Inequalities: A sub group of Dorset ICS Elective Care Oversight Group has been established this month to develop system-wide approaches to understanding and responding to Health Inequalities associated with elective and UEC recovery.

UHD will be making its first submission of linked data to the Dorset Information and Intelligence Service population health database in March 2021, which will enable access to interactive and filterable analytics of our activity by a number of metrics including deprivation. This will be used to inform future comms strategies, help clinicians to target hard to reach populations and support UHD to review and adapt its recovery plans and approaches to respond to health inequalities.

We anticipate being able to include a set of the data in the next IPR.

Quality, Safety, & Patient Experience

Infection Control:

- There were no new Covid-19 outbreaks reported across the Trust in February 2021.
- There remained only two on-going outbreaks at the end of February, both anticipated to be closed within the first week of March.
- In total during wave 2 of the pandemic there were 26 staff and patient reported outbreaks of Covid-19. Post infection reviews on all outbreaks have commenced.
- In partnership with Public Health Dorset, a review of nosocomial infection rates at UHD during wave 2 has begun.
- National guidance continues to be reviewed and implemented as required.

Patient Safety:

- Current serious incident themes:
  - Bowel care and constipation
  - Delirium and dehydration
  - Importance of accurate handovers for the delivery of care
  - Accountability of care delivery on accepting a patient
- The Trust continues to work towards the standardisation of policies and practices for UHD.
- Risk register funds have supported the purchase of additional flat lifting equipment, spinal boards and extension kits, high risk cushions for older persons services at Poole and anatomical models to support care of spinal patients.

Safeguarding:

- There have been a number of cases in relation to acquiring specialist mental health beds for adults and children. These cases have led to safeguarding concerns for the patient, other patients and our staff. Work is on-going with system partners to expedite these transfers and create clearer patient pathways.
- Delays in accessing social care placements for 16-17 year olds on the Bournemouth site has also led to safeguarding concerns and processes are being reviewed.

Nursing Care Hours per patient day (CHPPD)

The Trust remains well aligned with the national peer average for CHPPD. This was achieved through a variety of workforce initiatives:

- Registered aspirant nurses (third year student nurses); these staff commenced in February 2021 and will remain in the Trust for 12 weeks.
- Registered international nurses (newly arrived international nurses working towards NMC registration). It is anticipated that these nurses will move onto the NMC register within 12 weeks.
- Mutual aid from the military remained in place throughout February 2021 and is expected to cease in early March.

Workforce

12 month rolling rates to February 2021:

		20/21 YTD	19/20 YTD	Variance
Turnover		10.6%	12.2%	-1.7%
Vacancy Rate		0.9%	4.7%	-3.9%
20/21 only up to Oct 20				
Sickness Rate		4.8%	4.0%	0.8%
Appraisals	Values Based	44.1%	62.5%	-18.4%
	Medical & Dental	55.3%	81.8%	-26.5%
Statutory and Mandatory Training		86.8%	89.0%	-2.2%
Staff Friends & Family Test	Caring	N/A	87.4%	
Note: 19/20 Q1 & Q2 only	Work		72.7%	

Performance:
The trend in overall **turnover and vacancy levels** continues lower than last year which is likely to be due to the continuing atypical market conditions and impact of lock down restrictions.

Overall sickness levels have decreased this month (Feb 8.3%, Jan 10.3%) Numbers of staff shielding have increased with the Governments' recent additions to the clinically extremely vulnerable list, although, many have been able to continue to work from home.

Statutory and Mandatory training compliance has dipped a little this month but continues in the high 80s which is encouraging as we continue to establish BEAT on the Poole site.

Appraisal levels for our medical and dental staff have fallen back this month and continue to track low due to Covid and operational pressures.

There has been an operational impact of holiday numbers increasing in March as people use up any leave they are not able to carry over or sell back.

Factors impacting on standard

Appraisals	Appraisals are lower than a normal year and we expect this position to improve following the launch of the new updated Appraisal process next month.

CPO Headlines:

Employee Vaccinations:

The key statistics for employees who have had first vaccines are as follows:

- 84% of our substantive/fixed term workforce
- 79% of our bank staff
- 77% of BAME staff

	• Some staff are now coming forward for first vaccines which takes a bit of forward planning as it is complicated by the type of vaccine and the need to ensure there is a second dose. • We are trying to reach the remaining staff who have not yet come forward by for example mini surveys to identify what how we target communications for the best return. We are unable to identify and follow up on individuals more specifically due to GDPR however we are updating the risk assessment so that this becomes part of the risk conversation. • The programme of second workforce vaccinations commenced on 17.3 and should last 5 weeks at Bournemouth site (to include external care workers etc) and 2 weeks at Poole site. • We are looking to ensure that Shielders have been able to have their second vaccine 2 weeks before they return. **People Operations:** • The Operational team continues to deal with a high level of employee relations cases while supporting departments to develop their post-merger reconfiguration plans. • HR has supported the 4 main Tier 3+ consultations which were launched on 23rd February 2021 and may run the full 45 days to 8th April or may close earlier by agreement. In scope are most nursing, operations, medical leadership and general management posts reporting to a Tier 2 role plus other associated posts, included to ensure appropriate pooling. This amounts to circa 120 people. Each person in scope has been invited to attend a consultation meeting and has been offered support. • The HR Merger integration team will be dissolved from April as HRBPs move back into the main structure, however, there will continue to be additional programme leadership and coordination support. This change coincides with the HRBPs moving to establish themselves in their new care groups/departmental leadership teams. • Work is underway to support managers to prepare for the return of shielding staff from April, including guidance on return to work conversations. Shielders will receive a letter to confirm the range of support for their return to work including a Live Teams event taking place on the 25th March. Support includes updates on wellbeing, annual leave, phased returns, vaccination progress and the new risk assessment. **Organisational Development: Staff Survey** • The NHS Staff Survey 2020 results were published on 11 March for our two legacy trusts, and we have been able to access a combined UHD report via Quality Health for our internal use. This provides us with a clear baseline for our new organisation, and allows us to hear the voices of staff from across the whole trust. • Despite working through an organisational merger at the same time as providing services in the midst of the pandemic, 76% of those taking part in the survey would recommend our Trust as a place to work and 84% would recommend our Trust to friends and relatives as a place for treatment. **Both of these combined figures represent an improvement on the previous year.** • Overall, UHD has scored significantly better than our comparator group of other acute trusts in England in seven of the 10 themes. • More specifically, our staff engagement score remains positive at 7.31/10, demonstrating how involved, engaged and motivated staff feel about working in UHD.

	• Our results show our views through a year of unprecedented change and so our UHD report, combining all our results, provide us with a strong foundation on which to focus on our ambitions and development agenda for UHD. The staff voices in the report will provide useful information for leaders to understand how their staff feel on key areas which matter to us in specialties and departments across all our hospital sites. We are now working on a distribution plan to ensure specific data at care group / directorate level is reviewed for action and improvement. **Resourcing, Systems and Temporary Workforce:** • There is a continued focus on NHSI initiatives including the recruitment of 200 international nurses by 31 October 2021 and on-boarding of those by 31 March 2022. • There is the potential for a more competitive market as all trusts are encouraged to scale up international nurse recruitment, and a review of 'protected countries' has removed some countries as source for agencies. • OSCE and Induction training is having to be geared up with a demand for OSCE centre places to allow for new recruits to join the rota as NMC registered nurses within the target 7/8 weeks • We continue on target to move to one payroll from April 2021 and to merge the 2 Allocate Health Rosters by late March 2021. • We are processing the carry-over of up to 10 days 2020/21 leave (including the option of sell back up to 5) in line with the agreed approach . • Temporary staffing continues to be very busy with pressures in ED on the Bournemouth site and Elderly Medicine on both sites. • Total Agency expenditure remains high (Feb '21 £1.1m compared to £1.3 same period last year). This is approx. 3.4% of total pay. Breaking down as 75% on Nursing; 8.5% Medical; 16% other clinical and 0.5% Admin & Clerical, this reflects the ongoing pressures in relation to Covid19, vacancies, sickness and absence. **Health and Wellbeing** • We continue to actively support staff with COVID-19 enhanced wellbeing offer (individual and team) and secured charity funding in excess of £500k (linked to NHSCT) to support (psychologists, wellbeing practitioners, team recognition pot, H&WB interventions for disadvantaged groups) • Collaborating with Dorset ICS to ensure good integration with national Mental Health Hubs provision and agreed fast track referral to Steps2Wellbeing • Developed a draft 'Building Healthy Working Lives' strategy to be considered by WDC and Board (April 2021) outlining 3-year plan for a sustainable and easily accessible H&WB offer for all staff • Developed and implemented a range of targetted education and support sessions for line-managers to encourage them to have 'psych savvy' conversations with their staff and teams • Growing appetite to improve the working environment alongside our planned building works so currently re-looking into alternative spaces such 'pods' to provide 1-2-1 / individual rest and recuperation • Ensuring close working links with FTSU to develop Wellbeing Ambassadors across UHD **Leadership and Talent Management** • New values-based appraisal to be launched (late March – early April 2021) with supporting documentation and training for appraisers

- 2nd cohort of *Leading through Change* leadership development programme completed with excellent feedback and 9 places secured on Our Dorset System Leadership programme
- Re-fresh of support modules for managers involved in transition and Tier 3 consultation underway and available for roll out (late February / early March 2021) with coaching model in development

Equality, Diversity and Inclusion
- Board EDI executive champions identified and inaugural EDI Group convened (January 2021)
- Equality, Diversity and Inclusion strategy developed in collaboration with staff networks and other key stakeholders
- EDIG terms of reference and membership and EDI strategy to be approved by WDC (February 2021) and BoD (March 2021)
- Engaged in EDI Internal Audit – draft report received from BDO and comments under review for approval by Audit Committee (March 2021)

Vision, Strategy and Values
- Appreciative inquiry completed with staff and culture champions and UHD values agreed for new organisation
- Values launched in *The Brief* (February 2020)
- Values Week designed and launch planned (22 February 2020) and included *Thank You* letter from Chairman / Chief Executive to all UHD staff. Week included launch of internet / intranet pages, public facing videos, activities for line managers, Twitter takeover and distribution of branding gifts. Feedback extremely positive.

Staff Engagement and Culture
- Designing next stage of culture programme to include a) reward and recognition b) ensuring our staff voice is heard during COVID-19 recovery phase (*what does recovery mean to you?)* and c) supporting integration
- Wellbeing hubs and short online survey used to 'check in' with staff
- Staff Survey 2020 results received with management report identifying clear areas for action. Summary presentation included in pack. More detailed analysis and plan for circulation / briefings in progress and for care group / department action planning (early April 2021)

Teamwork
- Team development and OD consulting model designed and working with Chief Operating Officer on how this is built into COVID-19 recovery programme (early March 2021)
- Outstanding Affina trainees working to be accredited with a rollout plan to communicate team development offer more widely (early April)
- Commence design of care group development programme in parallel with Tier 3 management consultation (early April)

Quality Improvement
- Developing close links with improvement team and development of QI Academy to build strong foundations for a community of improvers
- Planning next cohort of management / leadership programmes with QI tools and techniques and 'leading for improvement' built into learning objectives (March / April 2021)

	Finance Consistent with the national interim financial framework the Trust has set a planned deficit of £5.6 million for the period to 31 March 2021, inclusive of ongoing COVID-19 costs, recovery of elective services and winter preparedness. Against this plan, the Trust is currently reporting a favourable variance of £4.5 million resulting from lower than planned expenditure in relation to ongoing COVID-19 costs, winter preparedness and the recovery of elective services. The Trust has also received notification of £3.3 million additional national funding to off-set the lost non-NHS income; £2.8 million of which has been included within the year to date position. This welcomed confirmation has allowed the Trust to forecast with confidence a full year financial break-even position. The operational challenges throughout the year have had a material impact upon the Trusts capital programme. Many planned schemes have been unable to progress at the pace required due to access limitations within clinical areas. The forecast underspend is now expected to be £4.1 million by 31 March, however this is dependant upon significant expenditure during March. This forecast represents a significant movement from the forecast reported last month, due to changes in the funding allocation agreed with NHS England and Improvement. Cost improvement savings of £1.3 million have been delivered to date which is £39,000 behind plan. This shortfall is expected to be delivered in March resulting in total forecast savings of £1.6m consistent with the plan. The Trust is currently holding a consolidated cash balance of £144.7 million. This significant balance includes the March contractual payment of £49.2m which will be corrected in March as the national interim cash arrangements come to an end. This balance is also artificially high due to the increased value of capital creditors together with the PDC payment which is paid half-yearly in March and September. During February the Trust has agreed to reschedule the STP Wave 1 capital funding drawdown, meaning that the planned £7.122m will be drawn in 2021/22 rather than 2020/21. This has reduced the capital underspend by £7.1m, from £13.0m to £4.1m. This forecast is predicated on significant capital expenditure during March, which remains a risk and would result in a higher underspend.
Options and decisions required:	No decisions required
Recommendations	**Members are asked to:** Note • The areas of the Board focus for discussion • The impact of wave 3 Covid on inpatients on operational patient flow and the impact of cancellation of routine elective activity.
Next steps:	Work will continue in addressing the actions raised as part of the escalation reports and through Trust Management Group.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Continually improve the **quality of care** so that services are safe, compassionate, timely and responsive – achieving consistently good outcomes and an excellent patient experience To be **a great place to work**, by creating a positive and open culture, and supporting and developing staff across the trust, so that they are able to realise their potential and give of their best To **transform and improve our services** in line with the Dorset ICS Long term Plan, by separating emergency and planned care and integrating our services with those in the community
BAF/Corporate Risk Register: (if applicable)	**UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak **UHD 1383** - COVID -19 risk relating to HCAI **UHD** (risk ref tbc) – COVID -19 impact on staffing **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** - Demand for acute inpatient beds will exceed bed capacity (Demand & Capacity) **Existing RBCH/Poole site risks (*1011, 801, 1332 – UHD ref no. awaited*)** re ED: *1) Performance; 2) Ambulance handovers; 3) Patient safety* ***Existing RBCH/Poole site risks (1053 – UHD ref no. awaited)*** *re Long Length of Stay / Discharge to Assess* **RBCH 808** Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2019/20 are not met **PHT 1074** Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards **UHD 1347** – Financial Control Total 2020/21.This entry highlights the potential risk of the Trust failing to achieve the required break-even outturn position, resulting in a revenue deficit and an unplanned reduction in cash available to support the capital programme. However, following the additional guidance received in February and confirmation of additional funding to off-set the continued loss of non-NHS income; the Trust is confidently forecasting a financial break-even position. This risk has therefore been reduced from a risk score of 16 (highly likely and major impact) to a risk score of 3 (unlikely and moderate impact). No further mitigating actions are required at this stage, however the financial position will continue to be managed very closely during March. A new risk will be added to the risk register in March, reflecting the financial risk associated with the 2021/22 financial performance. Full detailed will be included within future reports. **UHD 1416** – GIRFT & Model Hospital. This entry highlights the risk of not achieving the efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision. This risk has remained unchanged following review in February with a risk score of 9 (possible with a moderate impact), reflective of the current position (operational and financial) during the pandemic. It is fair to say that there has been less focus on productivity and efficiency whilst all efforts have been focused on keeping patients safe and looking after our staff. Unwarranted variation therefore continues to exist within some services as evidenced through GIRFT reviews and the model hospital metrics. This risk will be updated to align with the operational planning for 2021/22, including the updated model hospital metrics once released (expected in March). This update will set out the proposed actions, including early operational planning for 2022/23 recognising the financial and operational challenges ahead and the increasing requirement to maximise productivity and efficiency.

CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Board (Full report)	Mar 2021
Quality Committee (Quality)	Mar 2021
Finance & Performance Committee (Operational / Finance Performance)	Mar 2021
Trust Management Group	Mar 2021

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




February 2021

Created March 2021

RESPONSIVE

Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	22	10	24	34	8	201	-76
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	187	75	982	-340
	ENA Risk Assessment	Falls		62%	61%	61%	61%	61%	51%	59%	60%	
	*infection eNA assessment went live at RBCH during April 20	Infection*		74%	73%	70%	64%	73%	54%	62%	72%	N/A
		MUST		64%	64%	63%	65%	61%	57%	63%	63%	8%
		Waterlow		61%	61%	61%	61%	60%	52%	59%	59%	8%
RTT	18 week performance %		92%	49.0%	56.2%	60.4%	63.4%	64.8%	63.0%	59.3%		
	Waiting list size		42,587	41,172	43,123	44,320	44,349	44,117	44,615	45,524		
	Waiting List size variance compared to Mar 19 %		0%	-3%	1.3%	4.1%	4.1%	3.6%	4.8%	6.9%		
	No. patients waiting 26+ weeks			16,950	17,001	14,220	12,131	10,738	10,904	11,672		
	No. patients waiting 40+ weeks			6,395	6,921	7,197	7,799	8,031	7,258	7,006		
	No. patients waiting 52+ weeks		0	2,050	2,636	2,998	3,242	3,439	4,273	5,325		
	Average Wait weeks		8.5	20.8	20.6	19.5	18.3	18.6	18.3	18.3		
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%	69%	67%		
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%	60%	62%		
	NOFs (Within 36hrs of being clinically fit - CCG)		95%	69%	10%	50%	74%	56%	67%	90.0%		
Outpatients	**Referral Rates**											
	GP Referral Rate year on year +/-		-0.5%	-45.8%	-37.8%	-34.4%	-32.0%	-28.2%	-29.5%	-29.0%		
	Total Referrals Rate year on year +/-		-0.5%	-45.3%	-37.1%	-32.2%	-28.7%	-24.5%	-22.8%	-22.2%		
	Outpatient metrics											
	Follow up backlog			13,652	13,941	13,722	13,099	13,941	14,883	15,775		
	Follow-Up Ratio		1.91	1.46	1.44	1.44	1.48	1.44	1.63	1.54		
	% DNA Rate		5%	5.7%	6.6%	7.0%	6.6%	6.0%	5.5%	5.0%		
	Patient cancellation rate			9.2%	9.9%	10.3%	9.5%	10.4%	12.1%	8.8%		
	30% reduction in face to face attendances											
	% telemedicine attendances		25%	52.9%	44.5%	42.0%	43.1%	39.4%	52.1%	52.8%		
DM 01	**Diagnostic Performance (DM01)**											
	% of <6 week performance		1%	19.5%	16.9%	9.8%	1.4%	2.7%	6.4%	5.9%		
Cancer	2 week wait (RBH not being monitored)			99.3%	95.4%	-	-	-	-	-		
	62 day standard		85%	76.6%	76.1%	77.9%	80.3%	77.5%	78.5%	69.5%		
	28 day faster diagnosis standard		75%	80.3%	72.9%	76.6%	86.7%	78.6%	72.5%	80.6%		
Emergency Dept	Arrival time to initial assessment		15	5.7	5.7	5.1	5.0	6.0	6.0	5.0		
	Clinician seen <60 mins			4065	4399	4664	4484	4385	4526	5136		
	PHT Mean time in ED		200	227	206	210	230	235	266	235		
	RBCH Mean Time in ED		200	211	217	226	219	259	258	222		
	Patients >12hrs from DTA to admission		0	0	0	0	7	8	3	1		
	Patients >6hrs in dept			1833	1454	1540	1488	2126	2052	698		
	ED attendance Growth (YTD)			-26.0%	-23.2%	-15.7%	-21.2%	-21.8%	-22.6%	-31.4%		
SWAST SCAST	Ambulance handover growth (YTD)					-6.7%	-7.5%	-7.0%	-4.7%	-11.9%		
	Ambulance handover 30-60mins breaches			313	228	249	213	261	296	126		
	Ambulance handover >60mins breaches			56	52	48	57	103	203	12		
Patient Flow	Emergency admissions growth (YTD)			-11.9%	-10.5%	-12.1%	-15.4%	-16.4%	-13.1%	-19.3%		
	Bed Occupancy		85%		85.9%	86.0%	85.4%	85.2%	87.4%	84.6%		
	Stranded patients:											
	Length of stay 7 days				380	394	385	311	443	311		
	Length of stay 14 days				197	214	219	155	242	155		
	Length of stay 21 days		108		108	126	132	86	144	86		
	Non-elective admissions				6089	6279	5673	6034	5231	6034		
	> 1 day non-elective admissions				3796	3932	3554	3686	3521	3686		
	Same Day Emergency Care (SDEC)				2291	2346	2118	2344	1710	2344		
	Conversion rate (admitted from ED)		30%		34.40%	36.10%	38.30%	36.90%	42.30%	36.90%		

Performance at a Glance - Key Performance Indicator Matrix

				standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	ytd	ytd var	trend
SAFE														
Quality	Presure Ulcers (Cat 3 & 4)				12	6	10	8	12	12	13	133	76	
	Inpatient Falls (Moderate +)				5	2	3	5	4	4	5	43	16	
	Medication Incidents (Moderate +)				1	2	5	4	9	2	4	30	-9	
	Patient Safety Incidents (NRLS only)				1379	1341	1654	1581	1537	1492	933	14,565	297	
	Hospital Acquired Infections		MRSA		0	0	0	0	0	0	0	0	1	
			MSSA		1	2	3	9	8	4	3	44	-7	
			C Diff		7	6	1	3	1	2	7	48	13	
			E. coli		3	12	4	8	1	7	2	55	33	
EFFECTIVE														
Mortality	HSMR	Latest	(Dec 20 - UHD)											
	Patient Deaths		YTD		207	185	265	244	249	469	299	2646	-166	
	Death Reviews		Number		83	61	54	28	29	36	2	481	n/a	
	Deaths within 36hrs of Admission				30	35	40	36	49	47	39	412	17	
	Deaths within readmission spell				15	13	15	22	25	36	18	199	-53	
CARING														
	Complaints Received				57	48	51	56	62	53	53	519	153	
	Complaint Response in month				57	48	51	48	49	43	59	490	206	
	Section 42's				0	2	0	0	0	0	1	27	1	
	Friends & Family Test				90%	91%	91%	91%	91%	91%	91%	91%	-	
WELL LED														
Safety	Risks 12 and above on Register				36	38	39	31	32	27	31	27	-14	
	Red Flags Raised*				31	47	51	43	73	129	51	478	-90	
	*different criteria across RBCH & PHT													
	Overall CHPPD				9.5	8.8	9.0	9.4	9.4	8.3	10.7	10.1	2.2	
	Patient Safety Alerts Outstanding				0	0	0	0	0	0	0	0	0	
People	Turnover				10.40%	10.70%	10.40%	10.20%	10.00%	9.80%	9.40%	10.6%	-1.7%	
	Vacancy Rate *(only up to Oct 2020)*				1.0%	0.7%	1.3%	-	-	-	-	0.9%	-3.9%	
	Sickness Rate				4.2%	4.2%	4.2%	4.4%	4.5%	7.1%	4.9%	4.8%	0.8%	
	Appraisals		Values Based		41.6%	53.5%	57.3%	61.5%	63.9%	63.7%	63.1%	44.1%	-18.4%	
			Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	61.6%	62.7%	55.3%	-26.5%	
	Statutory and Mandatory Training				86.52%	86.96%	88.37%	85.90%	85.80%	87.20%	86.50%	86.8%	-2.2%	

Quality - SAFE

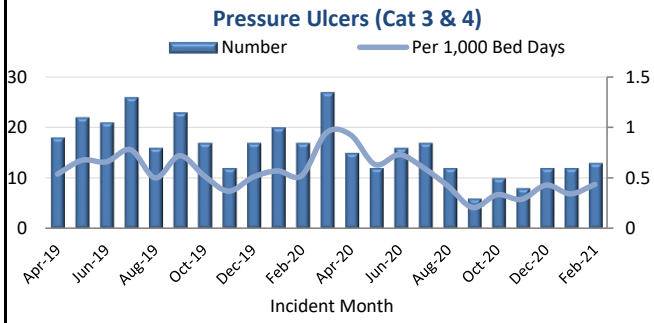
Commentary on high level board position

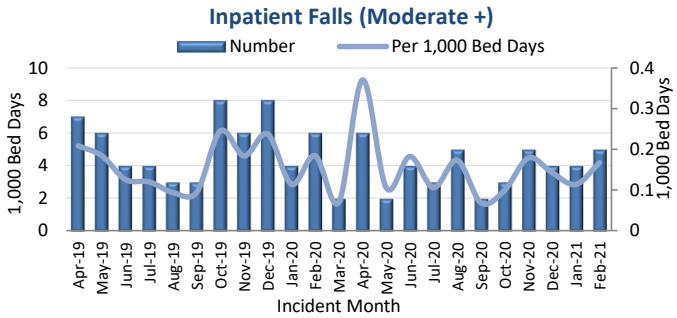
- One (1) Serious Incident reported in February 21 - Delayed diagnosis of an ectopic Pregnancy (Heterotopic). Escalated at Learning Panel- to Externally reportable SI. YTD total below trajectory compared to 2019/20. However number of reportable Never Events is above total for previous year.
- A Trustwide QI project has been esatablished to look at surgical checklists. The Associate Medical Director, Dr Morgan, is presenting the learning from work on standardinsation of chest drain checklist procedures and training at UHD to the CCG Patient Safety Meeting on the 24/3/21.
- Ward reviews for pressure ulcers and in-patient falls are on-going with lessons learnt shared corporately. As noted in January the increase in frailty linked to Covid-19 has had an impact during wave 2.

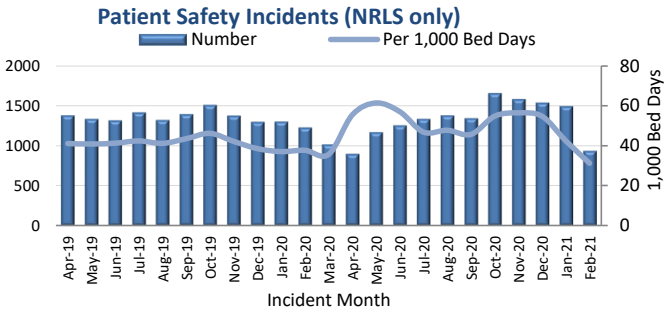
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	133	209	76
	Per 1,000 Bed Days	0.45	0.58	0.13
Inpatient Falls (Moderate +)	Number	43	59	16
	Per 1,000 Bed Days	0.15	0.16	0.02
Medication Incidents (Moderate +)	Number	30	21	-9
	Per 1,000 Bed Days	0.10	0.06	-0.04
Patient Safety Incidents (NRLS only)	Number	14,565	14,862	297
	Per 1,000 Bed Days	49.31	41.00	-8.31
Hospital Acquired Infections	MRSA	0	1	1
	MSSA	46	37	-9
	C Diff	48	61	13
	E. coli	55	88	33

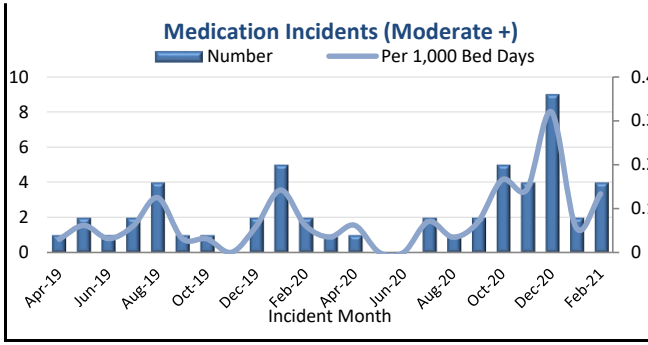
High Level Trust Performance

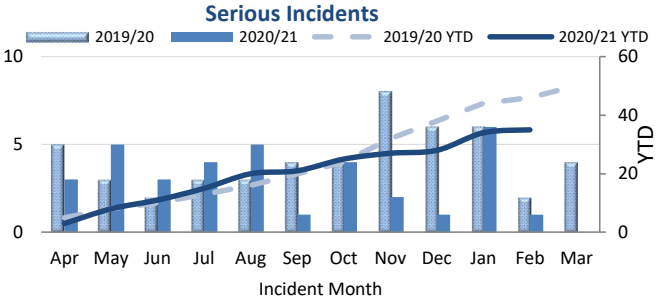


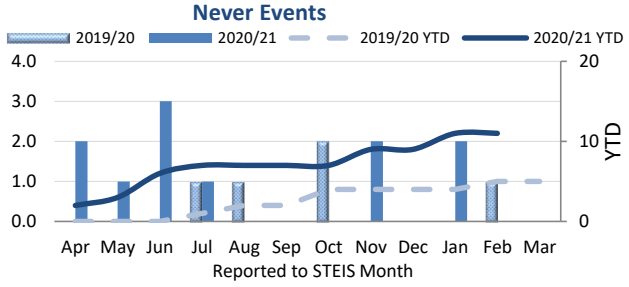




0 (Jan 21) MRSA 0 (Feb 21) | 4 (Jan 21) MSSA 5 (Feb 21) | 2 (Jan 21) C Diff 0 (Feb 21) | 7 (Jan 21) E. coli 0 (Feb 21)







Quality - RESPONSIVE

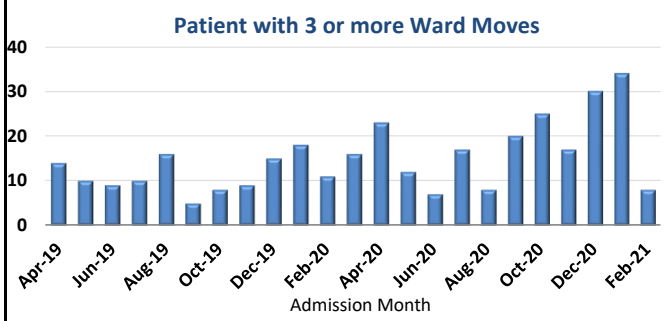
Commentary on high level board position

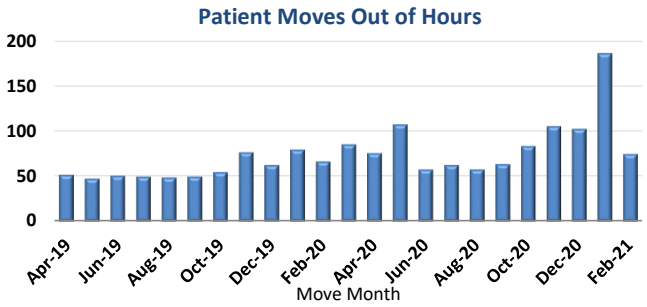
- A noticeable drop in patient moves is noted for February 2021. The reduction aligns with the decreasing numbers of Covid-19 patients within the organisation. The management of Covid-19 cases and outbreaks has been challenging with infection control practices around isolation and social distancing impacting on patient moves as cases were identified. Balancing caring for patients in the right environment often involved multiple moves across the organisation to maintain safe infection control standards.
- A dip in performance across all ENA risk assessmentsis noted for January with a return to usual performance in February 2021. This is also considered to be linked to wave 3 of the pandemic, where professional judgement was encouraged for the prioritisation of care assessments. The Red Flag and implementing safest staffing policy was piloted during January which sets out the principles for safely implementing and monitoring the use professional judgement.
- Reporting on mixed sex accomodation remains on hold nationally, the Trust however continues to aspire to maintain this standard

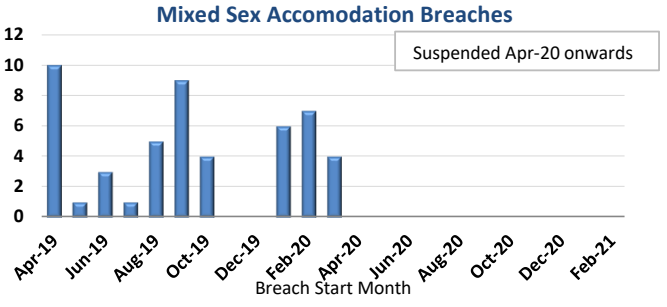
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)		201	125	-76
Patient Moves Out of Hours (Non-Clinically Justified Only)		982	642	-340
Mixed Sex Acc. Breaches Suspended Apr-20 onwards due to Covid		0	46	N/A
ENA Risk Assessment				
**infection eNA assessm went live at RBCH during April 20*	Falls	60%	52%	7%
	Infection*	72%	16%	N/A
	MUST	63%	55%	8%
	Waterlow	59%	53%	6%

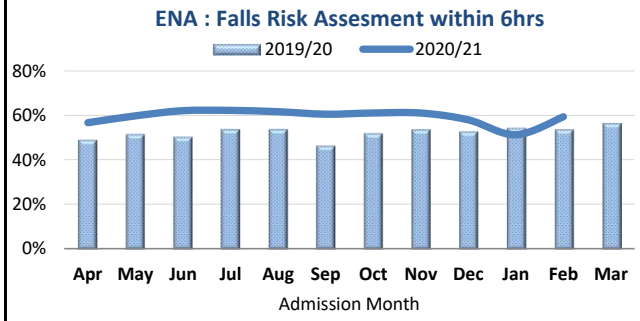
High Level Trust Performance

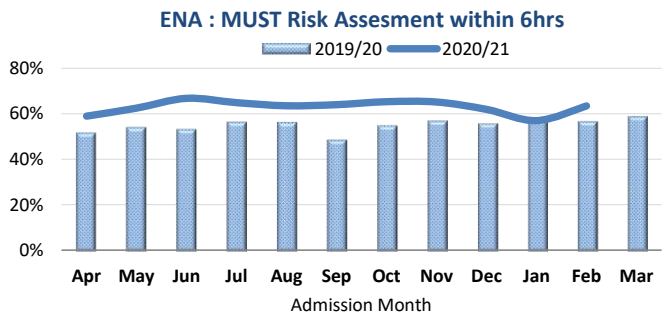


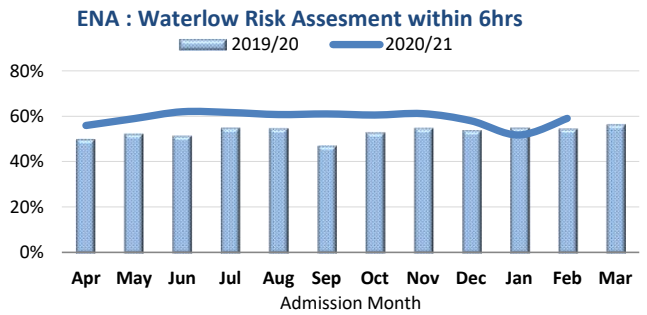




51.3% (Jan 21) Falls 59.3% (Feb 21) | 54.3% (Jan 21) Infection 61.6% (Feb 21) | 56.9% (Jan 21) MUST 63.4% (Feb 21) | 51.7% (Jan 21) Waterlow 59% (Feb 21)







Quality - EFFECTIVE AND MORTALITY

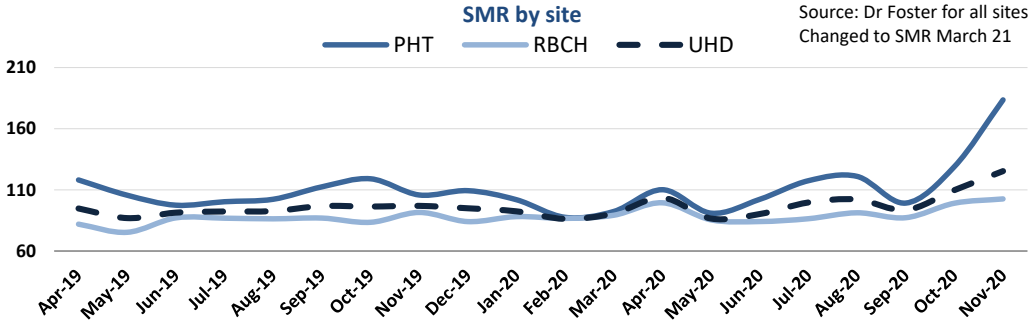
Commentary on high level board position

- The Medical examiner service has remained in place throughout the pandemic and has continued to ensure 100% of cases are reviewed and patients families/NOK contacted where available.
- The number of formal case note mortality reviews have reduced again in month due to covid activity. However there remains still clinical engagement in learning from deaths at the Trust Mortlaity Surveillance Group.
- A thematic review of covid deaths at Poole Hospital has been completed and the report reccomedations, actions and learning has been shared with Trust Mortality Surveillance Group and CCG pan Dorset Mortality Group undertaken.

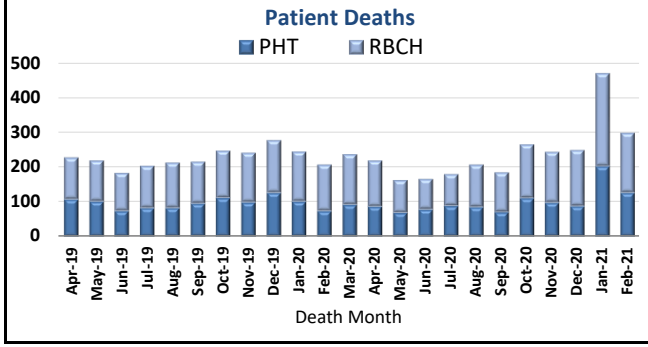
High level Board Performance Indicators

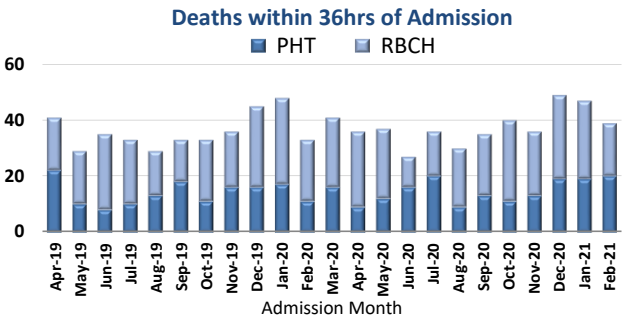
			20/21	19/20	Variance
SMR (Source: Dr Foster for all sites)	Latest	(Nov 20 - UHD)	125.4	97.0	
Patient Deaths		YTD	2646	2480	-166
Death Reviews		Number	481	928	N/A
Note: 3 month review turnaround target		Percentage	19%	47%	
Deaths within 36hrs of Admission			412	395	17
Deaths within readmission spell (Patient readmitted within 5 days)			199	252	-53

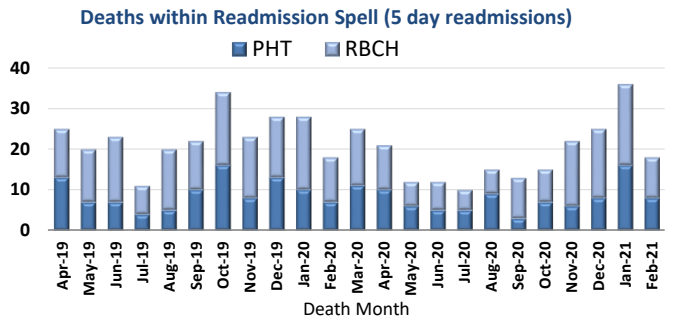
High Level Trust Performance



109.9 (Oct 20) SMR 125.4 (Nov 20) | 469 (Jan 21) Patient Deaths 299 (Feb 21) | 20.5% (Oct 20) Deaths Reviewed 12% (Nov 20)







Quality - CARING

Commentary on high level board position

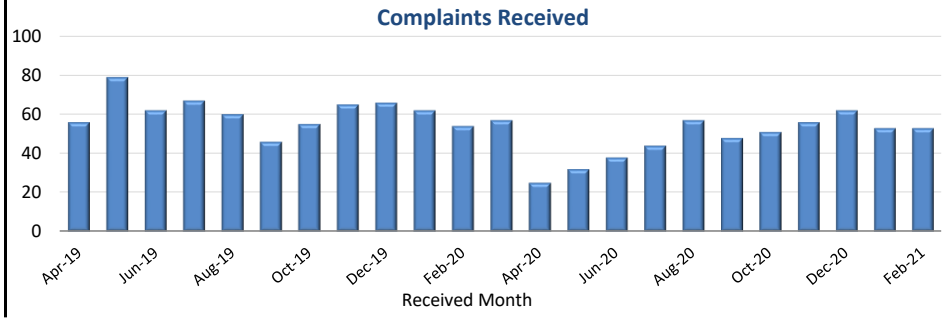
- The overall Friends and Family Test rating of good/very good has been fairly consistent at 91-93% . The results from our inpatients are highest , at 94%, with Day of Surgey at PH achieveing 100% (66 patients).
- **FFT Comments**: *"Staff were very conscious of infection control and constantly cleaning hands or wiping things down .well done". " Your staff are amazing ...they really listened to me". "Every member of staff was very kind and respectful. Thank you everyone".*
- This month, the number of complaint responses completed has exceeded the number of complaints received; this means that the growing backlog and extended response times seen during the pandemic will start to see an improvement.
- YTD there have been 26 section 42 concerns raised across UHD, with 9 raised in the last quarter of which one met the section 42 criteria, but was subsequently closed with no further action.

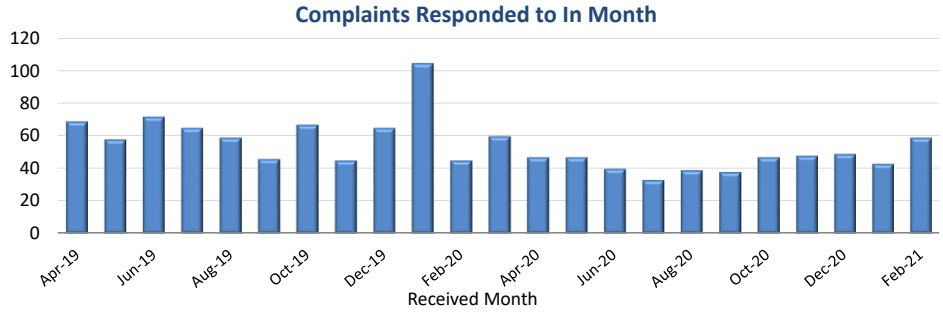
High level Board Performance Indicators

	20/21 YTD	19/20 YTD	Variance
Complaints Received	519	672	153
Complaint Response Compliance	TBC		
Complaint Response in month	490	696	206
Section 42's	27	28	1
Friends & Family Test	91%	N/A	-

Return changed 20/21

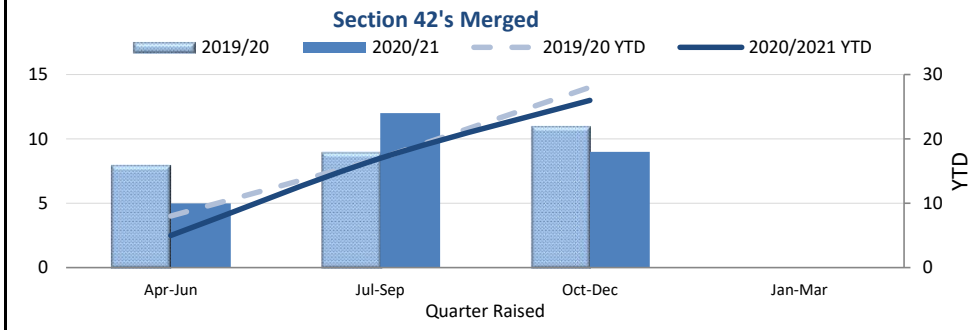
High Level Trust Performance

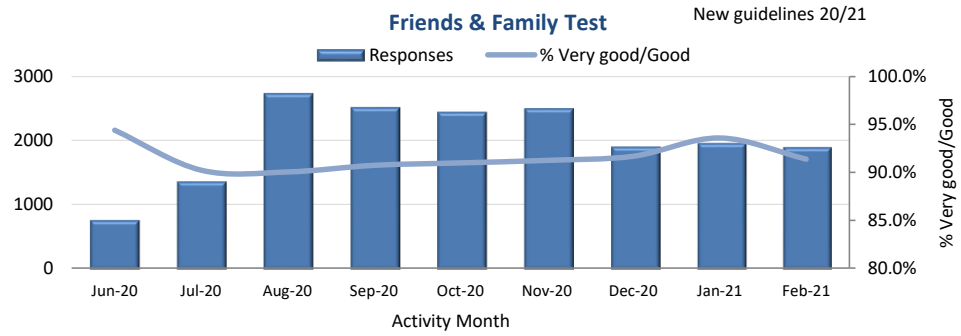




53 (Jan 21) Complaints Received 53 (Feb 21)

43 (Jan 21) Complaint Responses 59 (Feb 21)





Quality - WELL LED

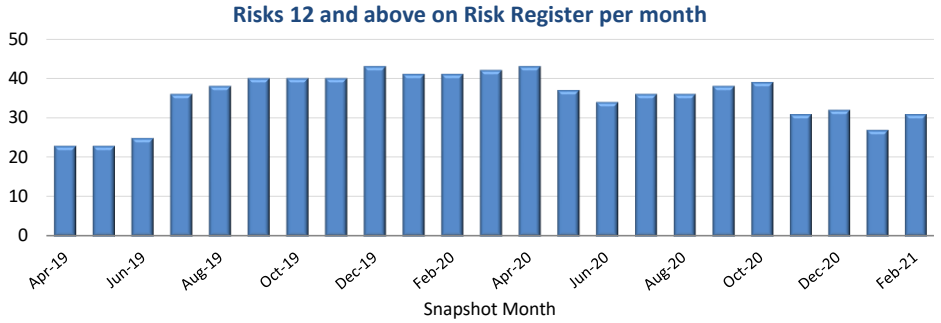
Commentary on high level board position

- Work continues to move all risks from the RBCH Datix system to the Poole system by the 1/4/21. All risk 12+ and all BAF risks have been successfully moved.
- All risks on the risk register have been linked UHD monitoring committees and new standard reports developed to enable close review at Board and Board sub committees.
- A new set of Red Flags for UHD was launched and implemented in January 2021 with both sites now reporting against these. Staffing in January and Early february was challenging, however the use of additional resources including, International registreed and Aspirant Nurses alongside system mutual aid supported maintaining safe staffing numbers.
- The overall CHPPD data scores well against the national average of 9.1 for all nursing , midwifery and AHP staff.

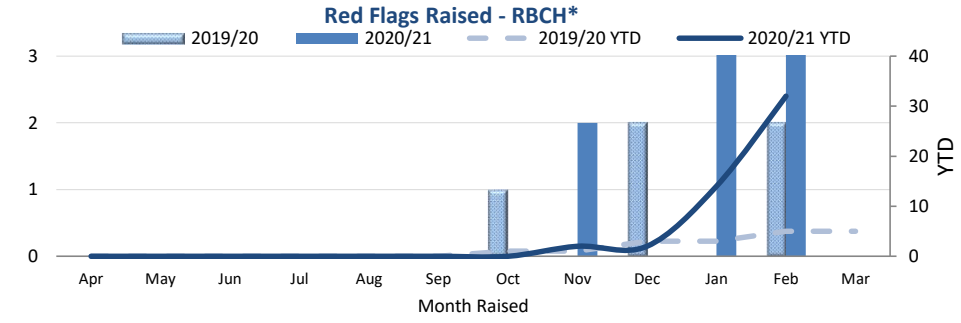
High level Board Performance Indicators

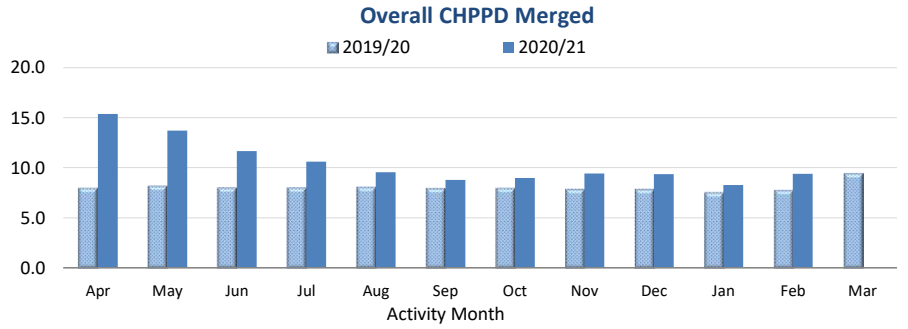
	20/21 YTD	19/20 YTD	Variance
Risks 12 and above on Register	27	41	-14
Red Flags Raised* *different criteria across RBCH & PHT	478	568	-90
Overall CHPPD	10.1	7.9	2.2
Patient Safety Alerts Outstanding	0	0	0

High Level Trust Performance

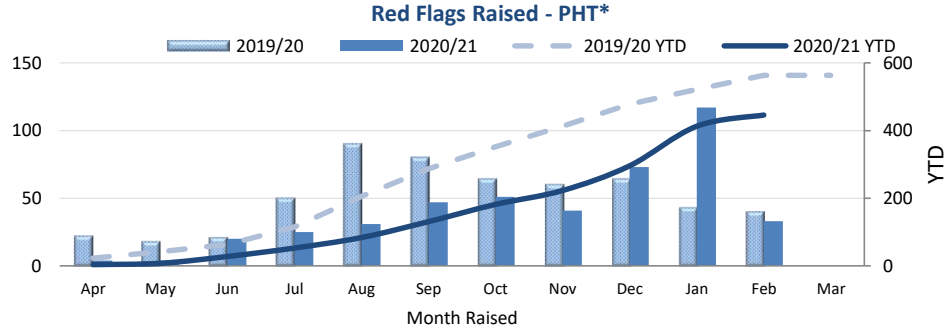


27 (Jan 21) Risks 12+ 31 (Feb 21)





8.3 (Jan 21) Overall CHPPD 9.4 (Feb 21)



Workforce

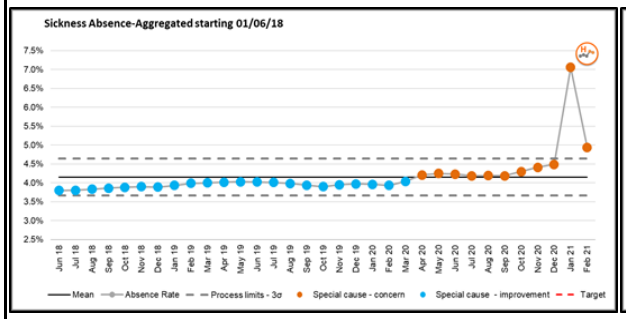
Commentary on high level board position

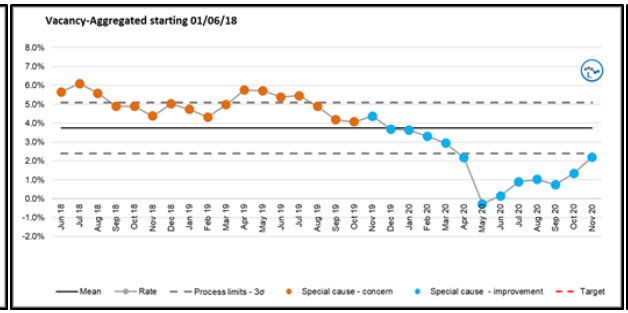
- The trend in overall **turnover and vacancy levels** continues lower than last year which is likely to be due to the continuing atypical market conditions and impact of lock down restrictions.
- **Overall sickness** levels have increased this month . Numbers of staff shielding have increased with the Governments' recent additions to the clinically extremely vulnerable list, although, many have continued to work from home and all are due to return to work from April.
- **Statutory and Mandatory training** compliance has dipped a little this month but continues in the high 80s which is encouraging as we continue to establish BEAT on the Poole site.
- **Appraisal levels** have fallen back this month and continue to track low. The new values-based Appraisal process for non-medical staff is due to be launched in April.
- There has been an operational impact of **annual leave** increasing in March as people use up any entitlement they are not able to carry over or sell back.
- 84% of our substantive/fixed term workforce have now had the **first covid vaccine**, 79% of our bank staff and 77% of BAME staff.
- The programme of **second workforce vaccinations** commenced on 17.3 and should last 5 weeks at Bournemouth site and 2 weeks at Poole site.
- **Staff survey** headlines are very encouraging with 76% of those taking part in the survey recommending our Trust as a place to work and 84% recommending our Trust to friends and relatves as a place for treatment.

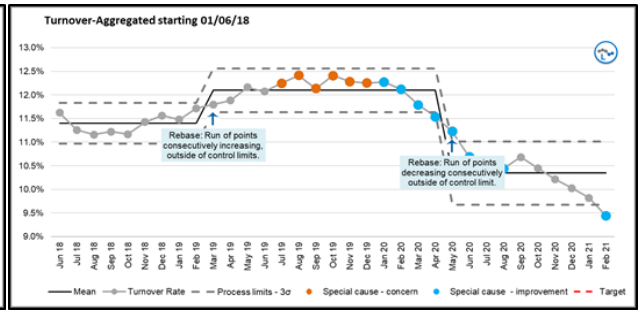
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Turnover		10.6%	12.2%	-1.7%
Vacancy Rate *20/21 only up to Oct 20*		0.9%	4.7%	-3.9%
Sickness Rate		4.8%	4.0%	0.8%
Appraisals	Values Based	44.1%	62.5%	-18.4%
	Medical & Dental	55.3%	81.8%	-26.5%
Statutory and Mandatory Training		86.8%	89.0%	-2.2%
Staff Friends & Family Test *Note: 19/20 Q1 & Q2 only*	Caring	N/A	87.4%	
	Work		72.7%	

High Level Trust Performance





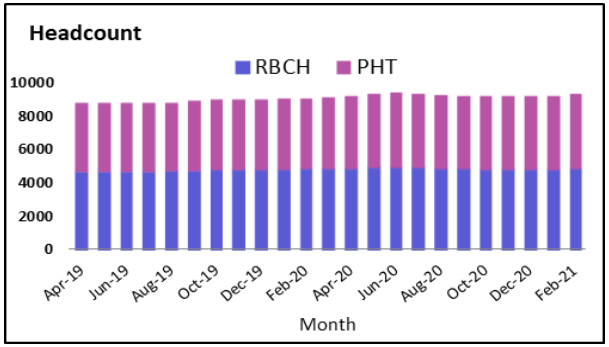


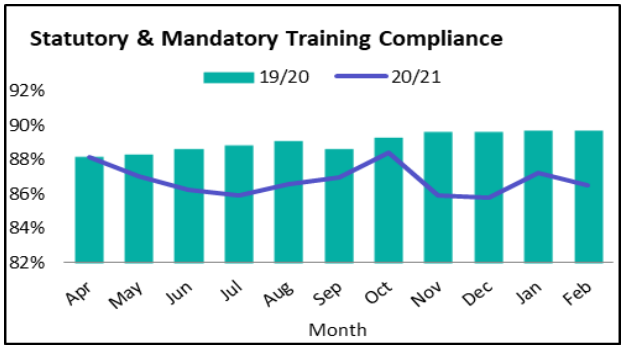
61.6% (Jan 21) | Appraisals (Medical) | 62.7% (Feb 21)

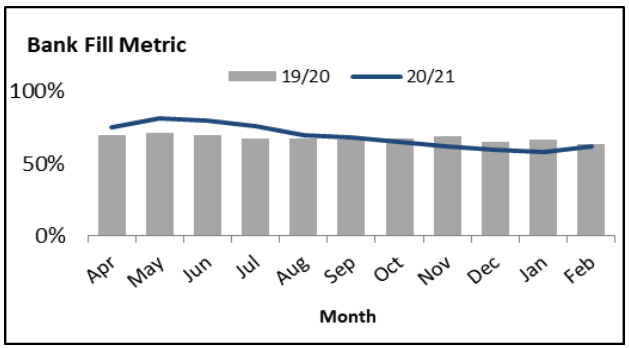
63.7% (Jan 21) | Appraisals (Values) | 63.1% (Feb 21)

9.8% (Jan 21) | Turnover | 9.4% (Feb 21)

7.1% (Jan 21) | Sickness | 4.9% (Feb 21)







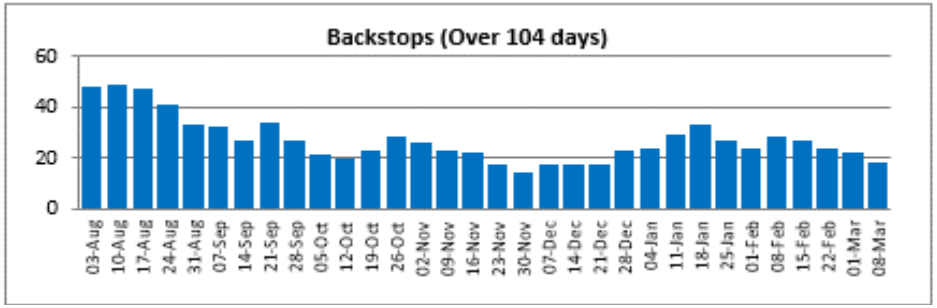
Cancer - Actual January 2021 and Forecast February 2021

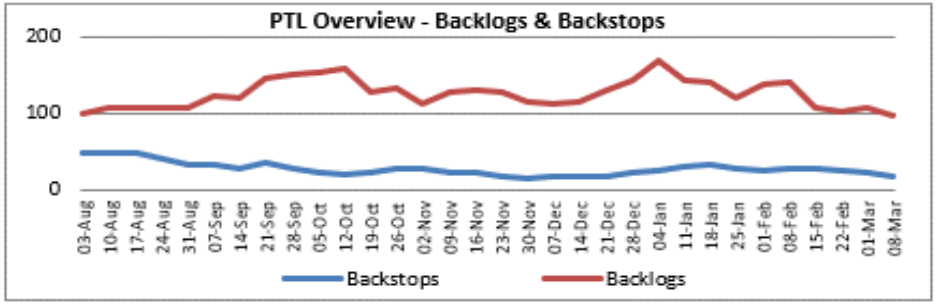
Commentary on high level board position

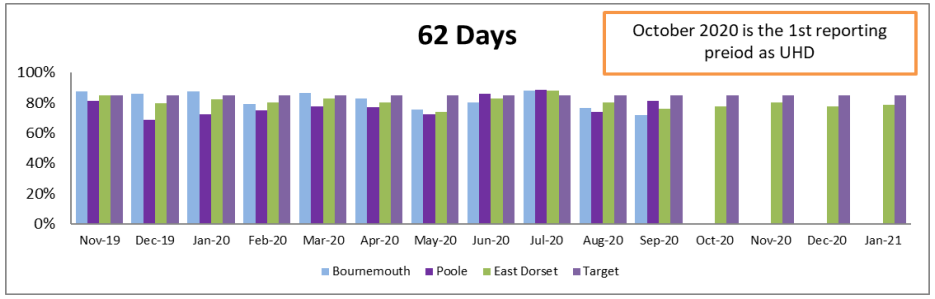
The decrease in referral numbers seen in January is already showing an increasing position again in February which for some tumour sites is continuing to add pressure, (especially an issue for head and neck and gynaecology pathway). Of significant positive note in terms of patient experience is the continued improvement in both the backlog and backstop positions - the Trust is now back at pre-COVID level with only 0.8% of the PTL being over 104 days. In terms of other KPI's the Trust continues to be challenged in performance, whilst activity levels remain near to previous years - in both January and February there were several patients who had already breached the threshold by the time they were treated, due largely to complex pathways and patient choice (wishing to have vaccination prior to attending).

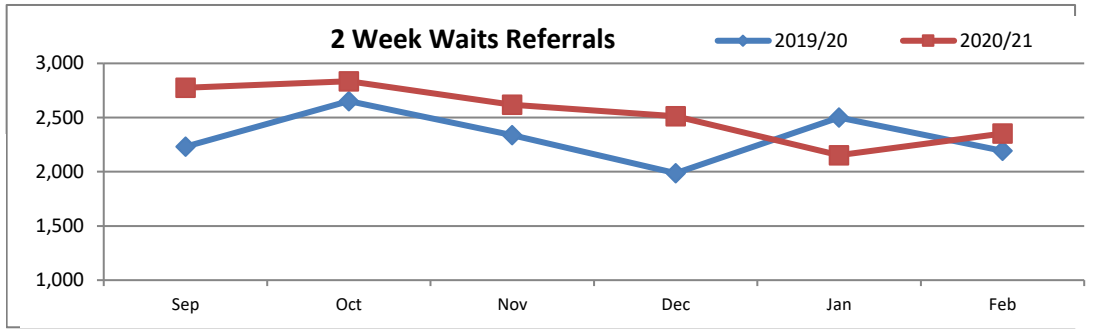
High level Board Performance Indicators & Benchmarking

Cancer Standards	Standard	UHD Jan-21	Predicted Feb-21
31 day standard	96%	96.6%	95.0%
62 day standard	85%	78.5%	69.5%
28 day faster diagnosis standard	75%	72.5%	80.6%

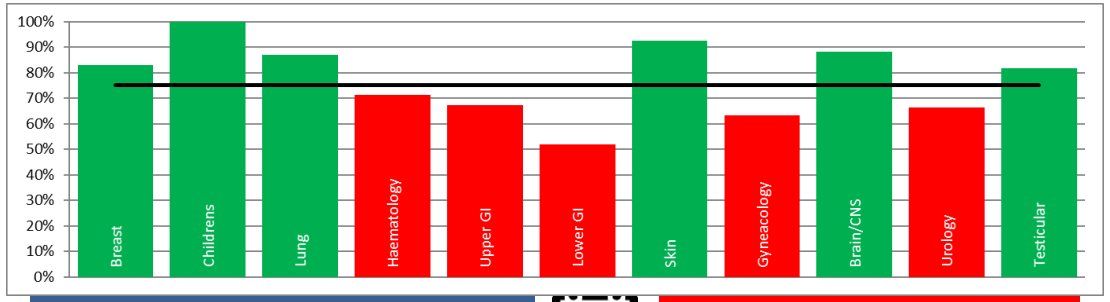




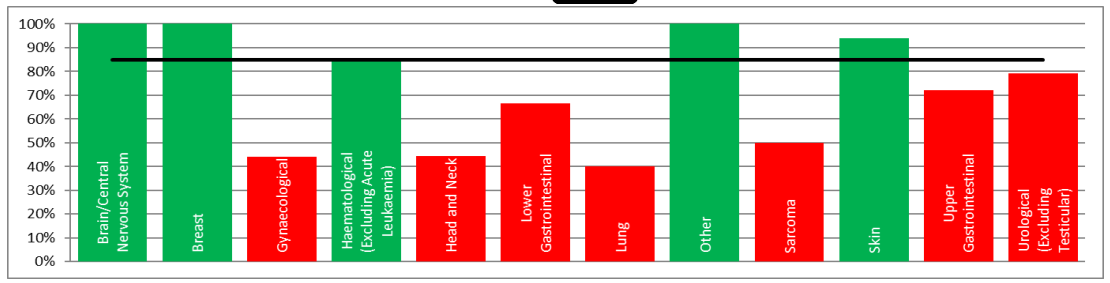




Target 75% | **28** | **UHD: Jan 2021: 72.5%**



Target 85% | **62** | **UHD: Jan 2021: 78.5%**



Emergency

Commentary on high level board position

Both Departments have made significant improvements in Ambulance Handover times, with 36 waiting over 60 minutes (previous month 205) and 173 exceeding 30 minutes (previous month 304). Average daily Ambulance conveyances were consistent at 135 per day for both January and February, noting RBH site seeing higher conveyances and levels consistent with last year. Poole site saw 120 less per week than last year.

Both departments made significant improvements in overall mean time compared to January, but neither achieved the required meantime of 200 minutes. On the Poole site the non-admitted mean time was 180 minutes, with admitted 294 minutes. This analysis will be available for both sites from Q1 21/22 following a signicant piece of work by the UEC and BI teams to move to a single consistent reporting dasboard.

No patients waited in either department for more than 12 hours after a decision to admit, an improvement over the 2 previous months. It is anticipated that when new UEC standards are introduced (following the recently closed national consultation) that the new standard will be 12 hours from arrival, and UHD is updating escalation policies ahead of this change.

Overall attendances remain significantly lower than the same period last year, by

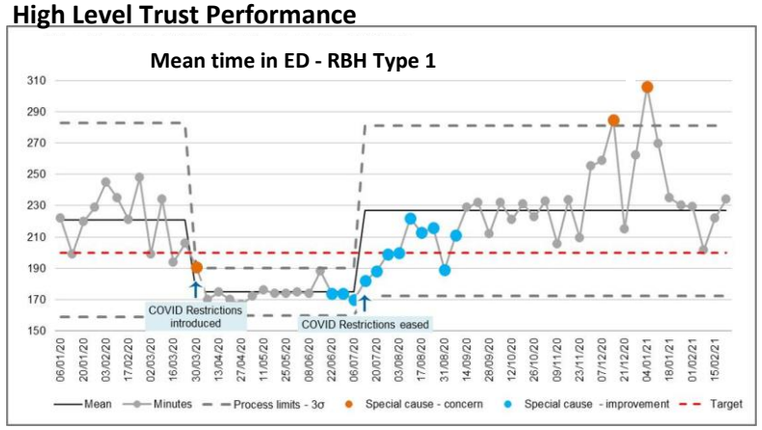
High level Board Performance Indicators

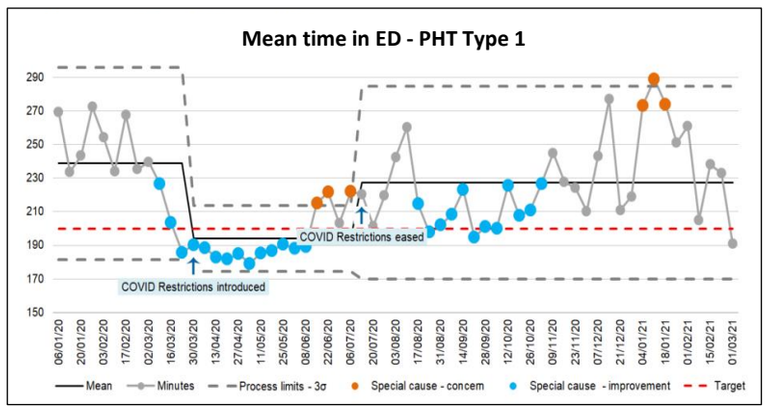
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	5
Clinician seen <60 mins		4438
PHT Mean time in ED	200	235
RBCH Mean Time in ED	200	222
Patients >12hrs from DTA to admission	0	0
Patients >6hrs in dept		1322
ED attendance Growth (YTD)		-31.4%
Ambulance Handover		
Ambulance handover growth (YTD)		-11.9%
Ambulance handover 30-60mins breaches		173
Ambulance handover >60mins breaches		36
Emergency Admissions		
Emergency admissions growth (YTD, all types)		-19.3%

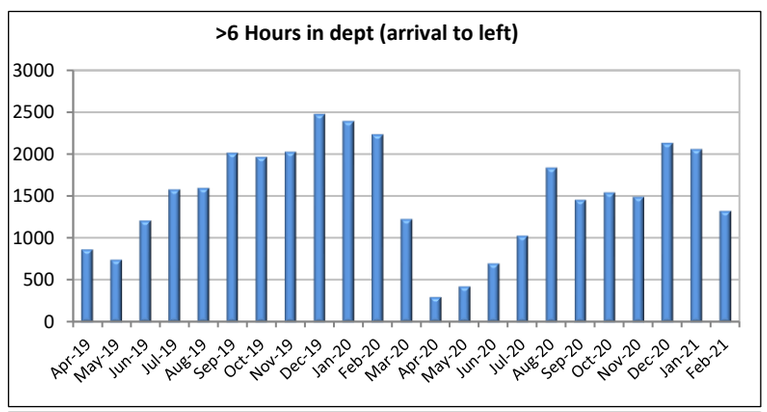
6 mins Jan-21 → Mean time to initial assessment → 5 mins Feb-21

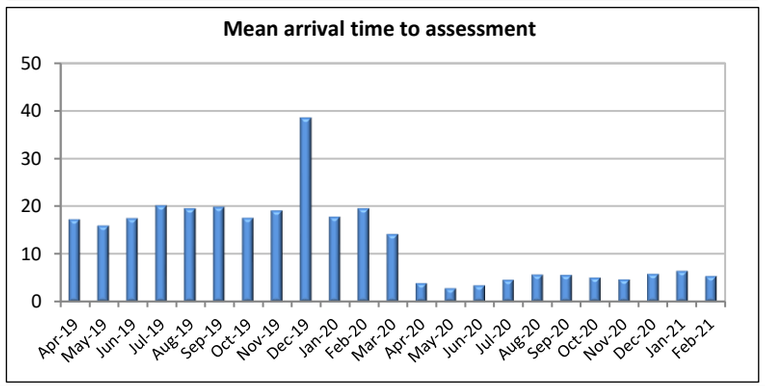
262 mins Jan-21 → Mean time in Dept. RBH & PHT → 228 mins Feb-21

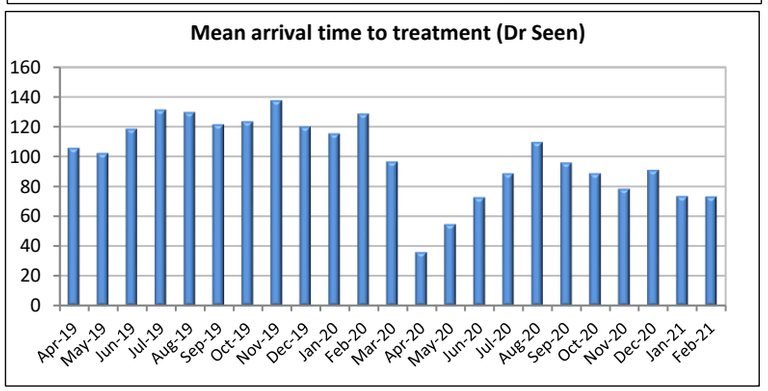
High Level Trust Performance

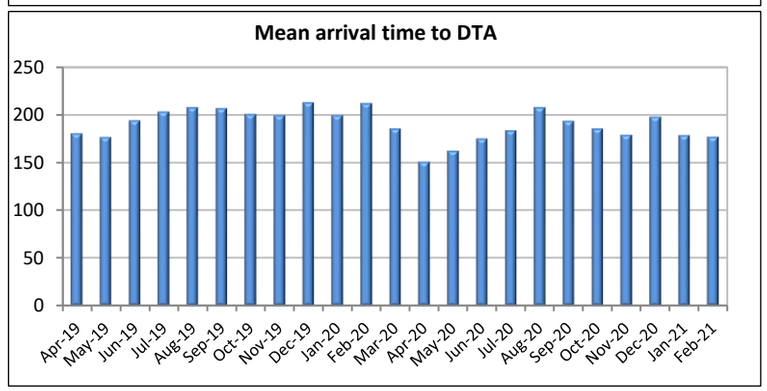












Elective & Theatres

Commentary on high level board position

18 Weeks Referral to Treatment

• The Trust's 18 week RTT performance is **59.3**% against the 92% standard. This is due to cancellation of elective work in line with national guidance, constrained capacity due to COVID and the impact of infection control guidance which has reduced efficiency.
• The >78 and >52 week backlog waiting list has increased since last month.
• The Trust number of incomplete pathways is above the March 2019 target.(6.9%).
• Specialty level recovery plans have been developed and discussed jointly with a focus on system wide working in relation to 52 week waiters. This will not deliver the RTT standard in the short to medium term due to reduced capacity as a result of efficiency and utilisation limitations. Additional capacity plans have been proposed via the Adopt and Adapt initiative (and bids)
• At the end of January 2021 the Trust reported **5,325** 52 week breaches. Dorset wide leads are progressing joint plans in 5 key specialties: Endoscopy, Ophthalmology, Orthopaedics and ENT/Oral Surgery. Focus for improvement is to reduce the number of 52 week breaches on the non admitted pathway. The number of 52 week waiters increased during January as a result of further COVID related pressures.

Theatre utilisation

• The current theatre utilisation rates are low as they do not include activity undertaken within the Independent Sector and therefore is not a true reflection of the position. The activity undertaken at the acute trusts will be focused on cancer and emergency cases which can also impact adversely on utilisation rates.

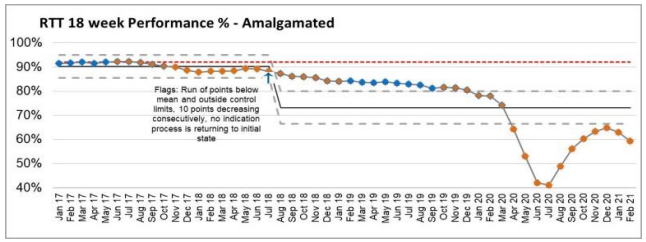
Trauma

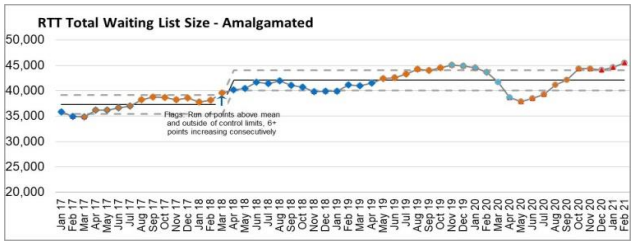
• Hip fractures within 36 hours of being clinically fit for surgery (CCG 95% standard) is currently 90% (67% last month)

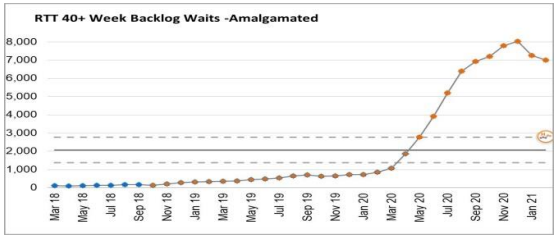
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust
Referral To Treatment		
18 week performance %	92%	59.3%
Waiting list size	42,587	45,524
Waiting List size variance compared to Mar 19 %	0%	6.9%
No. patients waiting 26+ weeks		11,672
No. patients waiting 40+ weeks		7,006
No. patients waiting 52+ weeks (and % of waiting list)	11.7%	5,325
No. patients waiting 78+ weeks		726
Average Wait weeks	8.5	18.3
Theatre metrics		
Theatre utilisation - main	80%	67%
Theatre utilisation - DC	85%	62%
NOFs (Within 36hrs of being clinically fit - CCG)	95%	90%

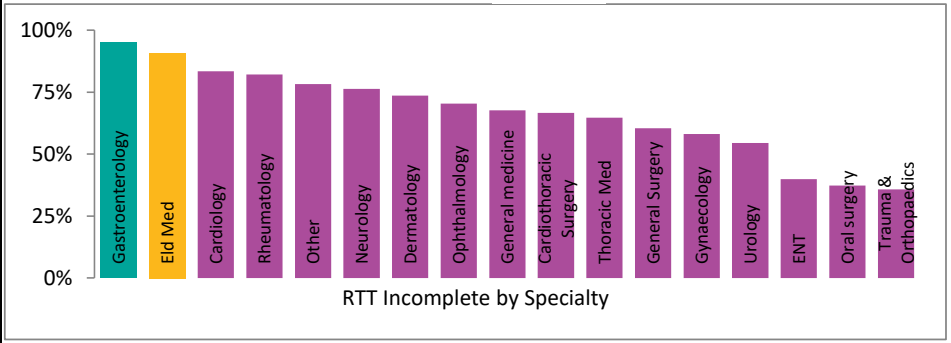
High Level Trust Performance



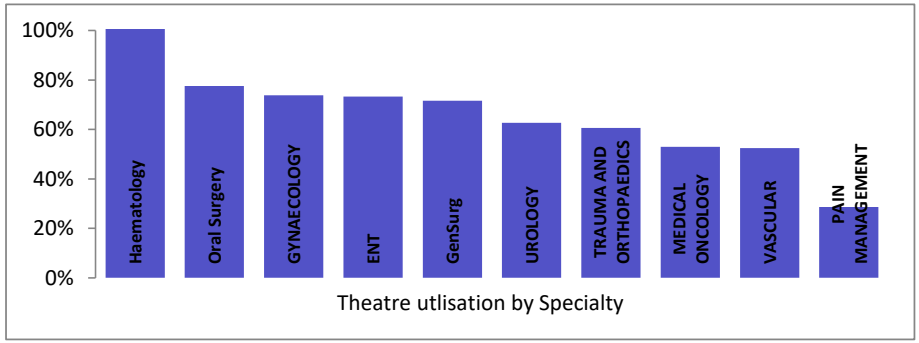




RTT Incomplete 59.3% <18weeks 18 WEEKS (Last month 63.0%) Target 92%



Theatre Utilisation 66% (Last month 68%)



Referral to Treatment (RTT)

What is driving under performance?

92% of all patient should be seen and treated within 18 weeks of referral.
Performance **59.3%** of all patients were seen and treated within 18 weeks at the close of February 2021.
The overall waiting list (denominator) was **45,524** which is higher than previously and above the March 19 waiting list of 42,587.

At the end of February 2021 5,325 patient pathways were reported as having exceeded 52 weeks.

February 2021 (compared with previous month)

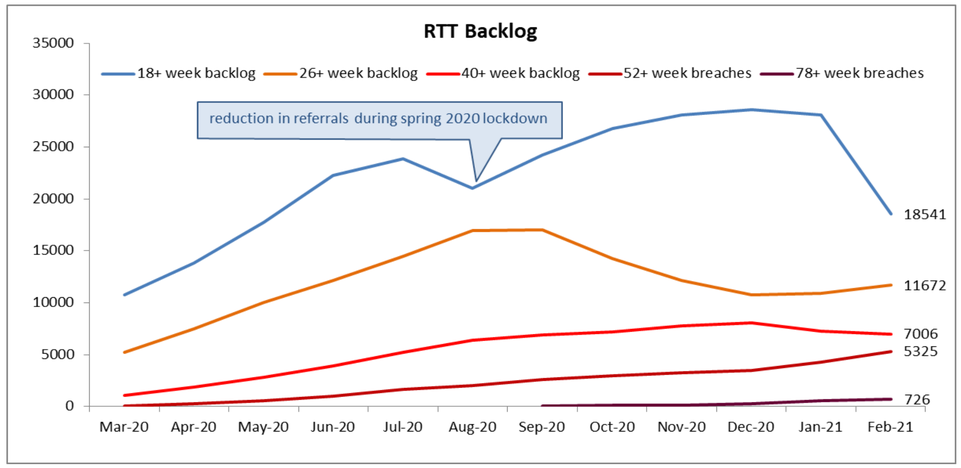
18,541 decrease > 18 weeks
11,672 increase > 26 weeks
7,006 decrease > 40 weeks
5,325 increase > 52weeks

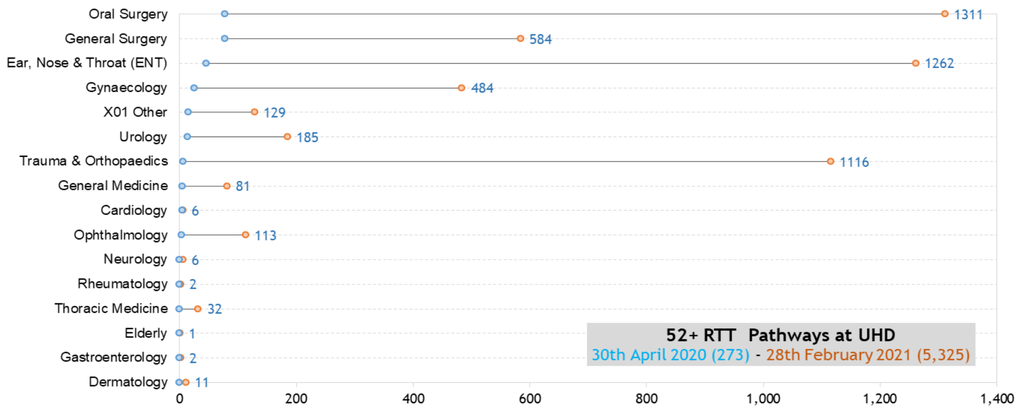
From October all trusts are required to provide patient level exception reports for all patients waiting > 78 weeks, this was paused for 2 weeks centrally over Christmas/New Year.

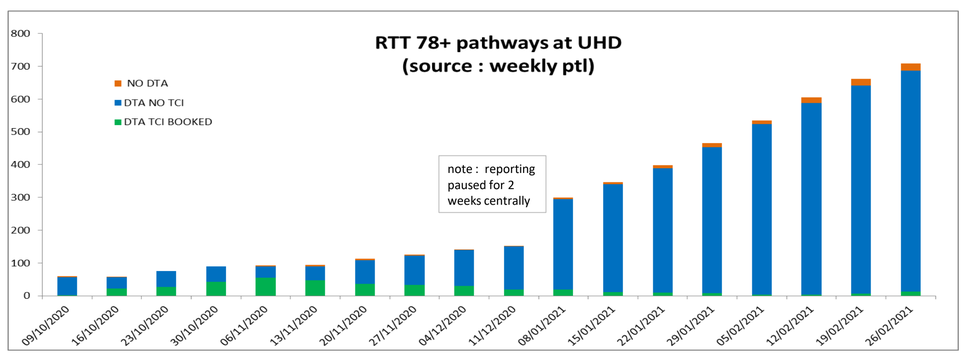
During the first wave of the Covid-19 pandemic the priority was to undertake essential emergency/urgent services whilst adhering to national guidelines on social/physical distancing, shielding and self isolation. This led to a significant reduction in elective activity including out patient appointments which were managed as digital non face to face, whilst this continues the specialties are also recovering by seeing patients face to face where necessary.

Non admitted and Admitted Performance
In addition to the above further reasons for under performance in 18 week patient pathways are:

- Royal College guidelines on the numbers of patients that can be safely seen during Covid leading to many patients being deferred for both outpatients and elective surgery
- Patients chosing not to attend hospital due to concerns about Covid, this number is increasing as prevalence of COVID-19 in the community has increased.
- National requirements regarding testing, PPE and infection control processes restrict a full recovery of activity over the coming months.
-Clinical prioritisation of cancer pathways during period of reduced capaciy / activity







What actions have been taken to improve performance ?

Additional theatre and treatment capacity contiues to be provided by the Indpendent Sector. Close working with colleagues in the Independent Sector continues as it is essential that this capacity is fully utilised.

Endoscopy remains a key priroity with all urgent and Fast Track patients across both Bournemouth and Poole booked first and existing capacity across both sites is being used optimally. The use of the Independent Sector and insourcing has created additional capacity and the use of day theatres on the Royal Bournemouth site is also contributing to an increase in activity levels.

An Operational Performance, Assurance and Delivery programme was launched in October to oversee improvements in performance, activity and reducign patients with a long wiaign time for treatment.

All patients on an admitted pathway have been cliinically reviewed and prioritised in accordance with the national protocol.

Waiting lists are being merged into one to enable easier management of treating our longest waiting patients in order.

Health Inequalities
Phase 4 planning guidance expected on 25th March is anticipated to include a requirement to recover the maximum elective activity possible taking into account opportunities to transform service delivery – focus on clinical urgency, very long waiters, work with IS, developing community diagnostic hubs and health inequalities. A sub group of Dorset ICS Elective Care Oversight Group has been established this month to develop system-wide approaches to understanding and responding to health inequalities associated with elective and UEC recovery.

UHD will be making its first submission of linked data to the Dorset Information and Intelligence Service population health database in March 2021, which will enable access to interactive and filterable analytics of our activity by a number of metrics including deprivation, such as most and least 20% deprived, as well as other vulnerabilities including risk of social isolation, unhealthy behaviours and active safeguarding flags. This will be used to inform comms strategies, help clinicians to target hard to reach populations and support UHD to review and adapt its recovery plans and approaches to respond to health inequalities.

We anticipate being able to include a set of the data in the next IPR.

Wave 3 Surge COVID 19
Plans have been reassessed to recover elective care performance with a particular focus on long waiters noting that many routine elective patients were canceleld towards end of December and into January/February in repsonse to emergency operational pressures.

Executive Lead Mark Mould Trustwide Lead Author

Escalation Report

Feb-21

Trauma Orthopaedics -67% compliance achieved against fractured neck of femur target of 95% of clinically appropriate patients to surgery within 36hrs.

Activity | Response

Definition of Trauma Quality Targets & Compliance Achieved

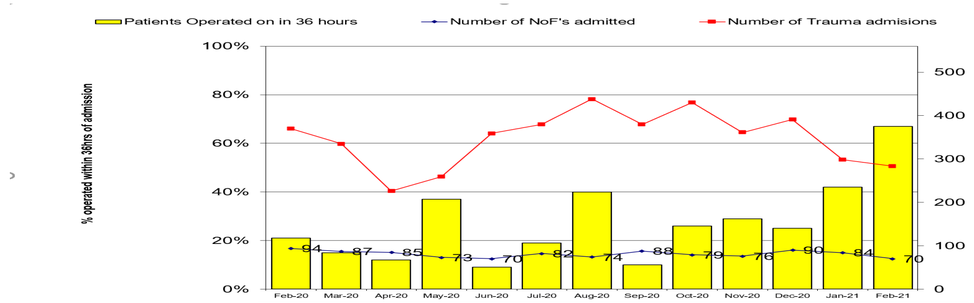
NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission
Febuary 2021 Compliance: 67%

CCG 2018-19 Quality Target: 95% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission or of being clinically appropriate for surgery, increasing to 95% by March 2019 (internal target remains at 95% on a monthly basis)
Febuary 2021 Compliance: 90%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
Febuary 2021 Compliance: 97%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	4
Patients on anti coagulants	11
Other NoF patients prioritised	3
Loss of weekend capacity due to theatre staffing	5
Awaiting x-ray/scan availability	0
Required medical review pre-op	0
Patient refused surgery	0
Delayed transfer from RBH	0
Awaiting specialist surgeon	0
Total breached NoFs	23

Demand on Trauma Directorate during Febuary 2021



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Patients Operated on in 36 hours	21%	15%	12%	37%	9%	19%	40%	10%	26%	29%	25%	42%	67%
Number of NoF's admitted	94	87	85	73	70	82	74	88	79	76	90	84	70
Number of Trauma admisions	370	335	226	259	359	380	438	380	430	361	391	298	283

Escalation Activity in Febuary 2021

283 trauma patients admitted in Febuary which includes 70 patients with # NOF. We operated on 69 of the 70 as 1 was for a trial of mobilisation.
This month's figures are our best in a long period of time with 67% of patients with a # NOF having surgery with36 hours of admission and 90% within 36 hours of being fit for surgery, these figures would have been better had we not lost our third theatre lists both Saturday and Sunday on the last weekend of the month, as 10 # NoF's had been admitted on the Thursday and Friday prior. The NoF's that breached towards the beginning of the month were due to the volume admitted in a 24 hour period 7 admitted on 08/02.
We have spent the majority of the month out of escalation with only 6 days in Stage one which means greater than 24 patients awaiting surgery. During February we have continued with our covid theatre capacity i.e. 3 list a day one of which is a 3 session list, though due to issues with staffing trauma lost 21 theatre sessions this month which were mostly the third session of an 3 session list or the third list at the weekend.
Radiology provision continues to be problematic, to the extent trauma have been allocated only one radiographer when we have 3 lists running in the morning on several days (we run out of non-x-ray cases and theatre capacity not utilised).

Mitigations and Reset

Application of national clinical guidelines: Major trauma, #NOF, Spinal, discharge, flow.
Front door support: 7 day SHO front door cover with mid grade support
Theatre efficiency: as a result of following national guidelines = max 3 cases per session
Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate
VFC capacity increased to provide same day access.
RTT Performance 92%. Complete PTL validation and clinical review complete
Bed base, reduction in core capacity to provide critical care capacity, purple and green
Medical cover: continued ward SHO and support of medical SHO cover, established shadow consultant on call rota with escalation plan to include fellows and senior registrars.
SHO recruitment successful with all SHO positions now in post.

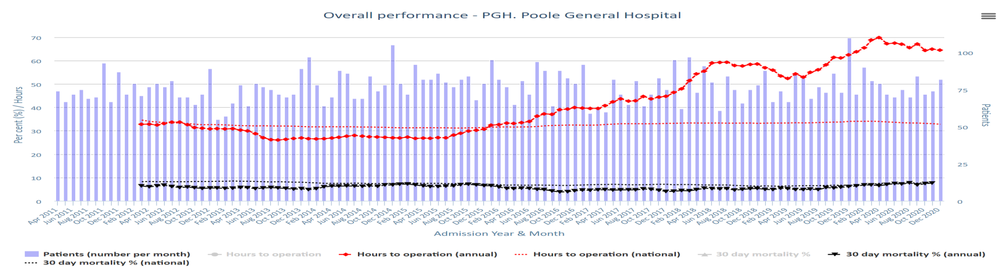
No decrease in the average daily NOF admissions leading to backlog of patients awaiting surgery
"other" trauma admissions initially reduced by 70% now on the increase
Conservative treatment options considered before operative intervention, Eg application of bone stimulators with 100% success rate.
Availability of timely fracture clinic reviews, both F2F and telephone
Direct support for front door teams reducing admissions.
Business case for 2 additional conultant posts approved at september HEG, interviews planned for beginning of December.

Complexity of Case Load

Soft Tissue	No. of pts
Patients requiring returns to theatre	10
Additional theatre slots required	9
Complex Surgery	**No. of pts**
Total Hip Replacements for NoFs	8
Revisions carried out	0

The majority of patients who were unfit for surgery on admission this month were on a DOAC and at present need to wait 48 hours from their last dose before surgery can be performed; an aneasthetic review of this policy will soon be changing so the patient can have their surgery 24 hours post last dose of a DOAC and reduce the risks of prolonged wait for surgery.
Eight patients had a THR for their # NoF in February, 1 of who went on the day of admission due to surgeon and theatre availability.
The number of trauma admissions continues to be low - the effect of 'lockdown', though the NoF numbers are pretty static.
There was also a reduction in the number of patients requiring 2 or more trips to theatre, equating to an additional 10 theatre visits, which is approximately 9 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

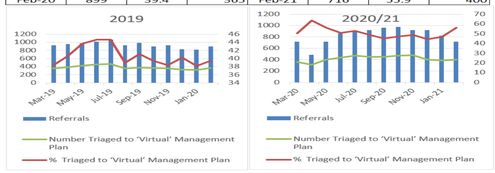
Neck of Femur QSPC Focus



Name	Code	Number of cases submitted	Surgery on day of, or day after, admission	Surgery supervised by consultant surgeon and anaesthetist	General anaesthetic	General anaesthetic and nerve block (of all GA)	Spinal anaesthetic	Spinal anaesthetic and nerve block (of all SA)	Proportion of arthroplasties which are cemented	Eligible displaced intracapsular fractures treated with THR	Trochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
Poole General Hospital	PGH	921	21.7	8.2	81.6	52.9	18.3	24.4	97.7	26.4	49.0	88.5
Queen Elizabeth Hospital, Edgbaston	QEB	867	59.0	99.8	71.9	0.0	23.2	0.0	57.7	19.6	56.1	87.8
Norfolk and Norwich Hospital	NOR	842	71.6	66.3	71.3	0.0	28.9	0.0	99.1	14.2	72.6	92.3
Leicester Royal Infirmary	LER	821	64.8	68.2	23.3	79.5	77.5	55.7	98.7	19.8	81.7	90.6

January Update on virtual fracture clinic

2019 Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	2020/21 Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355	Mar-20	716	50.4	361
Apr-19	953	40.6	387	Apr-20	484	63.6	308
May-19	972	43.7	425	May-20	716	55.9	400
Jun-19	1012	44.6	451	Jun-20	861	50.8	438
Jul-19	1064	44.6	467	Jul-20	908	52.6	473
Aug-19	926	38.9	352	Aug-20	922	48.6	448
Sep-19	988	41.1	375	Sep-20	964	45.2	452
Oct-19	899	39.4	365	Oct-20	978	47.2	467
Nov-19	924	38.4	355	Nov-20	922	48.8	478
Dec-19	832	40.2	332	Dec-20	918	44.2	403
Jan-20	822	38.2	314	Jan-21	823	46.6	383
Feb-20	899	39.4	365	Feb-21	716	55.9	400



In comparison to 2019 activity we have seen an increase in patients managed virtually, with up to 64% of all referrals managed as such. over the comparable months there has been an over all increase to 55% Vs 40% in 2019. this has undoubtably helped to mitigate demands on F2F fracture clinics and remains a huge succsess.

Author John West

Patient Flow

Commentary on high level board position

Patient Flow

The number of discharges versus the number of admissions have broadly been in balance for the last 2 months (net gain of 11 residing patients).

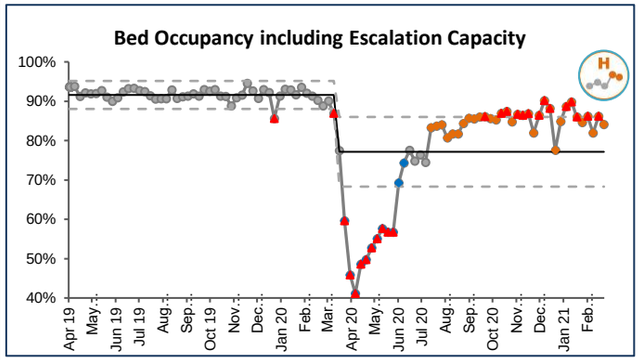
The number of beds consumed by patients with a length of stay greater than 7 days recovered in February following the peak observed in January. An average of 383 beds a day were consumed in February compared to 442 in January (and compared to 491 in February 2020). Bed consumption by patients with a length of stay of over 21 days also recovered and has stabilised. An average of 127 beds a day were consumed In February compared to 144 in January (and compared to 180 in February 2020).

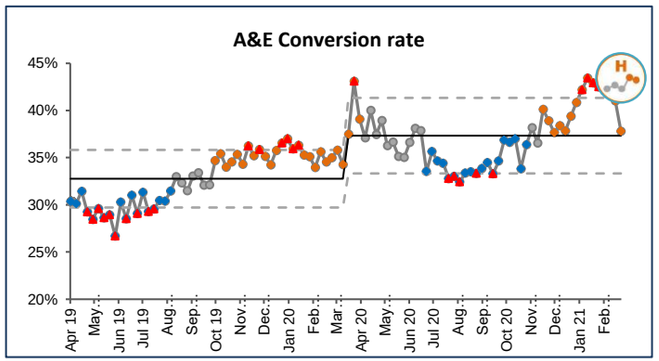
The stabilised discharge to admission ratio and length of stay metrics is reflected in a favourable occupancy rate of 84.6% in February (87.4% in January), and this remains below the 90.8% observed in February last year. It should be noted however, that a lower occupancy is required to manage covid/non covid pathway flow and cohorting through the admission units and wards.

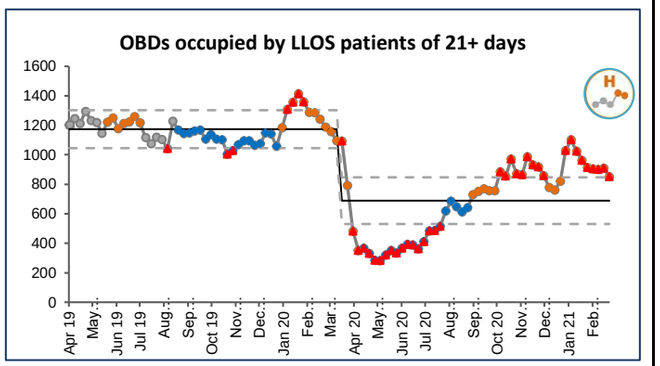
High level Board Performance Indicators & Benchmarking

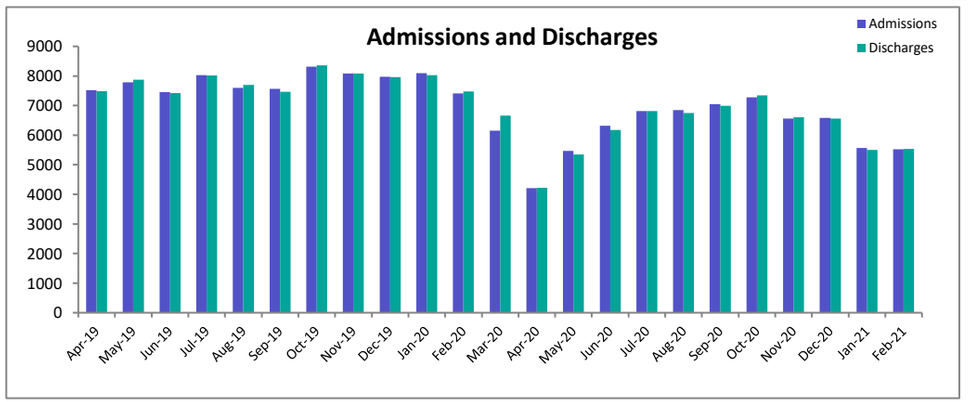
February 2021	Standard		Merged Trust
Patient Flow			
Bed Occupancy	85%		84.6%
Stranded patients:			
Length of stay 7 days		*42%*	383
Length of stay 14 days		*21%*	211
Length of stay 21 days	108	*12%*	127
Non-elective admissions			5,103
> 1 day non-elective admissions			3,233
Same Day Emergency Care (SDEC)			1,866
Conversion rate (admitted from ED)	30%		41.2%

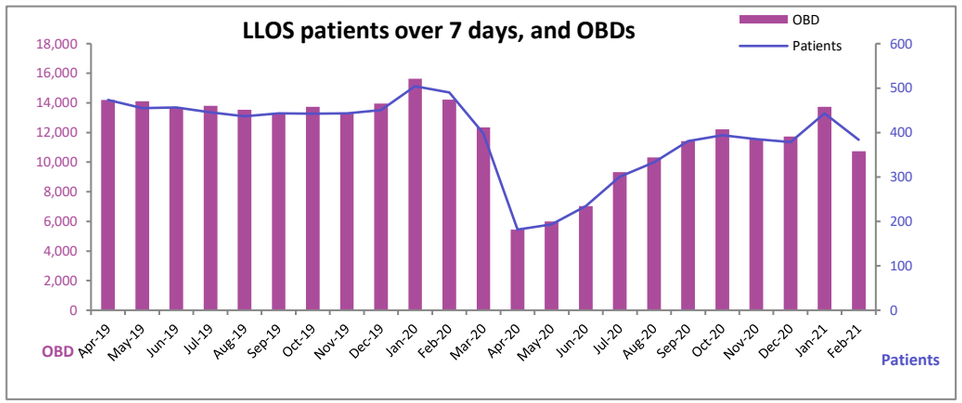
High Level Trust Performance (weekly)











Exception Report

February 21

OCCUPANCY

What is driving occupancy?

The number of discharges versus the number of admissions have broadly been in balance for the last 2 months (net gain of 11 residing patients).

The number of beds consumed by patients with a length of stay great than 7 days recovered in February following the peak observed in January. An average of 383 beds a day were consumed in February compared to 442 in January (and compared to 491 in February 2020). Bed consumption by patients with a length of stay of over 21 days also recovered and has stabilised. An average of 127 beds a day were consumed In February compared to 144 in January (and compared to 180 in February 2020).

The stabilised discharge to admission ratio and length of stay metrics is reflected in a favourable occupancy rate of 84.6% in February (87.4% in January), and this remains below the 90.8% observed in February last year.

The increase in the number of patients no longer meeting the criteria to reside during February prompted a risk assessment to be presented to the system showing the impacts to both patients and services, including the threat to being able to recover elective services.Some overall improvement in external delays has been seen late Feb/early Mar.

Challenges

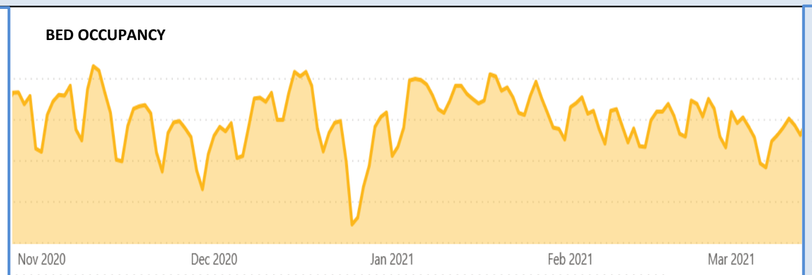
- Local Authority brokerage teams are reducing care home and care agency capacity in line with the termination of 6 week post-discharge funding due to cease on 31.03.21
- This will also mean that for patients leaving on pathway 2, the use of care home beds for interim support,will no longer be an option. Community beds including Figbury and Coastal Lodge, will be the only option for patients needing rehabilitation.
- Despite new guidance underpinning discharge to care homes for COVID+ patients outside of isolation period, the sector remains extremely anxious regarding accepting clients from hospital setting.
- The services supporting Pathway 1, or those patients returning the their usual place of residency across the Bournemouth and Christchurch area continue to struggle to meet demand. There is a qestion around sufficiency of commissioned services since the merger of Bournemouth and Poole LA with Christchurch, particularly as areas such as New Milton has a high number of elderly residents.
- The processes underpinning the D2A model are not fully optimised and at times are encouraging superfluous assessment on wards ,which is hampering the move to assess outside of an acute environment.
- Very limited designated care home bed capacity for Covid positive patients with only one care home across Dorset (10 beds) being accredited by CQC. The admission criteria for these beds is high resulting in unused bed capacity.
- Community Hospital beds have in turn a dependency on the availability of care homes, domiciliary care hours etc., increasing the occupancy across the bed base which in turn is impacting outflow from acute beds.
- Ongoing system flow challenges are resulting in patients being admitted into community beds who would otherwise be cared for at home.
- End of Life pathways are challenged by a lack of capacity. Marie Curie was commissioned to provide additional support from December, however ongoing integration of operational management arrangements within Home First Clusters is currently being worked-up.
- Large care packages are difficult to source. Mitigation is to discharge to interim bed ;however ,this is limited by the challenges described regarding the care home sector.
- High staff absence rate within the discharge team during the latter half of Feb impacted the PH site. Cross site support was provided to minimise this.
- Social admissions are still occuring as demonstrated by ward reviews and long length of stay reviews. The system lacks the rapid response services needed to support the immediate social needs of those being conveyed; or, presenting to acute trusts.
- Internal challenges remain in recognising the point at which an acute bed no longer benefits a patient ,as seen through long length of stay reviews.

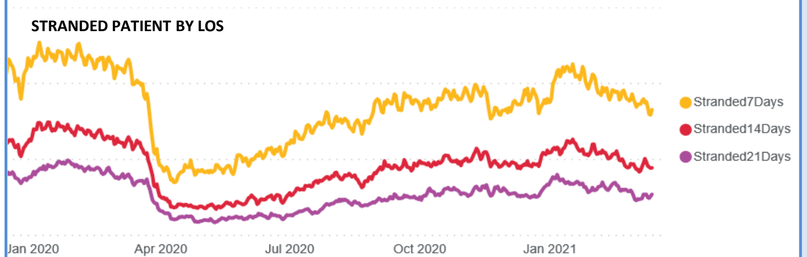
Governance

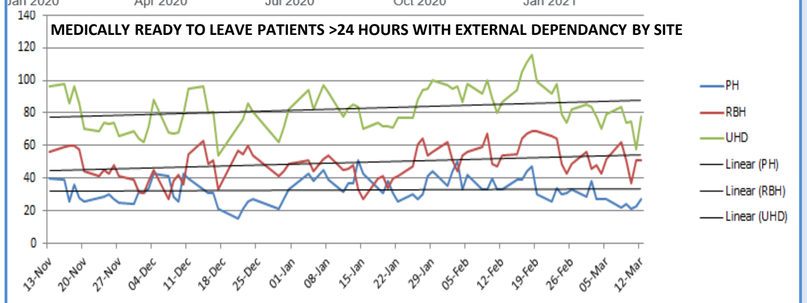
- Home First Board with Executive sponsorship and leadership continues to oversee the implementation of D2A.
- Bronze system command remains in place to ensure system wide focus on the 'here and now,' action s needed to reduce occupancy ,including the Criteria to Reside Risk Assessment & Action Plan owned by all partner organisations across the Dorset ICS
- Internal Criteria to Reside focused programme delivered through the weekly Implementation group with oversight from the UEC Quality & Performance Improvment Programme and Operational Performance Group.

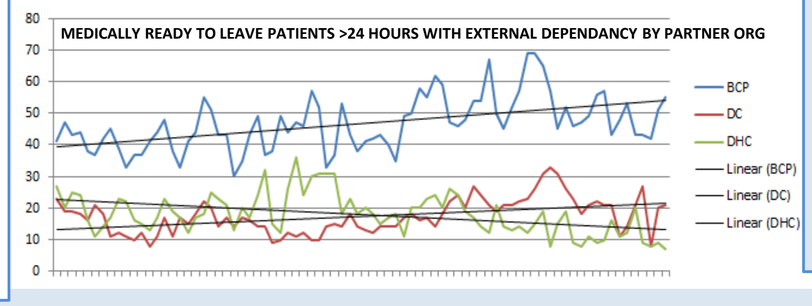
Delivery

- The System D2A delivery group reports to the Home First board with its function being to design and implement the future D2A model and trouble shoot the current operational challenges The Board has 5 work streams chaired by members of the delivery group and will support the recommendations of the John Bolton Strategic design of D2A & Home First for Dorset going forwards.
- System wide Bronze team assembled in response to winter pressures charged with the delivery of a system wide plan to reduce bed occupancy with oversight from Silver Command.









Actions Taken

Improvement Actions - winter

Dorset wide action plan in place to reduce occupancy across acute and community beds , which has incorporated all agreed actions in response to the risk assessment agreed by the system. This risk has now been added to the system risk register.

D2A 'Home First' Model - Internal

- The Criteria to Reside Pilot has commenced across 7 wards, to refine the processes that underpin the Discharge to Assess/Home First programme as well as to determine the reasons for patients meeting or not meeting the national 'Criteria to Reside guidance.
- Long Length of Stay reviews undertaken to identify internal opportunities to support patients having an optimised length of stay that supports best outcomes and quality for patients. The reviews have been presented to system partners to ensure learning and action for all. These will be captured using a 100 day plan with NHSE/I supporting the system in moving forward.
- Dr John Bolton has agreed to work with Dorset in establishing a more effective discharge model, including the commissioning needed to underpin a 'home first,' model.
- Discharge Team Weekend cover in place across UHD to support additional complex discharges on D2A pathways via community services.
- All system and reporting changes complete to enable full migration to Health of the Ward for Criteria to Reside Reporting
- Criteria to Reside Implementation and engagement plan including improvement trajectory developed
- Criteria to Reside /Board Round Improvements - pilot wards have commenced on Poole & RBH sites across Trauma, Surgery, Medicine and OPS
- Support from the ECIST team in place to assist with engagement and implementation of Criteria to Reside
- NHSE&I working with the Dorset system to support further improvements to the D2A model including UHD LLOS review exercise which has complemented the internal Criteria to Reside Implementation plan and Dorset ICS Action Plan

System Support

- NHSE/I - 100 Day Improvement Plan supported by all partner organisations across Dorset ICS to reduce number of patients who no longer meet criteria to reside. Existing Risk Assessment Action plan will complement the 100 day improvement plan.
- Improved flow through community beds - plans being progressed to step down all patients from acutes who require a pathway 2 option ,to avoid inappropriate use of care home beds .
- Personal Health Commissioning Team (PHC) operational policy being developed to support complex patients on P3 & P1 pathways following the cessation of the 6 week post hospital discharge funding (scheme 2).
- A review of all pathway 1 services is being undertaken with a view to free up capacity to support acute and community transfers. This bringing together of services will reduce complexity and more effectively meet demand as services are 'pooled.'
- Cluster Team review to provide localised operational improvements across acute hospital and interfacing community services to reduce the number of patients who do not meet criteria to reside.

Lead Director Mark Mould

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- DNA rates have decreased and achieved the 5% standard however patient cancellation rates remain high, some feedback that patients are more cautious about attending face to face appointments again.
- Increasing Covid Tier restrictions and lockdown since December has resulted in increased DNAs and patients not wanting to attend for F2F OPAs and Diagnostics

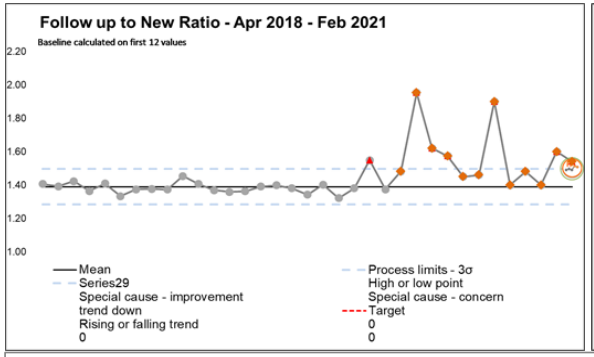
Diagnostics

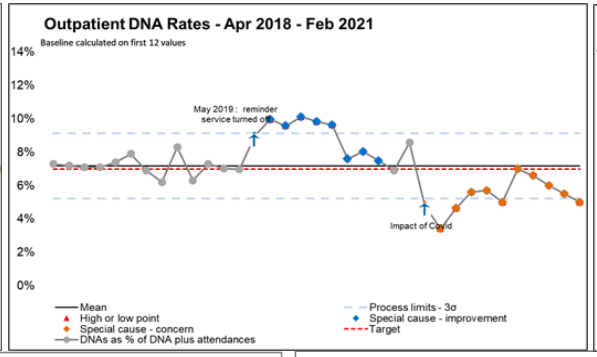
- Increased slightly from 93.6% to 94.1% of all diagnostics tests were achieved within the required 6 weeks, of which Radiology has achieved > 99.5% for the last 6 months
- Endoscopy and imaging capacity constrained by Infection Control requirements . Endoscopy overall dropped to 72.5% within 6 weeks as staff were deployed to support inpatient areas
- Consolidation of Endoscopy IT systems begun - moving to single waiting list
- Cardiac echo recovery plan constrained by availability of insourcing solution, and process of transfer to PH from RBH. Improved significantly from 85% to 92.2% within 6 weeks in the DM01 99% standard.
- IS assisting with MRI, CT and Plain Film. Additional WLIs and weekends planned.
- Loss of activity due to national lockdown has impacted on DM01

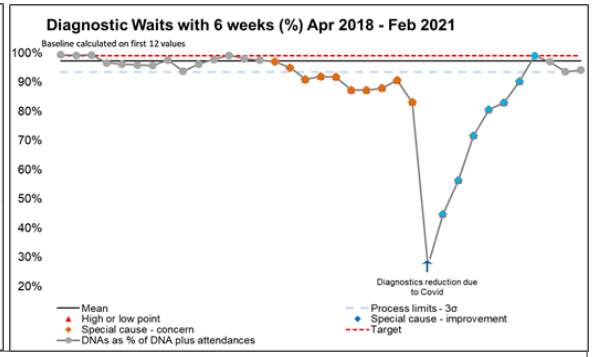
High level Board Performance Indicators & Benchmarking

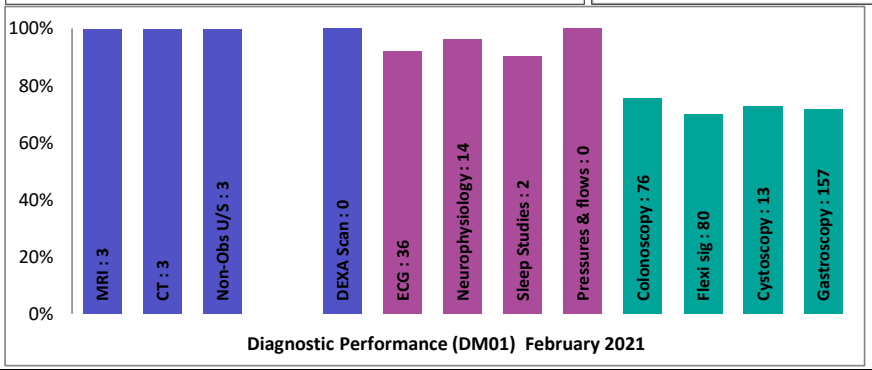
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 19/20 v 20/21)*	-0.5%	113834 / 80858	-29.0%
Total Referrals Rate year on year +/-		-0.5%	198452 / 154422	-22.2%
Outpatient metrics				
Follow up backlog				15,775
Follow-Up Ratio		1.91		1.54
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%	24400 / 1296	5.0%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*		24400 / 2356	8.8%
reduction in face to face attendances				
% telemed/video attendances	*(Total Atts / Total Non F-F)*		24400 / 12886	52.8%
Diagnostic Performance (DM01)				
% of <6 week performance	*(Total / 6+ Weeks)*	1%	6609 / 387	5.9%

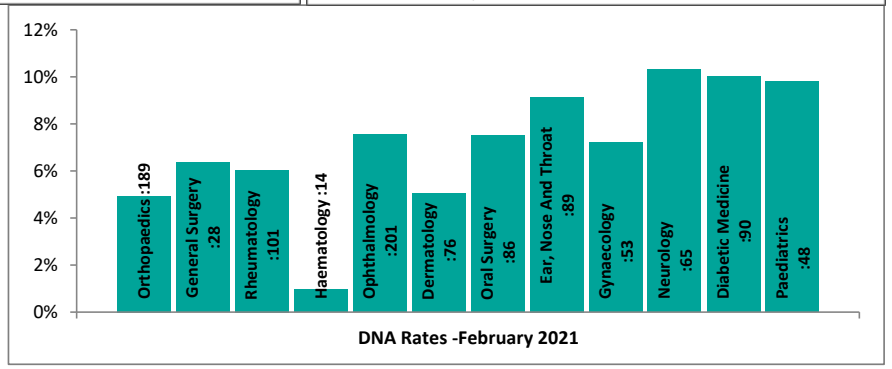
High Level Trust Performance



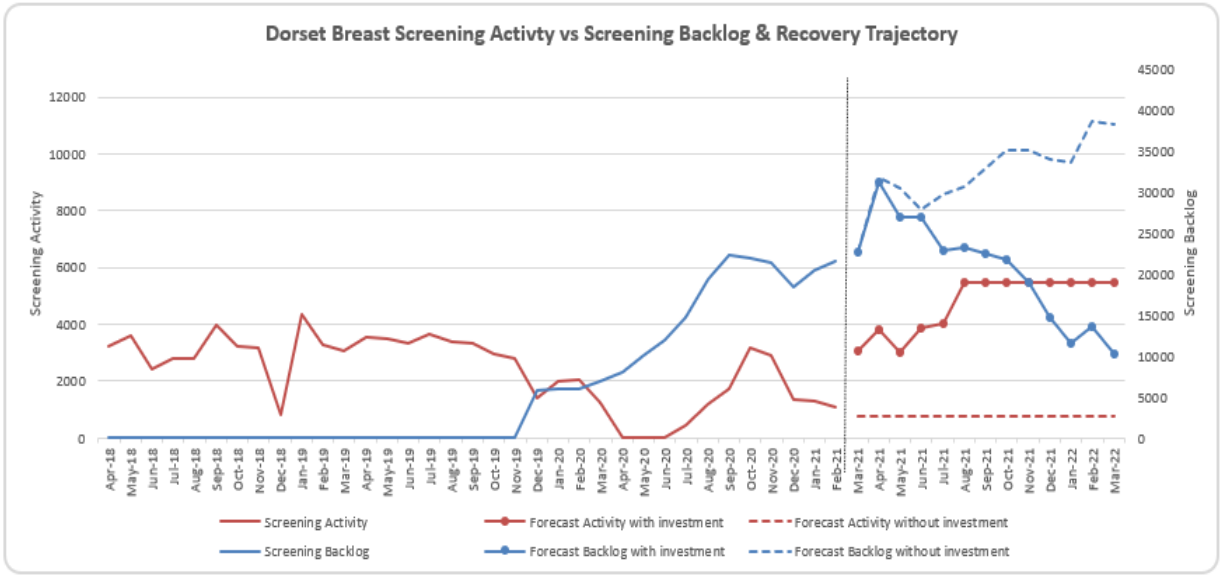








Breast Screening



<u>Screening to normal results:</u>
99% within 14 days
(National Minimum Standard is 95% within 14 days)

<u>Screening to Assessment:</u>
Screening to 1st offered appointment 100% within 3 weeks
(National Minimum Standard is 98% within 3 Weeks)

<u>Round Length:</u>
12.5% between the ages of 50-70 were screened within 36 months
(National Minimum Standard is 90% within 36 months)

7.5 min vans

Increase Evenings

7.5 min statics

Plymouth Van

Key summary points

Update.
The team have taken a bold decision to reduce appointment times to 7.5 minutes as a trial to achieve the target date. This is in line with the lowest time in the region and will put us above pre COVID capacity. This is essential if we are to recover in the region of March 22.
4th mammo screening kit ordered.
Plan to loan Plymouth van until a site for the 4th mammo kit is found (discussions on-going).

Ongoing actions include:
We are currently screening 1-2 Saturdays a month where staffing allows. Evening clinics have been reintroduced as of 1st March twice weekly – staffed with standard working hours.

- Fortnightly restoration/monitoring meetings with PHE offering support and updates from the national perspective are still on-going.
- Weekly department management meetings are still on-going.
- Utilisation of PHE modelling tool is updated each time we increase/reduce screening.
- A business case has been put in for 3 breast radiologists, we are still awaiting te decision.
- DBSU has joined a regional international recruitment process, with interviews planned.

Recovery ***could*** be achieved by March 2022 (the PHE target.) This is dependent on investment, extra staffing and no further peaks of COVID. The current plan starts April 1st to get to the target. With every months delay the recovery will be pushed back.

Bowel Screening

Selected screening centre:	Dorset
Raw 'pyramid' data (extracted directly from BCSS)	
Screen positive: People who have not seen an SSP	55
Screen positive: Waiting for a diagnostic test	120
Screen positive: Potentially need subsequent diag test	14
Invited but not screened: FOBt	17,431
Delayed an invitation: FOBt	19,515
Expected colonoscopies, based on assumptions made	
Screen positives in pathway (all 3 groups)	178
FOBT people invited but not screened	206
FOBT people delayed an invite	230
TOTAL	**614**

Uptake and positivity (Acceptable standard =52%; Achievable = 60%)

Month	Invited	Adequately screened	Definitive abnormals	Uptake	Positivity
Oct-20	10,534	7,837	147	74.40%	1.88%
Nov-20	10,064	7,619	125	75.71%	1.64%
Dec-20	8,154	6,137	113	75.26%	1.84%
Grand Total	64,469	47,504	917	73.69%	1.93%

SSP Clinic Wait Standard (Acceptable standard =95%; Achievable = 98%) Feb 21 = 100%

Diagnostic Wait Standard (Acceptable standard =90%; Achievable = 95%)

Month	Referred	Within Target	Outside Target	Within Target %
Dec-20	107	98	9	91.59%
Jan-21	93	87	6	93.55%
Feb-21	107	106	1	99.07%
Total	782	658	124	84.14%

Key summary points

Bowel Cancer Screening was paused during the first wave of the Covid pandemic. FIT+ patients paused during that time, with a cancer risk of up to 16%, have now been scoped.

Current modelling using the Public Health England Individual Centre Capacity Modelling tool suggests that the Dorset screening centre will now need to perform around 614 colonoscopies to clear the current backlog. The capacity within the service is 54 colonoscopies/week (including insourcing) meaning that it will take approximately 12 weeks. As the initial backlog is being cleared, more people will become due for screening (reaching their 60th birthday / next test due date). This means that at the end of the 12 weeks, there will be an additional backlog of 384 screening subjects.

With agreement from PHE, the invitation rate has again been increased in January 2021 to 3231 per week against a pre Covid rate of 1894. The programme is starting to experience the impact of this increase with higher demand for SSP clinics. At this rate the programme would expect to be at -6 weeks of normal inviting at w/c 29/03/2021 and at 0 weeks w/c 10/05/2021. In the last month the overall backlog figure has reduced by 3277 subjects. Recovery modelling is based on the assumption that screening subjects engage with their invitation at the same level as the pre Covid uptake rate.

PHE have agreed to fund insourcing in Q1 2021/22 to support the additional capacity required to manage this demand.

Actions to support recovery:

- Insourcing funded by bowel scope underspend – two weekends at end of March 2021
- Maintaining increased invitation rate
- Insourcing weekends funded by PHE in Q1
- Planning to manage the bowel scope cohort invited then paused in 2020 in Q1 (c.900 subjects)
- Planning to start age extension from Q1/2 2021/22

FINANCE

Commentary

Consistent with the national interim financial framework the Trust has set a planned deficit of £5.6 million for the period to 31 March 2021, inclusive of ongoing COVID-19 costs, recovery of elective services and winter preparedness.

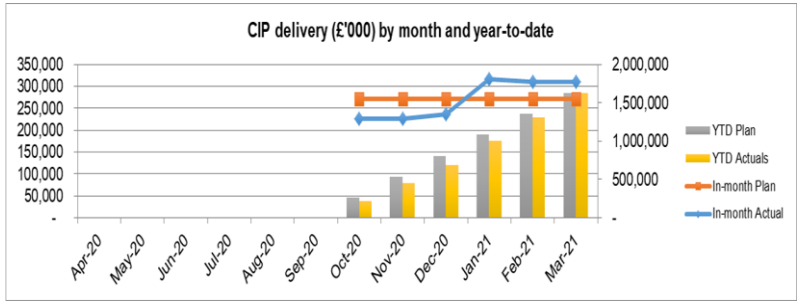
Against this plan, the Trust is currently reporting a favourable variance of £4.5 million resulting from lower than planned expenditure in relation to ongoing COVID-19 costs, winter preparedness and the recovery of elective services. The Trust has also received notification of £3.3 million additional national funding to off-set the lost non-NHS income; £2.8 million of which has been included within the year to date position. This welcomed confirmation has allowed the Trust to forecast with confidence a full year financial break-even position.

The operational challenges throughout the year have had a material impact upon the Trusts capital programme. Many planned schemes have been unable to progress at the pace required due to access limitations within clinical areas. The forecast underspend is now expected to be £4.1 million by 31 March, however this is dependant upon significant expenditure during March. This forecast represents a significant movement from the forecast reported last month, due to changes in the funding allocation agreed with NHS England and Improvement.

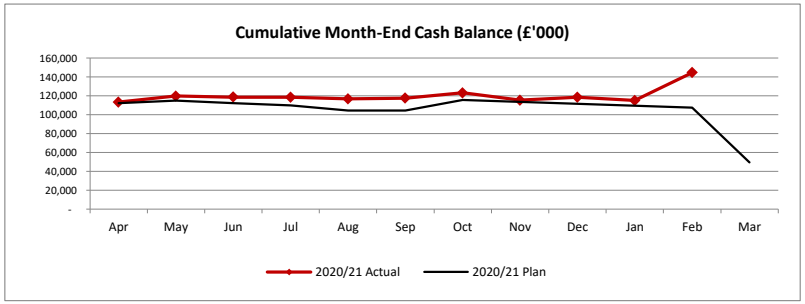
Cost improvement savings of £1.3 million have been delivered to date which is £39,000 behind plan. This shortfall is expected to be delivered in March resulting in total forecast savings of £1.6 million consistent with the plan.

The Trust is currently holding a consolidated cash balance of £144.7 million. This significant balance includes the March contractual payment of £49.2 million which will be corrected in March as the national interim cash arrangements come to an end. This balance is also artificially high due to the increased value of capital creditors together with the PDC payment which is paid half-yearly in March and September.

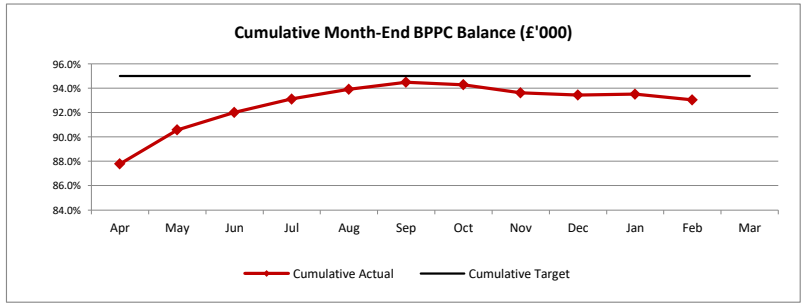
FINANCIAL INDICATORS	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000	Forecast Variance £'000
Control Total Surplus/ (Deficit)	(4,188)	267	4,455	5,558
Capital Programme	68,478	34,845	33,633	4,078
Closing Cash Balance	107,568	144,653	37,085	50,182
Public Sector Payment Policy	95%	93%	-2%	0



REVENUE	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000	Forecast Variance £'000
Surgical	(55,312)	(54,743)	568	(594)
Medical	(73,487)	(72,722)	764	(731)
Specialties	(63,733)	(61,995)	1,738	322
Operations	(9,432)	(9,381)	52	328
Corporate	(27,450)	(27,331)	119	1,456
Trust-wide	224,868	225,647	779	4,278
Surplus/ (Deficit)	(4,546)	(525)	4,021	5,060
Consolidated Entities	0	338	338	0
Surplus/ (Deficit) after consolidation	(4,546)	(187)	4,359	5,060
Other Adjustments	358	454	96	498
Control Total Surplus/ (Deficit)	(4,188)	267	4,455	5,558



CAPITAL	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000	Forecast Variance £'000
Estates	6,911	2,696	4,215	2,341
IT	9,454	6,825	2,628	763
Medical Equipment	7,650	4,083	3,567	(1,379)
Covid-19	1,449	1,464	(15)	0
Strategic Capital	43,014	19,776	23,238	2,353
Total	68,478	34,845	33,633	4,078



University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 8.2

Subject:	CMO Mortality Report

Prepared by:	Alyson O'Donnell – Chief Medical Officer Divya Tiwari – Mortality Lead for UHD
Presented by:	Alyson O'Donnell

Purpose of paper:	This report advises the Board of the Mortality metrics within the Trust.
Background:	This is a combined mortality report for the new organisation.
Key points for Board members:	The Board is asked to note the combined metrics which can now be reported by site. All UHD metrics are as or better than expected. Further work is ongoing to align processes and metrics across the sites The board is asked to note the progress in two significant thematic reviews of mortality related to Covid-19 and Pneumonia
Options and decisions required:	No decisions required
Recommendations:	For information
Next steps:	For information

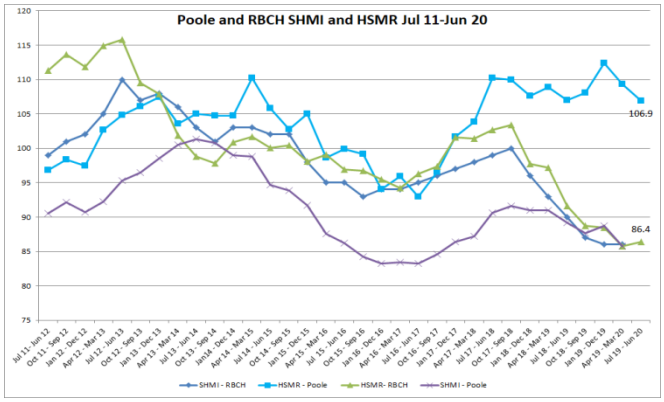
Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

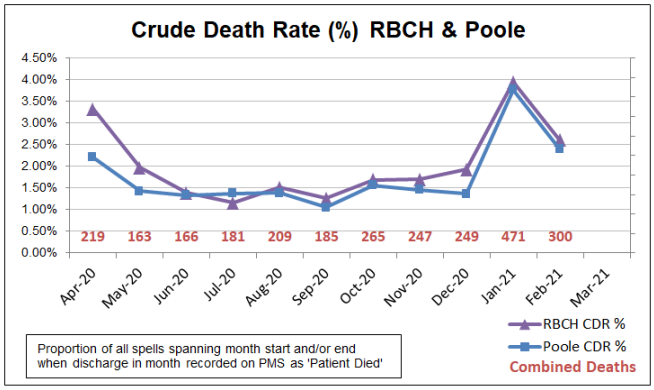
Committees/Meetings at which the paper has been submitted:	**Date**

University Hospitals Dorset
NHS Foundation Trust

Chief Medical Officer's Report to the Board

Mortality Update





HSMR/SHMI December 19 to November 20 (merged organisation)

Indicator	Site	Value	Range
HSMR	RBCH	79.7	Better than expected
	Poole	109	Higher than expected
	UHD	95.3	Better than expected
SMR	RBH	83	Better than expected
	Poole	109.8	Higher than expected
	UHD	97.5	As expected
SMHI	RBCH	81	Better than expected
	Poole	90	As expected
	UHD	89	Better than expected

Deaths in learning disability

Site	Aug-20	Sep-20	Oct-20	Nov-20	Dec20	Jan 21	Feb 21
RBCH	0	0	1	2	1	2	0
Poole	1	1	1	0	0	1	0

Medical Examiner Screening

Site	Aug-20	Sep-20	Oct-20	Nov-20	Dec20	Jan21	FEB 21
RBCH	100%	100%	100%	100%	97.3%	100%	100%
Poole	95%	89%	96%	100%	100%	100%	100%

Mortality Ratios

The National picture is very complex; HSMR and SHMI indicators do not include 'Covid 19' mortality, whilst SMR includes all mortality. UHD HSMR (Dec 19-Nov 20) is in the 'better than expected' range and SMR is 'within the expected' range. Bournemouth site HSMR and SMR are in the 'better than expected range'. However, Poole HSMR and SMR are in the 'higher than expected' range. This is mainly driven by the high mortality ratios recorded in October and November 2020. Work is ongoing to ensure that all potential data issues have been addressed as there was a significant drop in the denominator of cases during this time which may be an impact of covid activity on other admissions. Specific diagnostic reviews have also been commissioned as below.

Diagnostic and Procedural Alerts

MSG noted no new diagnostic or procedural alerts in the January Dr Foster upload. The following alerts are under review, the learning and action plans will be disseminated in March.

Dr Foster Alert	Type of Alert	Site	Action Plan	Completion Date
Multiple myeloma	Diagnostic (Relative risk)	RBH/ Poole	Case notes review	Review completed
UTI	Diagnostic (Relative risk)	Poole	Case notes review	Second phase
Urethral catheterizati Of bladder	Procedural	Poole	Associated With UTI	Second phase
Other screening for Suspected condition	Data quality	Poole	Coding	Mortality validation In place (Jan 21)
Pneumonia	Diagnostic(Relative risk)	Poole	Case notes review	Review Complete, Action plan agreed
Total excision of bladder	Procedural (Relative risk)	RBH	Internal revie Case	Review complete Action plan agreed
#NOF	Procedural alert (within expected for 12 month, very high for November and expected to climb)	Poole	Yet to be agreed	May 2021

Covid 19 Mortality (Poole site)

UHD MSG Chair/CMO commissioned the review of Covid-19 associated mortality following an outbreak at the Poole site in October 2020. The final SI Panel was chaired by the CMO on 17th December to consider findings of the RCA, a review of delayed discharges and to finalise the learning outcomes/action plan/duty of candour. Key action plans were agreed with the panel with a review date of June 2021:

Pneumonia Mortality Review (UHD)

Following a mortality alert for the Pneumonia diagnosis an MSG panel undertook a structured review of 40 sets of case notes where pneumonia was listed as the primary cause of death. Findings of this review were analysed and presented to a Panel chaired by the CMO. Key learning points and a draft action plan were agreed by the panel members and will be reviewed with the wider MSG membership in April.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 9.1

Subject:	Equality, Diversity and Inclusion (EDI) Strategy

Prepared by:	Deborah Matthews, Director of Organisational Development
Presented by:	Karen Allman, Chief People Officer

Purpose of paper:	To approve: • Equality, Diversity and Inclusion (EDI) Strategy
Background:	This document has been reviewed and endorsed by the Workforce Strategy Committee on 17 February 2021
Key points for members:	The EDI Strategy outlines a 3-year programme for equality, diversity and inclusion. It has been developed in conjunction with our staff networks and builds on the previous work of our legacy organisations. Following approval, an executive summary will be developed for circulation within the organisation, highlighting the lived experience of our staff.
Options and decisions required:	For approval
Recommendations:	To approve: • Equality, Diversity and Inclusion (EDI) Strategy
Next steps:	Equality Diversity and Inclusion Group to fully develop work programme for 2021/22.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	A great place to work
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
Equality Diversity and Inclusion Group	21/01/2021
Workforce Strategy Committee	17/02/2021

University Hospitals Dorset
NHS Foundation Trust

Leading for Equality, Diversity and Inclusion

Creating a kind, civil and respectful culture

Strategy 2021 – 2024

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FORWARD

Equality, Diversity and Inclusion (EDI) matter greatly to us as a Trust. The Board recognises the importance of EDI as being critical to delivering excellent patient care and supporting staff to feel UHD is a great place to work, an employer of choice.

We are committed as a Trust to the elimination of discrimination, harassment and reducing health inequalities by promoting equality of opportunity and dignity and respect for all our patients, service users, their families' carers and our people.

This new strategy for our combined Trust aligns with the National NHS People Plan equality, diversity and inclusion actions and our UHD People Plan. It also builds upon the success of our heritage organisations' positive progress and has been developed in partnership with our leaders, staff network groups, patient partners, Freedom to Speak Up Guardian, patient engagement leads, staff partnership forum representatives and staff. We have made positive progress on many aspects; however information collected from interactive listening and engagement events, survey and demographic data demonstrates differences in the lived experience and outcomes for certain individuals.

Our staff network groups have been instrumental in providing increased feedback to inform the Trust of the need for change to reduce potential organisational barriers and we are thankful to our staff network leads. We want to move beyond compliance and 'tick boxing' to create an inclusive organisation and a sense of belonging, where all individuals are treated fairly as part of our cultural change journey. We want to ensure that every member of staff feels properly valued and engaged in the development of our new organisation.
We will also share our progress at regular intervals and look forward to celebrating the progress we are making. On behalf of the Trust Board, we look forward to working with you to deliver this work.

> "The NHS must be a place where all are welcome, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms. The NHS must be a place where discrimination, violence and bullying have no place."
>
> ***NHS People Plan (NHSI)***

David Moss	**Debbie Fleming**
Chairman	Chief Executive

INTRODUCTION

University Hospitals Dorset NHS Foundation Trust (UHD) was created on the 1 October 2020 following the merger of Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Leading for Equality, Diversity and Inclusion outlines our ambitions to become a truly inclusive employer and service provider for our staff, patients and local health community.

It builds upon the collaborative joint working during the merger transition period and supports our vision *to positively transform our health and care services as part of the Dorset Integrated Care System.*

Our new values have been developed by staff and are at the heart of our organisation. They define who we are and how we behave and our EDI commitment is part of our working to evidence these in practice.

As a large NHS employer, UHD recognises we have a corporate responsibility and opportunity to engage our whole community. Valuing diversity ensures an inclusive environment for potential staff and service users. We also know that celebrating individual difference and bringing diverse teams together with disparate styles and talent will foster innovation and continuous improvement for patients, service users, their families, carers and our staff.

We are extremely proud of our joint achievements so far. Through our active staff networks and the lived experience of our staff and patients, together with the evidence from our statutory EDI reporting, we understand that we need to do more to actively take account of equality, diversity and inclusion in our core business. This strategy outlines our approach and intent – a deliverable plan that will strive to:

- eliminate unlawful discrimination, harassment and victimisation;
- improve year on year the reported patient and staff experience for protected groups;
- reduce health inequalities for protected groups by improving access to all services.

SETTING THE CONTEXT

National and local

In the last twelve months all NHS organisations, including UHD have responded to the COVID-19 pandemic. This has impacted our patients, local community and staff in every aspect of our lives.

COVID-19 has shone the spotlight on the health inequalities faced by many of our communities. As well as lived experience of disadvantage and inequality, recent data demonstrates people from different backgrounds have been disproportionately affected by the pandemic.

We recognise this is the time for real action rather than words to tackle the underlying causes of health inequality. Now, more than ever, it is essential to focus on addressing these inequalities and to value the diversity of our staff by developing and sustaining an inclusive and compassionate workplace. This means positively and overtly valuing equality, diversity and inclusion both for its own sake and for its impact on care quality and staff wellbeing.

Our work to develop this strategy acknowledges the long term impact of COVID-19 will be felt by many and our recovery response will require strong and effective partnerships as part of the Dorset Integrated Care System (ICS). This will include working collaboratively with Dorset based professional and community organisations including Dorset Race Equality Council, Prejudice Free Dorset, Bournemouth University and other local NHS organisations to progress our EDI practice.

Our EDI strategy has also evolved in response to engagement with our staff networks, data from our NHS Staff Survey, gaps in our compliance against national standards and the NHS People Plan. The experience of COVID-19 has thrown into even sharper relief the need to engage with and listen to our staff to understand the differences they face. We want to ensure that lessons learnt and best practice in supporting staff and patients influence our inclusion practices going forward, including:

- early staff involvement and effective communication - to proactively check-in with those affected;
- confidence to develop a local and organisational response in the absence of national guidance;
- the power of sharing personal lived experiences to shift mindset and culture.

Equality in Action [1]

***Hopes, dreams and aspirations*: the voice of our staff networks**

Our aim is to move beyond statistics and compliance, providing opportunities to hear the impact of unintentional organisational practices which may adversely impact certain groups is essential for ongoing culture change.

We are fortunate to have a thriving set of staff network groups who play an essential role in supporting the EDI strategy and proposals. The purpose of these employee-led groups is to provide support and guidance to other employees and also to provide insight and partner with the organisation to assist in improving the culture and experience. We will continue to invest in our network leaders via our Inclusion Champions Programme, ensuring they have the skills and the opportunity to be heard and influence.

Our network groups have made huge strides and are proactively networking across both Dorset and nationally to share their best practice.

"The network and leaders have been instrumental in supporting our staff and working with our HR teams to develop direct communications and the risk assessment process for those identified at increased risk and vulnerability to the COVID-19 virus"

Debbie Fleming, Chief Executive UHD

*"There are many versions of the saying 'y*ou can't understand someone until you've walked a mile in their shoes'. A*lthough we can never physically "*walk a mile in their shoes"*, if we can learn to listen carefully to the lived experience of both patients and staff, we will develop a better understanding of what it means to be perceived by others as being different."*

Rosie Martin, Patient Partner

Moving beyond statistics and compliance, providing opportunities to hear the impact of unintentional organisational practices which may adversely impact certain groups is essential for ongoing inclusive positive culture change.

Inclusive leadership in practice requires leaders to be open, transparent and educationally vulnerable in order to learn and empower those individuals less heard and to proactively remove the unintentional organisational barriers which may be hindering progress and productivity.

We will continue to deepen and empower our staff network groups to inform and guide the organisation's development of culture and service provision.

"An effective employee voice (networks) is the cheapest smoke alarm organisations can install. Let's not remove their batteries. Test (messages) regularly"

Selvin Brown MBE, Director, Engagement and Policy, (Home Office)

Equality in Action [2]

Reverse Mentoring

Our Reverse Mentoring Programme is a positive action inclusion programme aimed at personally developing staff with protected characteristics (in the first instance) to act as mentors to other staff in positions of power within the organisation.
We will continue with our Reverse Mentoring Programme and extend the participation wider amongst leaders and individuals from protected groups working in partnership with our staff network groups.

Our legal duties

The Trust is also required to provide assurance of delivery against a number of national standards and compliance frameworks for equality, diversity and inclusion (EDI). These include:

- The Equality Act (2010)
- The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 (GPG)
- The NHS Constitution
- The Public Sector Equality Duty (PSED)
- The NHS Equality Delivery System (EDS2)
- The Workforce Race Equality Standard (WRES)
- The Workforce Disability Equality Standard (WDES)

Further details of our legislative framework are described in Appendix 1.

OUR STRATEGY

Our ambition is to be a great place to work where morale is high. Building on a culture of openness, we aspire to be an organisation where staff are engaged and proud to work for UHD, living our values and demonstrating these on a daily basis.

We will work collaboratively with staff and act on their feedback. Staff will feel fulfilled, free to speak up and believe they are being treated fairly. Their involvement will be encouraged and celebrated at the earliest opportunity to shape the services we provide for patients, carers and their families.

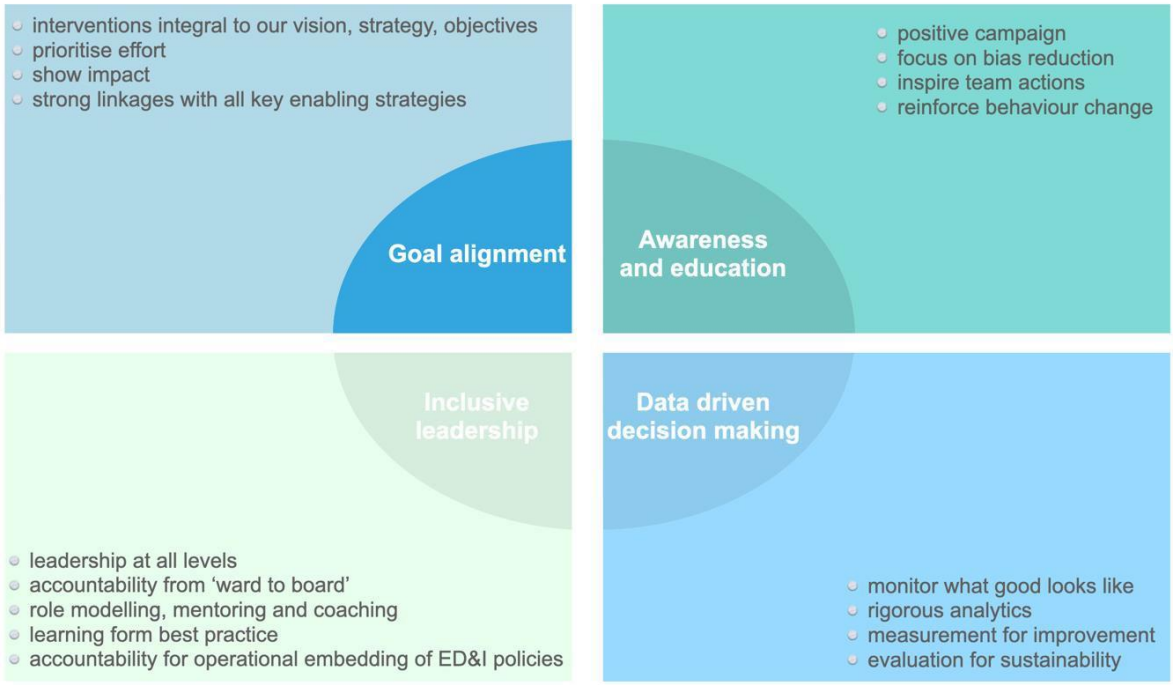
Our board of directors and senior leadership team will be visible and accessible with *Team UHD* building a reputation as a truly inclusive employer and service provider for our staff, patients, local health and social care community.

We are committed to the elimination of discrimination, reducing health inequalities, promoting equality of opportunity and dignity and respect for all our patients, service users, their families, carers and our staff. We want to create an environment and culture that celebrates diversity and inclusion and in line with our values, nurtures and a harnesses difference for the benefit of patients.

The objectives within our *Leading for Equality, Diversity and Inclusion* strategy link closely to those described in the NHS People Plan, The Trust's People Plan, Quality Strategy and the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well led. It will be refreshed every twelve months as part of our annual planning round.

Overarching principles and approach

We have agreed a set of core principles that underpin the development and delivery of our ambitions and priority areas. These will help guide our work and refresh our approach to equality, diversity and inclusion. We want to achieve deeper cultural change moving beyond compliance and 'tick boxing' to a truly inclusive way of working. These principles will raise our level of aspiration and quicken the pace of change.



Goal Alignment

We will optimise our efforts by linking our EDI strategy to our corporate objectives. EDI will be clearly defined as an integral part of our hospital vision, firmly embedded and fundamental to its success. A standalone or silo approach to EDI will not be enough to create change or visible progress. In partnership with our staff networks, we will align all of our interventions directly with the objectives of the organisation to help us prioritise effort and show impact. Our organisational development plan acknowledges the importance of promoting equality, diversity and inclusion in everything we do, including our culture programme, health and wellbeing and leadership and talent management.

Inclusive Leadership

Diversity and inclusion is '*everybody's business'* and everyone in the Trust is therefore expected to take an active part, supported by the work of our specialist teams.

To make sustained diversity and inclusion progress it is imperative that we have the right level of leadership commitment and accountability at all levels within the organisation. We aim to create diverse and inclusive teams where individuals can reach their potential without unnecessary organisational barriers.

Our board of directors will lead by example in relation to inclusive practice, with board diversity champions, staff network sponsors and participation in EDI education and engagement events. Our senior leadership team will challenge poor inclusion practice and behaviours and work to proactively embed EI good practice to stimulate action and commitment.

This will encourage leaders to positively challenge their own thoughts and attitudes.

Awareness and Education

To foster a diverse and inclusive workplace we need to create the right levels of EDI awareness and education, focusing on challenging unconscious bias, privilege and micro aggressions and promoting allies. Our staff networks also play an important role in creating education opportunities for their members and allies. This will be a central component to engage the hearts and minds of all our staff, inspire team actions and accountability for change.

Data Driven Decision Making

We need to monitor what good looks like to ensure our interventions have an impact and report regularly to the board of directors. A data-driven approach will enable us to dispel any myths regarding our baseline (*where are we now?*) and track progress.

We will align our data to create a new benchmark and monitor *what good looks like* to ensure our interventions have an impact and report regularly to the board of directors.

A data-driven approach will continue to enable us to dispel any myths regarding our baseline and track progress. Our BAME and EU staff survey infographic will be a blueprint for easy interpretation. We will identify a small number of metrics we feel are the most critical to ensure success and use quality improvement (QI) methodology to experiment with new ideas and interventions. An end of stage evaluation framework for sustainability of the benefits will also be available to support our leadership teams and help them undertake meaningful equality analysis.

To support these core principles, we will ensure we maintain a balance between planning (*what should be happening)* and space for emergence and dialogue (*what is actually happening)* [1]. This requires our diversity and inclusion approach to be deeply collaborative - listening to lived experiences, listening to understand, listening to make change. We believe a kind, civil and respectful inclusive culture will require us to a) be educationally and culturally curious rather than jumping to quick solutions b) adopt a mutual learning philosophy and c) accept vulnerability, learning and forgiveness.

We also recognise there is no quick fix solution and that we need to keep our ambitions and long term goals for diversity and inclusion simple and easily understood. This approach will help us consider what critical interventions work and can make a real difference in a complex

[1] Dialogic Organisational Development (Gervase, Bushe and Marshak 2015); Relational Organisational Gestalt (Chidiac 2018)

system so that we aren't defeated by lack of resources and competing pressures. We will actively involve staff in changes to policies, procedures and service improvements that will affect them.

OUR WORK PROGRAMME

Our Equality, Diversity and Inclusion Strategy will focus on four key areas.

Talent – *our staff*

We will:

(a) ensure our senior leaders routinely talk about and engage their staff on EDI issues and communicate the benefits

(b) embed the concept of inclusive leadership behaviours in all our management and leadership development programmes

(c) strengthen accountability and visible leadership via EDI objectives at care group and directorate level

(d) develop EDI capability and skills through the alignment and relaunching of a *bias reduction* tool kit and learning package

(e) support the development of a diverse talent pipeline to senior leader roles via sponsorship, mentoring and coaching and promoting positive action programmes e.g. *Ready Now, Stepping Up, Reverse Mentoring Programme*

(f) support the next stage in the development of our value based appraisal system, building in greater consideration of talent management approaches

(g) ensure our recruitment and selection processes are free from bias so we make the fairest and best selection decisions and positively attract and retain diverse individuals within the workforce

(h) support our health and wellbeing agenda, creating positive working environments for all staff

(i) support career progression of staff with protected characteristics and improve development opportunities, taking positive action to promote equality from initial recruitment and beyond

Patients

We will:

(a) ensure positive attitudes towards welcoming the diversity of patients, carers and service users and endeavour to meet their diverse needs

(b) understand the potential impacts of the decisions we make on patients, their families, carers and service users, by protected characteristics and identify ways to mitigate these

(c) identify and act to reduce any unwarranted variations in access, safety and experience of the Trust's services

(d) improve the quality of the protected characteristic data by establishing service equality monitoring

(e) increase patient collaboration and co-production to ensure their views and perspectives inform our D&I work programme

(f) further identify and understand our local community, what their specific needs are and how these can be taken into account when planning the delivery of care

(g) enable the Trust to use these shared experiences to inform and improve the design of our services

(h) close the gap on the personal data we collect on patients to make sure we can accurately identify whether or not there are any equality related trends in patient activity that need to be looked into further

(i) improve the monitoring of patient data to shape the Trust's approach to understanding, achieving and measuring equitable access and outcomes for patients

(j) develop a community engagement strategy to benefit from the knowledge and expertise of our local community and help create the health services of the future

(k) work in partnership locally, regionally and nationally to share best practice and develop inclusive initiatives that improve patients outcomes

Improvement and innovation

We will:

(a) constantly reinforce the link between EDI and improvement to access diversity of thought and development of innovative ideas and solutions

(b) use our quality improvement (QI) methodology end experience based design to embed improvements in patient and employee experience

(c) use data and story-telling to identify outcome focused interventions for EDI

Living our values

We will:

(a) be open and transparent in our communications regarding employee experience data for different groups and will work with staff to develop employment practice where employee experience falls short of the standards we are striving for

(b) focus on effectively addressing bullying and harassment, abuse, violence and discrimination at work to improve and build psychological safety for staff identified as having a less positive experience in the workplace as reported in our national and local workforce standards (WRES / WDES / GPG)

(c) actively involve staff in changes to policies, procedures and service improvements that affect them

(d) champion and recognise inclusive behaviours to share good practice across the Trust

(e) celebrate and share good practice of both individuals and teams across our three hospital sites throughout the year

(f) improve our presence at EDI community events, such as local Pride and encourage staff to take the lead in campaigns

(g) ensure multiple options are available for staff requiring individual support and advice relating to EDI issues in addition to their managerial team and the EDI team including:

- Freedom to Speak Up Guardian
- staff networks and EDI champions
- council of governors
- HR / Workforce Team

MEASURING SUCCESS

To evidence the impact of our interventions we will:

- ensure our policies, processes and systems are supportive and monitored in line with the ambitions set out in *Leading for Equality, Diversity and Inclusion*
- regularly review our EDI priorities through feedback and information to ensure they are grounded in reality for patients, public, staff and volunteers;
- measure and publish progress against our priorities every twelve months on our website and intranet;
- share and celebrate examples of good practice and improvement;
- benchmark our EDI activities in line with national NHS best practice and local identified needs;

- in addition to the WRES BAME definition we acknowledge the similar needs of our European people to be recognised as an ethnic group and included in all programmes and interventions;
- work in partnership and collaboratively with stakeholders, partners and our local community;
- review Equality Impact Assessments (EIA) to support meaningful equality analysis and ensure leaders a) identify where a policy, procedural document, service, service developments or organisational change may have a negative impact on individuals or groups of people with protected characteristics under the Equality Act and b) develop action plans to address them;
- ensure ongoing assessment and compliance with the NHS Equality Delivery System (EDS2) and the opportunities included to advance EDI practice and outcomes;
- increase awareness of the NHS Accessible Information Standard to ensure patients with a disability, impairment or sensory loss receive appropriate communication support from all our services;
- measure progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and GPD and adhere to the fundamental principle of listening to the lived experience of our people;
- improve the quality of staff protected characteristic data collected by encouraging staff to update their records;
- review external best practice accreditations and standards including Stonewall and Mindful Employer;
- review progress against our gender pay gap (GPD), taking actions to support progress;
- review patient feedback through the national NHS Staff Survey, Staff Impression Surveys, Patient and Staff Friends and Family Test, national and local patient surveys and our complaints process;
- metrics including appraisal rates and access to training opportunities;
- feedback from exit interviews;
- informal observations and conversations as part of our ongoing culture programme and culture champion engagement with staff*;*
- look beyond the national standards and datasets, to review the data of all protected characteristics at every level within the organisation and seek to understand why there are gaps.

Delivery of *Leading for Equality, Diversity and Inclusion*

Our *Leading for Equality, Diversity and Inclusion* strategy demonstrates a three-year forward view of inclusion; however, given the pace of change required for NHS recovery and reset post COVID-19, it is important to identify a number of key outcomes for delivery in 2021 – 22 (Year1).

The outcomes will be used to provide assurance to the board of directors, commissioners, regulators, patients and staff that the improvement goals we set are being achieved. A more detailed action plan will be monitored by the Equality, Diversity and Inclusion Group (EDIG).

Key Programme Areas	Objective	Taking Action	Impact Measure *2021 – 22 Target*	Timeline	Lead
Talent – Our Staff **Living our Values**	**Improve employee experience**	Develop and launch employee value proposition to support reputation as a '*great place to work*'	Focus on *Welcome Me* [recruitment / induction] – *Develop Me* [share opportunities] – *Help Me Do My Role* [manage performance] – *Engage and Motivate Me* [retention] – *Recognise Me* [appreciation and recognition] – *Wish Me Farewell* [handling leavers]	March 2022	Organisational Development / Workforce / Communications Team and supported by Divisional / Corporate Leadership Teams
		NHS Workforce Race Equality Standard Improvement (WRES)	Significant improvement in % of BAME staff experiencing harassment, bullying or abuse from: • staff (NHS Staff Survey 2019 = 22% Bournemouth and 29% Poole) • patients (NHS Staff Survey 2019 = 26% Bournemouth and 33% Poole)	June 2021	Organisational Development / Workforce / Communications Team and supported by Divisional / Corporate Leadership Teams
		Establish additional mechanisms to monitor the experiences of other protected characteristics (not covered by national standards)	Use of local datasets	March 2022	Organisational Development / Workforce Teams and supported by Divisional / Corporate Leadership Teams

		Report ethnicity gap when entering into formal disciplinary processes[2]	Use of national decision-tree checklists for managers, post action audits on disciplinary decisions and pre-formal action checks	March 2022	Organisational Development / Workforce Teams and supported by Divisional / Corporate Leadership Teams
		Introduce core offer for *bias reduction* learning and development at all levels within the organisation	Implement training resources / toolkit on civility and respect for all staff to support our positive workplace culture. Roll out at directorate level.[3]	March 2022	Organisational Development and supported by Divisional / Corporate Leadership Teams
		Ensure an inclusive approach to our inaugural annual values recognition event	Year on year increase in awards / recognition representing our diverse workforce	March 2022 - ongoing	Organisational Development supported by Divisional / Corporate Leadership Teams

[2] NHS People Plan

Talent – our staff **Living our Values**	**Develop inclusive leadership capability**	Publish progress against *Model Employer* goals to ensure UHD workforce leadership is representative of overall BAME workforce / local community (whichever is higher)[4] Extend to include other protected characteristics and compare with local community Implement a development programme and talent pipeline to increase representation of BAME staff in (Agenda for Change) B8a – d, B9 plus Very Senior Managers (VSM) and the Board of Directors	Significant annual improvement towards 15% BAME composition target to improve leadership diversity by 2025	March 2022	Organisational Development / Workforce Teams and supported by Divisional / Corporate Leadership Teams

[3] NHS People Plan
[4] NHS People Plan

		Identify NHS Leadership Observatory best practice and practical advice / support[5]	Design and embed within all UHD Leadership Development Programmes and Talent Management Plan. All leadership and management programmes to increase focus on inclusivity as a core theme	March 2022	Organisational Development / Workforce Teams and supported by Divisional / Corporate Leadership Teams
		Build in national competency frameworks for board level positions within Board Development Plan[6]	Measurable progress on EDI and able to demonstrate positive impact as part of CQC *Well Led* assessment. Continue to share staff stories and promote experiences of our diverse workforce Design and deliver EDI training module(s) for Council of Governors	March 2022	Organisational Development and supported by Board of Directors and Divisional / Corporate Leadership Teams Organisational Development
		Include an inclusion standard within our performance management and capability frameworks and embed EDI objectives into all care group / directorate performance management reporting	Active reporting on EDI progress at care group / directorate level and case study examples shared at our annual staff recognition events	March 2022	Organisational Development and supported by Board of Directors and Divisional / Corporate Leadership Teams
Talent – our staff **Living our Values**	**Increase equal opportunities for career development**	Review recruitment and promotion practices[7]	Increase in staffing levels more reflective of diversity of local community and regional / national labour markets	March 2022	Organisational Development / Workforce Teams and supported by Divisional / Corporate Leadership Teams

[5] NHS People Plan
[6] NHS People Plan
[7] NHS People Plan

		Discuss EDI as part of the wellbeing conversations forming part of our new appraisal system[8]	Collect evidence to ensure continuous improvement in compliance rate	March 2022	Organisational Development and supported by Divisional / Corporate Leadership Teams
		Increase reverse mentoring scheme	Extend to cover senior leadership team (circa 40 leaders)	March 2022	Organisational Development and supported by Divisional / Corporate Leadership Teams
Talent – our Staff **Living our Values**	**Enhance staff network engagement**	Review governance arrangements to ensure staff networks are able to contribute to and inform trust decision-making processes[9]	Increase intersectionality by encouraging collaboration across the networks and with colleagues across the ICS, including primary care	March 2022	Organisational Development and supported by Executive / Divisional / Corporate Leadership Teams
		Identify opportunities and case studies for networks to share their work and engage formally in organisational decision making	Provide mentorship and support from chairs, sponsors and senior leadership team	March 2022	Organisational Development and supported by Executive / Divisional / Corporate Leadership Teams
		Promote leadership development via National Inclusion Champion Programme	Nominate one member of staff per year	Jan 2021	Organisational Development / Executive Team

[8] NHS People Plan
[9] NHS People Plan

Improvement and Innovation **Living our Values**	**Improve collection and use of all EDI data and compliance against national standards**	Develop a workforce and patient data set to increase awareness, activity and progress towards delivery of EDI objectives	Increase self-declaration rates and track action plan with targeted interventions against WRES, WDES and Gender Pay Gap	March 2022	Organisational Development / Workforce / Communications Team / Information and supported by Divisional / Corporate Leadership Teams
		Equality Impact Assessment (EIA)	Roll out of new Equality Impact Assessment (EIA) process and guideline toolkit and publish on EDI intranet site	March 2022	Risk Management / Organisational Development / Workforce / Communications Team and supported by Divisional / Corporate Leadership Teams
		Public Sector Equality Duty and Equality Delivery System (2)	Significant improvement across all domains with aspiration to become as a minimum 'Achieving' in all areas (Year 2)	March 2022	Organisational Development / Workforce / Communications Team and supported by Divisional / Corporate Leadership Teams
		Undertake Stonewall UK *Workplace Equality Index* to measure inclusion in the workplace	Track progress within *Top 100 Employers*	Commence in 2021—22 ongoing	Organisational Development / Workforce / Communications Team/ staff networks and supported by Divisional / Corporate Leadership Teams
Patients **Living our Values**	**Develop patient co-production and engagement to reduce**	Identify Executive Lead for tackling inequalities[10]	Appointed October 2020	Completed	Patient Experience / Organisational Development /Information and supported by Divisional / Corporate Leadership Teams

[10] NHS People Plan

	health inequalities	Put in place infrastructure for service equality monitoring in key patient pathways		Commence in 2021—22 ongoing	
		EDI patient dashboard to monitor data quality and compliance	As an ICS partner, audit progress against 8 urgent actions to reduce variation in outcomes across major clinical specialties within UHD[11] As an ICS partner, explore our role and contribution as an Anchor Institution (Health Foundation) to further establish our key role in the health and wellbeing of our local community	March 2022 March 2022	Board Director Lead for Health Inequalities / Board of Directors / Organisational Development and supported by Divisional / Corporate Leadership Teams
		Increase patient and public representation committees and groups as part of our continuous improvement plan	More patient / carer representation on UHD hospital groups and case studies	March 2022	Patient Experience / Organisational Development / Communications Team and supported by Divisional / Corporate Leadership Teams
		Pilot Quality Improvement (QI) training offer for patients and carers	Friends and Family Test	March 2022	Patient Experience / Organisational Development / Communications Team and supported by Divisional / Corporate Leadership Teams

GOVERNANCE AND ACCOUNTABILITY

Governance arrangements for EDI will ensure the board of directors receives regular assurance that the Trust is meeting its Public Sector Equality Duty (PSED) and EDS2 continuous assessment requirements.

The delivery of *Leading for Equality, Diversity and Inclusion* will be overseen by the Equality Diversity and Inclusion group (EDIG) and co-chaired by a Non-Executive Director and Chief Officer. EDIG is responsible for setting the strategic direction for our EDI objectives, monitoring their delivery and championing inclusive behaviour within the Trust. EDIG will also ensure that resources are targeted to support key priority areas.

Each care group and corporate directorate will be asked to set EDI objectives as part of their annual planning cycle drawing on their performance against objectives in or EDI strategy and the equality delivery system. Patient access and experience and staff data will be available to inform this planning process.

Membership includes representatives from each of our inclusion networks, clinical care groups and corporate directorate leads. A quarterly update report on progress against our EDI objectives will be provided to the board of directors. EDIG will also contribute to the Trust's annual report.

EDI Community of Practice

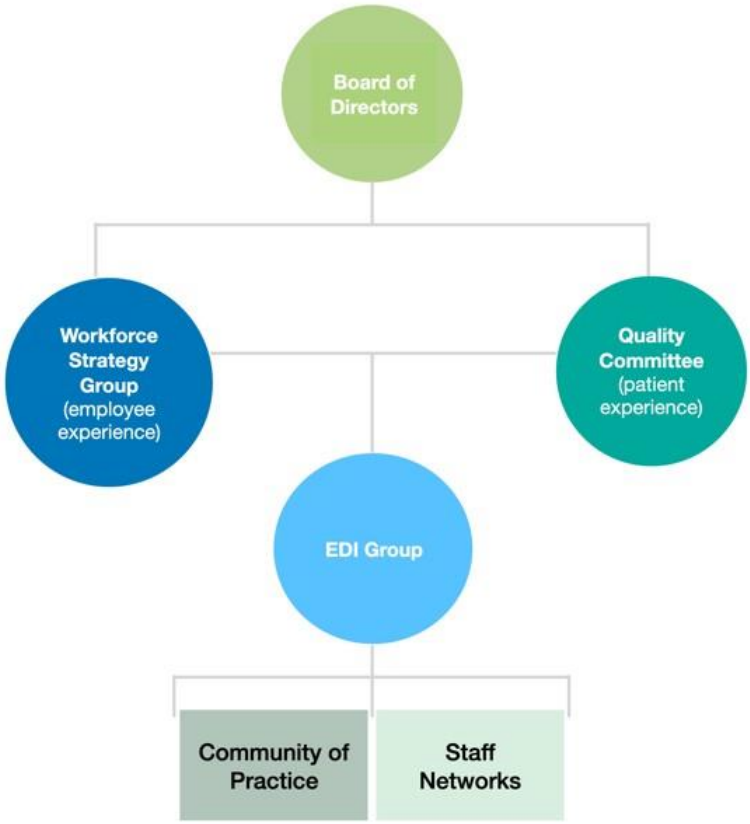
The EDI Community of Practice is responsible for designing key interventions within the *Leading for Equality, Diversity and Inclusion* strategy. It will also co-ordinate and reviewing progress in line with key actions and agreed timescales and collect feedback from on-going engagement activities.

Staff Inclusion Networks

Our current and proposed staff networks (BAME, European, ProAbility, LGBTQ+ and Armed Forces) are open to all staff, volunteers and students undertaking placements. Each network has an elected chair and secretary and is encouraged to attend EDIG on a monthly basis to provide updates on network activities.

EDI governance arrangements are illustrated in Diagram 1.

Diagram 1: EDI Governance Arrangements



Roles and Responsibilities

Board of Directors and Senior Leadership Team will:

- ensure EDI is at the heart of the organisation and everything we do;
- ensure all staff understand what our EDI strategy means for them and communicate the benefits of EDI;
- ensure assessment of the impact of policies and practices upon those with protected characteristics and take action, where appropriate.

Line Managers will:

- communicate the benefits of EDI and ensure their teams have access to, and are made aware of their responsibilities under our UHD equality policies.

Staff will:

- ensure they are aware of their responsibilities under the Trust's equality policies and seek further guidance if they are unclear.

APPENDICES

Appendix 1: What is equality, diversity and inclusion?

Equality is about fair treatment - making sure everyone is treated fairly and given the same life opportunities. It is about ensuring that every individual has an equal opportunity to make the most of their lives and talents, recognising that historically certain groups of people with protected characteristics have experienced discrimination. It is not about treating everyone in the same way, to achieve the same outcomes. Different people have different needs. Equality recognises that people's needs may need to be met in different ways.

Diversity refers to characteristics relevant to our identity and important for individual authenticity, including gender and gender identity, ethnicity and race, religion and belief, nationality, sexual orientation, disability, age and social class. It is about recognising and celebrating difference and the benefit to our Trust from having a diverse workforce group. People differ in all sorts of ways which may not always be obvious or visible. Everyone is an individual with their own background, experiences, styles, perceptions, values and beliefs and we need to understand, value and respect these differences. It is a sense of belonging, of feeling respected and valued for who you are.

Inclusion refers to an environment which values diversity and enables people to be their authentic self in the workplace. It is about positively striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential. An inclusive workplace is characterised by openness, equality and non-discrimination. Inclusion is the enabler of diversity in that it provides the environment for our staff to give their best. In an inclusive culture, different perspectives are actively encouraged and people are confident in their ability to progress within the organisation regardless of their particular background or identity. There is a high level of psychological safety within an inclusive organisation.

Diversity and Inclusion are integral to how we attract, retain, develop and engage our staff and the team relationships we have with each other. Inclusive workplaces are crucial for our wellbeing and for minimising risk.

Intersectionality is the interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group. Those (individuals or groups) with more than one diverse characteristic can face unique obstacles and increased inequality

because of the overlapping and interdependent systems of discrimination or disadvantage intersectionality creates.

Cultural intelligence is the ability to interact with people from different cultures and respond to their needs. Creating a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and the individual.

Intercultural English refers to the aim to use culturally neutral English principles to write in clear, translatable language that does not include culturally specific words and phrases (such as idioms or other local expressions).

Diversity and Equal Opportunities is a key driver in our plan. This is not about treating everyone the same; it is about removing organisational barriers to provide a level playing field where our staff members have equal access to opportunities. This concept also applies to the provision of health opportunities to our diverse patient population.

Appendix 2: What have we achieved together so far?

All our joint networks have supported history months and celebration events through the year as highlighted on the communications plan calendar. They have promoted the networks through posters, presentations and information sessions and supported each other through the inclusion champions' programme and understanding the aims and objectives of each network. This has involved working collaboratively on promoting the value of staff networks and the work being undertaken and holding listening events via MS Teams to encourage staff to approach and discuss issues or concerns in a safe space.

Black, Asian and Minority Ethnic (BAME) network

- Developed a growing and increasingly visible and engaged network of 300+ members
- Provided direct support for staff affected by Covid-19
- Developed the risk assessments process with HR/OH to include staff from a BAME ethnic background
- Held Overseas Nurses Wellbeing sessions to support
- Actively supported the Trust and CEO to send a letter to all staff identified as BAME on ESR, ensuring awareness of risks from covid-19 and the risk assessment process
- Developed workshops and seminars on being an ally, encouraging network allies
- Actively supported the Trust to develop a statement of support on Black Lives Matter
- Supporting staff to apply for the NHS Leadership Academy *Stepping Up Programme* and *WRES Expert Programme*

European Network:

- Raised awareness on the number of European staff in the Trust and their experience of working in our organisation (WRES data)
- Created an EU staff infographic on NHS Staff Survey data
- Challenged the national WRES team to include white ethnic minorities in positive action interventions as part of the wider NHS BAME strategies
- Supporting European staff with the EUSS (European Settled Status) applications
- Building relationships with local agencies supporting EUSS applications
- Supporting European staff to be part of the Reverse Mentoring programme

Lesbian, Gay, Bisexual, Transgender, Questioning plus (LGBTQ+) Network

- Developed NHS Rainbow badge and lanyard campaign – 3500 lanyards and badges distributed across both organisations to date
- Improved inclusive signage appropriate for people identifying as non-binary staff e.g toilet doors project with cardiology
- Developed and implemented Trans patient guidelines
- Attended Stonewall Conference
- Represented Trust at *Pride* and NHS at Bourne Free
- Raising awareness on prejudice and hate incidents related to homophobic behaviours

Pro-Ability Disabled Network

- Led WDES action plan published in the NHS England annual report March 2020.
- Developed and launched Health Passport in August 2020, consultation included staff, HR/OH and staff side representatives
- Developed and led deaf awareness and communication sessions (following mandatory face mask wearing – covid-19)
- Reviewing workshops and policies relating to staff working at home and shielding due to covid-19
- Developing advice for Access to Work support with Risk Management Team

International Doctors Support Initiative (IDSI):

- Raising awareness of overseas medical staff and their experience on joining the Trust
- Providing informal mentoring and support to new recruits from overseas

Armed Forces Network:

- Bringing the Armed Forces Covenant to UHD
- Supporting ex-forces staff and currently serving reservists in the Trust
- Supporting remembrance events and celebration days
- Raising awareness of support services available to Armed Forces families

Appendix 3: Legislation and national standards

There are a number of drivers that inform, regulate and monitor our equality work. These include:

The Human Rights Act 1998

Human rights are the basic rights and freedoms that belong to every person in the world. The Human Rights Act came into force in the UK in October 2000. The Act has two aims: To bring most of the human rights contained in the European Convention on Human Rights into UK law. To bring about a new culture of respect for human rights in the UK – Equality and Human Rights Commission (EHRC) Equality, Diversity and Human Rights is subject to regulation by the Equality and Human Rights Commission which is a public body set up to challenge discrimination, to protect and promote equality and respect for human rights and to encourage good relations between different people of different backgrounds. In addition to our legal duties, we are required to meet the standards set out by the Care Quality Commission (CQC). There are a range of standards determined by the CQC that are linked both directly and indirectly to equality, diversity and human rights. The delivery of our equality strategy will support us in ensuring that we continually meet these standards.

The Equality Act 2010

On 1st October 2010, the Government introduced the Equality Act. This Act brings together, harmonises and extends current equality law. It replaces the existing anti-discrimination laws with a single act. It simplifies the law, removing inconsistencies and making it easier for people to understand and comply with it. The Trust has a legal obligation to ensure consistency and protection for people listed under the Act's 'protected characteristics' (see Appendix 2) and introduced a new general duty on public bodies in carrying out their functions to have due regard to:

- the need to eliminate discrimination, harassment and victimisation;
- the need to advance equality of opportunity between persons who share a relevant protected characteristic and those who do not;
- the need to foster good relations between people who share a relevant protected characteristic and people who do not.

Due Regard (Equality Analysis). The Act also requires the Trust to have 'Due Regard' to the effects of its policies and practices on its service users and workforce in relation to the protected characteristics covered under the Equality Act. The Trust's Due Regard process is robust and has been implemented to gather information and mitigate any

adverse impact on vulnerable groups. The Due Regard process helps to make fair, sound and transparent decisions based on a detailed understanding of the needs and rights of the groups and individuals affected by the Trust's policies and practices.

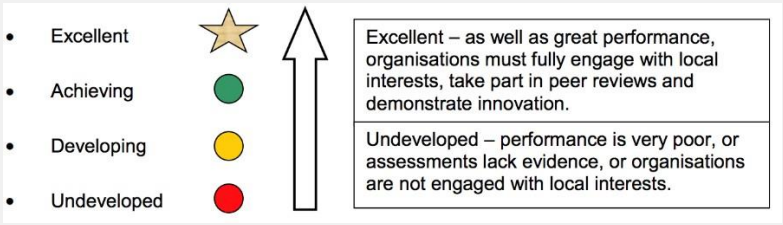
Public Sector Equality Duty (PSED)

The Public Sector Equality Duty came into force on 5th April 2011, a Duty which applies to all public authorities. It brings together previous gender, race and disability duties and extends the protection from discrimination on the basis of the 9 protected characteristics (see Appendix 2). PSED is supported by specific duties set out in regulations which came into force on 10 September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives.

The Equality Delivery System (EDS2)

The Equality Delivery System (EDS) is an NHS Employers initiative that is aimed at improving equality performance of the NHS and embedding equality into mainstream business. The EDS is about real people making real improvements that can be sustained over time. It focuses on the things that matter the most for patients, communities and staff. It emphasises genuine engagement, transparency and the effective use of evidence. By using the EDS NHS organisations will be able to meet the requirements of the Equality Act. There are 18 outcomes, grouped under four goals:

1. Better health outcomes for all
2. Improved patient access and experience
3. Workforce – the NHS as a fair employer
4. Inclusive leadership at all levels.



Based on transparency and evidence, NHS organisations and local interests should agree one of four grades for each outcome. Based on the grading, we will identify how the most immediate priorities are to be tackled, by whom and when. Each year, organisations and local interests will assess progress and carry out a fresh grading exercise. In this way, the EDS will foster continuous improvement.

Workforce Equality Standards

NHS Employers launched the Workforce Race Equality Standards (WRES) in April 2015 giving NHS Trusts a twelve month period to implement the standards and prepare for publishing 1 April 2016. Similarly the launch of the Workforce Disability Equality Standards (WDES) on 1 April 2017 gave NHS Trusts a twelve month period to implement the standards and prepare for publishing on 1 April 2018. Both schemes assists Trusts to identify areas for improvement in relation to staff from Black Minority or Ethnic (BAME) groups, or who have a disability or long-term health condition by monitoring processes and procedures to ensure equality and limiting discrimination.

Accessible Information Standard

The Accessible Information Standard directs defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. It is of particular relevance to individuals who are blind, deaf blind and / or who have a learning disability, although it will support anyone with information or communication needs relating to a disability, impairment or sensory loss (for example people who have aphasia, autism or a mental health condition which affects their ability to communicate). The Standard applies to our services and it specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing. In 2018 we commenced our active monitoring of the Accessible Information Standard. The systems prompt staff to take appropriate action and / or trigger auto-generation of information in an accessible format / other actions such that those needs can be met.

National Health Service Litigation Authority (NHSLA)

The National Health Service Litigation Authority handles negligence claims and works to improve risk management practices in the NHS. All NHS Organisations are assessed by the NHSLA against a set of core standards, which encompass equality and diversity. Equality Delivery System (EDS) The Equality Delivery System has been designed to improve the equality performance of the NHS and embed equality into mainstream business. By using the EDS all NHS organisations will be able to meet the requirements of the Equality Act and the CQC. UHD demonstrates its commitment to equality-based national drivers through providing a health service that respects and responds to diversity of the local population.

As described in *Leading for Equality, Diversity and Inclusion*, we oppose all forms of unlawful and unfair discrimination for both service users and our workforce.

Appendix 4: Definition of the 9 protected characteristics

Age – a person belonging to a particular age or age group. An age group includes people of the same age and people of a particular range of ages.

Disability – a person has a disability if the person has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Gender Reassignment – a person has this protected characteristic if they are proposing to undergo, are undergoing or have undergone a process (or part of a process) for the purposes of reassigning their sex, by changing physiological or other attributes of sex.

Marriage and Civil Partnership – people who have or share the common characteristics of being married or of being a civil partner can be described as being in a marriage or civil partnership. A married man and a woman in a civil partnership both share the protected characteristic of marriage and civil partnership. People who are not married or civil partners do not have this characteristic.

Pregnancy and Maternity – relates to women that are pregnant or within their allocated maternity period. Women that are not pregnant nor within their maternity period do not share this characteristic.

Race – for the purpose of the Act, 'race' includes colour, nationality and ethnic or national origins. People who have or share characteristics of colour, nationality or ethnic or national origins can be described as belonging to a particular racial group. A racial group can be made up of two or more different racial groups.

Religion or belief – the protected characteristic of religion or religious or philosophical belief, is also stated to include a lack of religion or belief. It is a broad definition in line with the freedom of thought, conscience and religion guaranteed by Article 9 of the European Convention on Human Rights.

Sex - people having the protected characteristic of sex refers to being a man or a woman, and that men share this characteristic with other men, and women with other women.

Sexual orientation – the protected characteristic of sexual orientation relates to a person's sexual orientation towards people of the same sex as him or her (in other words the person is a gay man or a lesbian); people of the opposite sex from him or her (the person is heterosexual); people of both sexes (the person is bisexual).

Appendix 5: Useful Links

NHS Employers Diversity & Inclusion Partners Programme
https://www.nhsemployers.org/retention-and-staff-experience/diversity-and-inclusion/partners-programme

King Fund
https://features.kingsfund.org.uk/2020/07/ethnic-minority-nhs-staff-racism-discrimination/index.html

Stonewall UK
https://www.stonewall.org.uk/

Disability Confident
https://disabilityconfident.campaign.gov.uk/

CQC
https://www.cqc.org.uk/

Inclusive Employers
https://www.inclusiveemployers.co.uk

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 10.1

Subject:	Anti-Slavery Statement

Prepared by:	Debbie Detheridge, Diversity and Inclusion Lead
Presented by:	Deb Matthews, Director of Organisational Development

Purpose of paper:	Approval
Background:	As a Public Sector body, we have a duty of care and responsibility to ensure our processes, supply chains and services are free of forced labour and human trafficking. External audits and reviews ask for the URL for our published statement to confirm our commitment to this legislation.
Key points for Board members:	The aim of the statement is to: • publicly commit to the principles of the Anti-Slavery legislation, • explicitly reference our processes we use to check our supply chains, employment practices and safeguard our patients • Linked to our values: Open and Honest. Inclusive
Options and decisions required:	Decision required to approve the statement and publish.
Recommendations:	Recommend the statement is approved and published on the external website.
Next steps:	Statement will be published on the external website.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
EDIG Workforce Committee	18.1.2021

University Hospitals Dorset
NHS Foundation Trust

Slavery and Human Trafficking Statement

This statement, made pursuant to section 54(1) of the Modern Slavery Act 2015, sets out the approach taken by University Hospitals Dorset NHS Foundation Trust (UHD) to understand all potential modern slavery risks related to its business, and the actions undertaken to mitigate any such risks during the financial year ended 31 March 2022

We are committed to delivering high standards of corporate governance and a key element of this is managing the Trust in a socially responsible way. We are absolutely committed to preventing slavery and human trafficking in our corporate activities and supply chains. We also expect the same high standards which we set for ourselves from those parties with whom we engage, such as our suppliers and customers.

The steps we have taken during the current financial year in relation to combating modern slavery and human trafficking are as follows:

In relation to our supply chains, which include the sourcing of all products and services necessary for the provision of high quality health care to our patients:

- We expect and require all of our suppliers to comply with all local, national and (where applicable) international laws and regulations.
- All our orders are placed in accordance with standard NHS terms and conditions (T's & C's). Within these terms are statements requiring suppliers to ensure they conduct business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy.
- Our suppliers must comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains.
- We expect all those in our supply chain and contractors to comply with our values.
- We will not support or deal with any business knowingly involved in modern slavery and human trafficking. All suspicions of modern slavery and human trafficking will be reported to the relevant authority.
- We will consider modern slavery issues when making procurement decisions.

In relation to due diligence and risk management (other than our supply chains):

- We undertake appropriate pre-employment checks and require our agencies on approved frameworks to do the same.
- We protect staff from poor treatment and/or exploitation, and comply with all respective laws and regulations including fair pay rates and terms of conditions of employment.
- We consult and negotiate with Trade Unions on proposed changes to employment, work organisation, and contractual relations.

In relation to our policies and procedures, which set the tone for how we as an organisation operate:

- We have a clear Whistleblowing Policy that applies to all individuals working for our Trust and is published on our intranet site. If there are any genuine concerns about any wrongdoing or breaches of the law, including modern slavery laws, these concerns can be raised in confidence and without fear of disciplinary action.
- We have appointed a Freedom to Speak Up Guardian and Ambassadors to promote, listen, support and provide an impartial view to staff when speaking up and to contribute to a culture of speaking up where staff feel safe and confident to raise concerns.

In relation to the training of our staff:

- Our training for staff includes how to recognise and respond to indicators of human rights abuses. It includes examples of red flags specific to our industry, explain our reporting procedures for suspicions and promote an organisation wide sense of responsibility.

- We have teams responsible for safeguarding of adults and children, to whom staff are responsible for reporting of concerns and who will train staff on how to recognise issues of concern.

This statement will be reviewed annually. This statement was approved by our board of directors on

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 10.1

Subject:	Public Sector Equality Duty

Prepared by:	Debbie Detheridge, Diversity and Inclusion Lead
Presented by:	Deb Matthews, Director of Organisational Development

Purpose of paper:	Approval of the Public Sector Equality Duty statement for publishing on the external internet page
Background:	As a Public Sector body, we have a legal duty to adhere to this legislation and must reference it in all our equality, diversity and inclusion work and reporting
Key points for Board members:	• A statement from the Trust Board committing to this duty provides the framework for publishing our statutory and contractual equality reports aligned to this duty. • Linked to our values: Open and Honest. Inclusive
Options and decisions required:	Decision is required to approve this statement for publishing
Recommendations:	Approval of the statement to be published
Next steps:	Statement will be published on our external web page with the relevant equality reports.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
EDIG	18.1.2021

Our commitment to equality, diversity and inclusion

The Trust Board recognises the importance of equality, diversity and inclusion (EDI) as being critical to delivering excellent patient care and being recognised as a good place to work, an employer of choice.

We are committed to attracting and developing a diverse workforce that reflects the communities we serve, creating a sense of belonging for all our people.

We are committed to embedding equality and diversity values into our policies, procedures, employment practice and the provision of our services.

We are committed to the elimination of discrimination, harassment, reducing health inequalities, promoting equality of opportunity and dignity and respect for all our patients, service users, their families' carers and our people.

We aim to provide equality and fairness for all, and not to discriminate on grounds of gender, gender identity, race, ethnic origin, colour, nationality, national origin, disability, sexual orientation, religion or age.

Our legal responsibilities are set out in the Equality Act 2010.

Our approach to equality and diversity

Our strategy for equality, diversity and inclusion sets out our approach to equality and diversity, both as an employer and as a healthcare organisation. This was developed in partnership with staff inclusion networks, community partners and patient representatives.

The strategy sets out our equality objectives and how we will deliver on key guidance and statutory requirements relating to equality and diversity, including the **NHS Constitution**, the **Equality Act 2010** and having due regard for the **Public Sector Equality Duty** and Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well led

The identified trust lead for equality, diversity and inclusion is the Chief Executive Officer. This role is supported by a Director and a Non-Executive Director, who have responsibility for equality, diversity and inclusion, including health inequalities within their portfolio.

Our equality, diversity and inclusion group (EDIG) serves to provide assurance that the Trust has an effective framework within which it can deliver the major projects and initiatives that form part of the equality, diversity and inclusion strategy. The group is chaired by the Non-Executive Director for equalities and attended by representatives from across the organisation including Managers, Trade Unions, staff inclusion networks, freedom to speak up Guardian, HR, Chaplaincy team, Governors and patients.

The EDIG is responsible for:

- ensuring UHD commits to an equality, diversity and inclusion agenda for the benefit of our patients and staff and in line with best practice and current legislation;
- monitoring implementation progress of all components of the ED&I strategy in line with national policy requirements;
- supporting and collaborating with the Dorset ICS to ensure the health needs of the diverse communities we serve are understood and best met;
- encouraging and promoting inclusive workplaces free from discrimination and where our diverse staff can flourish;
- challenging the organisation, holding it and individuals within it to account, where and when the above does not happen;
- ensuring all staff are supported in understanding the Trust's commitment to equality, diversity and inclusion and demonstrate this in their roles.

Our equality reports, strategic objectives and values reflect the UHD commitment to inclusion and therefore our approach across services and employment.

Accessible Communications

We want to make it as easy as possible for people to get involved in our work and find out more about local health services.

If you need information in an alternative format, such as Easy Read, Large Print, Braille, Audio or an alternative language, please let us know by contacting the Patient Experience team (patient.experience@uhd.nhs.uk) or our Patient Advice and Liaison Service (pals@uhd.nhs.uk)

All our internet pages are designed to work across different platforms and browsers. The Recite Me toolbar is available on our external website pages to enable visual enhancement and conversion to speech and language interpretation.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 10.3

Subject:	Appointment of Senior Independent Director

Prepared by:	Carrie Stone, Company Secretary
Presented by:	David Moss, Chairman

Purpose of paper:	To appoint the Senior Independent Director for University Hospitals Dorset NHS Foundation Trust
Background:	Clause 21 of the Constitution, notes that one of the non-executive directors may be nominated as the Senior Independent Director (SID). Annex 7 – Standing Orders for the Practice and Procedure of the Board Directors clause 3.4 sets out the appointment and role of the SID. The Board shall (following consultation with the Council of Governors) appoint one of the non-executive directors as the SID for such a period not exceeding the remainder of the individual's term of office as a non-executive director.
Key points for Board members:	The attached paper seeks the approval of the Board of Directors for the appointment of Caroline Tapster to the role of Senior Independent Director
Options and decisions required:	To approve the appointment of Caroline Tapster.
Recommendations:	The Board of Directors is asked to approve the appointment.
Next steps:	Update the Trust's website

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	Not applicable
CQC Reference:	Well Led

Committees/Meetings at which the paper has been submitted:	**Date**
None	

University Hospitals Dorset NHS Foundation Trust

Appointment and Role of the Senior Independent Director

The Constitution of University Hospitals Dorset NHS Foundation Trust outlines the appointment process of the Senior Independent Director.

1.1.1 The Senior Independent Director (SID) is a role that is undertaken by one of the Trust's Non-Executive Directors. The SID should be available to all stakeholders, particularly Governors and Members, should they have concerns which they feel unable to resolve via normal channels, such as through contact with the Chairman or Chief Executive, or in circumstances in which such contact would be inappropriate.

1.1.2 The Board shall (following consultation with the Council of Governors) appoint one of the Non-Executive Directors as the SID for such a period not exceeding the remainder of the individual's term of office as a Non-Executive Director.

1.1.3 The SID shall maintain sufficient contact with Governors to understand their issues and concerns.

1.1.4 In accordance with a process to be agreed between the Chairman and Council of Governors, the SID will lead in the process for evaluating the performance of the Chairman.

1.1.5 The SID shall lead a meeting of the Non-Executive Directors at least annually without the Chairman to evaluate the Chairman's performance, as part of the process agreed with the Council of Governors for appraising the Chairman.

The Chairman in consultation with the Non-Executive Directors agreed to nominate Caroline Tapster to the role of Senior Independent Director.

The Chairman consulted with the Council of Governors on the 4 March 2021 at the Council of Governors meeting regarding the nomination of Caroline Tapster as the Senior Independent Director. The Council of Governors were supportive of the nomination.

Recommendation

The Board is asked to approve the appointment of Caroline Tapster as the Senior Independent Director for three years or such a period not exceeding the remainder of the individual's term of office as a Non-Executive Director.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 10.4

Subject:	Independence of Non-Executive Directors

Prepared by:	Carrie Stone, Company Secretary
Presented by:	David Moss, Chairman

Purpose of paper:	To consider and approve the assessment and formal statement on determination of the independence of the Trust's non-executive directors.
Background:	Monitor's (NHS Improvement) Code of Governance. Code Provision B.1.1. The Board of Directors should identify in their annual report each non-executive director it considers to be independent. The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The Board of Directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination.
Key points for Board members:	The attached paper sets out the Board of Director's determination on the independence of non-executive directors and the formal annual report statement on the independence of non-executive directors for 2020/20.
Options and decisions required:	To determine the independence of non-executive directors.
Recommendations:	To APPROVE the formal statement on the independence of the non-executive directors
Next steps:	The approved statement will be included in the Annual Report 2020/21.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register		
Strategic Objective:		
BAF/Corporate Risk Register: (if applicable)	Not applicable	
CQC Reference:	Well Led	
Committees/Meetings at which the paper has been submitted:		**Date**
None		

University Hospitals Dorset NHS Foundation Trust

Report on Independence of non-executive directors

(Monitor's (now NHS Improvement) Code of Governance B.1.1 & B.1.2)

In compliance with paragraph B.3.3 of the Monitor code of governance for NHS foundation trusts, no executive director holds more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity during October 2020 to March 2021

All of the non-executive directors are considered to be independent by the board of directors.

As far as each individual director of University Hospitals Dorset NHS Foundation Trust is aware, there is no relevant audit information of which the foundation trust's auditors is unaware. Each director has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the foundation trust's auditor is aware of that information.

A director is regarded as having taken all the steps that they ought to have taken as a director in order to do the things mentioned above, and:

- Made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and
- Taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.

The board of directors has approved a policy for the provision of any non-audit service that might be provided by the trust's external auditor. This policy removes any unnecessary restrictions on the purchase of services from the external auditor but ensures that any non-audit service provided by them cannot impair or cannot be seen to impair the objectivity of their opinion on the financial statements. The trust's current auditors, KPMG, were appointed from April 2018 and have provided non-audit services to the trust since appointment.

Statement for Trust's 2020 /2021 Annual Report

All of the non-executive directors are considered to be independent by the Board of Directors.

Recommendation

The Board approves the assessment and formal annual report statement on the independence of non-executive directors.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 10.5

Subject:	NHS Improvement's Terms of Licence – Draft compliance report

Prepared by:	Carrie Stone, Company Secretary and the Executive Directors
Presented by:	Debbie Fleming, Chief Executive

Purpose of paper:	To present for approval an assessment of compliance with the Trust's Licence conditions.
Background:	As part of the Trust's Licence Conditions, the Board of Directors is required to meet the conditions of the Licence. Where the Trust does not meet a condition, the Board must inform NHS Improvement and provide an explanation and a plan to meet the said condition. The draft report was scrutinised by the Audit Committee on 18 March 2021 prior to presentation to the Board.
Key points for members:	For this year (2020/21) the document has been updated by the company secretary, the executive directors and non-executive directors prior to scrutiny by the Audit Committee and Board approval in March 2021. The Trust's current assessment is one of compliance with all applicable conditions.
Options and decisions required:	The Board is asked to note and approve the current assessment of compliance with the Licence.
Recommendations:	The Board is asked to approve the report.
Next steps:	The compliance report will be held on the FT Governance register.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well-Led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	18/03/2021

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

REGISTER OF COMPLIANCE WITH NHS PROVIDER LICENCE STANDARD CONDITIONS

Draft V1 2020/21 WORKING DOCUMENT (Audit Committee to review March 21 and BoD to Approve March 21)

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
Section 1 General Conditions These licence conditions will apply to all licence holders.			
G 1	**Provision of information**		
	1. Subject to paragraph 3, and in addition to obligations under other Conditions of this Licence the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for any of the purposes set out in section 96(2) of the 2012 Act.	CEO	The Board is aware that NHS England and Improvement, previously Monitor, may specify its requirements at appropriate times. The Trust will respond in accordance with the provisions of the guidance.
	2. Information, documents and reports required to be furnished under this Condition shall be furnished in such a manner, in such form, at such place and at such times as Monitor may require.	CEO	The Board notes this condition and shall comply.
	3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that: (a) in the case of information or a report, it is accurate, complete and not misleading; (b) in the case of a document it is a true copy of the document requested; and	CEO	The Board notes this condition and shall take all reasonable steps to ensure compliance.
	4. This condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	CEO	The Board notes the limitations on this condition.
G 2	**Publication of information**		
	1. The Licensee shall comply with any direction from Monitor for any of the purposes set out in section 96(2) of the 2012 Act (see definition in G1) to publish information about health care services provided for the	CEO (ADoC)	The Board is aware that NHS England and Improvement, previously Monitor may direct its requirements at appropriate times. The Trust will respond in accordance with

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	purposes of the NHS and as to the manner in which such information should be published.		the provisions of the Act.
	2. For the purposes of this condition "publish" includes making available to the public, to any section of the public or to individuals.	CEO (ADoC)	The Board notes this condition and shall comply.
G3	**Payment of fees to Monitor**		
	1. The Licensee shall pay fees to Monitor in each financial year of such amount as Monitor may determine for each such year or part thereof in respect of the exercise by Monitor of its functions for the purposes set put in section 96(2) of the 2012 Act. (see definition in G1)	CFO	The Board is aware and is awaiting any determination.
	2. The Licensee shall pay the fees required to be paid by a determination by Monitor for the purpose of paragraph 1 no later than the 28th day after they become payable in accordance with that determination.	CFO	The Board is aware and will comply with any such determination.
G4	**Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)**		
	1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.	CEO (Co Sec)	The Board is aware and will comply with this condition. This is a Constitutional requirement and annual declarations from Governors required at year end.
	2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.	CEO (CPO)	The Board is aware and will comply with this condition. This is a Constitutional requirement, declaration within contracts of employment. Annual declarations from directors are required at year end with sign off of each Fit and Proper Persons Declaration by the Chairman. For the new organisation, declarations were sought from all Board members – October 2020. Reminders are sent to directors by the Company Secretary that they need to disclose any of the potentially disqualifying conditions in the event that any become possible.
	3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.	CEO (CPO)	The Board notes and will comply with this condition.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	4. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.	CEO (CPO)	The Board notes and will comply with this condition.
	5. In this Condition an unfit person is: (a) an individual; i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or (b) a body corporate, or a body corporate with a parent body corporate: (i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or (ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or (iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or (iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or (v) which passes any resolution for winding up, or (vi) which becomes subject to an order of a Court for winding	CEO (CPO)	The Board has noted this definition. This is a Constitutional requirement for governors and installed within contractual requirement of directors.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	up.		
G5	**Monitor Guidance**		
	1. Without prejudice to any obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by Monitor for any of the purposes set out in section 96(2) of the 2012 Act. (see definition in G1)	CEO	The Board has noted this condition and shall comply.
	2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform Monitor of the reasons for that decision.	CEO	Where it is decided that such guidance is not followed it will be reported by the lead director to the Board. Any such decision will be noted and NHS England and Improvement, previously Monitor, shall be informed.
G6	**Systems for compliance with licence conditions and related obligations**		
	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	CEO	Description of Assurance (for complying with the conditions of this licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS) will be via: • the Trust's risk and performance management reporting frameworks • the mandatory in-year and annual reporting as required by NHS England and Improvement, previously Monitor • regular external governance reviews and • the reviewing of this register annually by the Audit Committee and Board.
	2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) regular review of whether those processes and systems have been implemented and of their effectiveness.	CNO	The Trust has a comprehensive and robust approach to risk management. The Board Assurance Framework is a systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust in achieving its strategic goals. The document gives a clear picture of the risks relating to each of the strategic objectives, including the controls, any gaps in control and actions required to close any gaps. The

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
			document was endorsed by the Shadow Interim Board for the new organisation in September 2020 and is subject to quarterly review by the Audit Committee and six monthly review by the Quality Committee and the Board of Directors. The Head of Internal Audit's opinion for 2020/21 was TBC The Risk Management Strategy was endorsed in 2020 and identifies the Trust's risk appetite. The strategy supports delivery of the Trust's corporate objectives and describes the organisation's approach to the identification, assessment and management of risk.
	3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.	CFO	By 31 May a certificate will be approved by the Board and submitted to NHS England and Improvement, previously Monitor, to the effect that regular review of whether those processes and systems to identify risks and guard against their occurrence have been implemented and of their effectiveness. The Associate Director of Communication will ensure completion is included on the check-list for the Annual Report.
	4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.	CFO (CNO/ADoC)	By 30 June (or in one month from the submission to NHS England and Improvement, previously Monitor,) each certificate will be published by the Associate Director of Communication in a manner to bring it to the attention of such persons who reasonably can be expected to have an interest in it.
G7	**Registration with the Care Quality Commission**		
	1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.	CNO	The Trust is and has been consistently registered with the Care Quality Commission for all the regulated activities it undertakes.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	2. The Licensee shall notify Monitor promptly of: (a) any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or (b) the cancellation by the Care Quality Commission for any reason of its registration by that Commission.	CNO	The Board of Directors approves all applications for registration or deregistration. There have been no proposals to deregulate any regulated activities of the Trust. The Board of Directors is notified of all Care Quality Commission actions in relation to the Trust. There have been no deregistration action taken by the Care Quality Commission.
	3. A notification given by the Licensee for the purposes of paragraph 2 shall: (a) be made within 7 days of: (i) the making of an application in the case of paragraph (a), or (ii) becoming aware of the cancellation in the case of paragraph (b), and (b) contain an explanation of the reasons (in so far as they are known to the Licensee) for: (i) the making of an application in the case of paragraph (a), or (ii) the cancellation in the case of paragraph (b).	CNO	The Board of Directors approves all applications for registration or deregistration. There have been no proposals to deregulate any regulated activities of the Trust. The Board of Directors is notified of all Care Quality Commission actions in relation to the Trust. There have been no deregistration action taken by the Care Quality Commission.
G8	**Patient eligibility and selection criteria**		
	1. The Licensee shall: (a) set transparent eligibility and selection criteria, (b) apply those criteria; in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and (c) publish those criteria in such a manner as will make them readily	COO	All Trust access policies and procedures will comply with national guidance in support of e-referral, RTT, 4 hour organisational standard, access to diagnostics (DMo1) and screening and cancer pathways including the DoH cancer waiting times guide. Trust policies and procedures are accessible on the Trust intranet and readily available.

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	accessible by any persons who could reasonably be regarded as likely to have an interest in them.		
	2. "Eligibility and selection criteria" means criteria for determining: (a) whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and (b) if the person is selected, the manner in which the services are provided to the person.	COO	As enshrined in the NHS constitution, this will be delivered through the contracts with the CCG and Specialised Commissioners.
G9	**Application of Section 5 (Continuity of Services)**		
	1. The Conditions in Section 5 shall apply: (a) whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service, and (b) from the commencement of this Licence until the Licensee becomes subject to an obligation of the type described in sub-paragraph (a), if the Licensee is an NHS foundation trust which: (i) was not subject to such an obligation on commencement of this Licence, and (ii) was required to provide services, or was party to an NHS contract to provide services, as described in paragraph 2(a) or 2(b); for the avoidance of doubt, where Section 5 applies by virtue of this subparagraph, the words "Commissioner Requested Service" shall be read to include any service of a description falling within paragraph 2(a) or 2(b).	CFO	The Commissioning Manager does maintain a register of CRS services and will ensure compliance with relevant conditions, reporting any potential breaches to the Director of Finance.
	2. A service is a Commissioner Requested Service if, and to the extent that, it is:	CFO	Definition noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance

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	(a) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or before 31 March 2013, was required to provide in accordance with condition 7(1) and Schedule 2 in the terms of its authorisation by Monitor immediately prior to the commencement of this Licence, or (b) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or after 1 April 2013, was required to provide pursuant to an NHS contract immediately before its authorisation date, or (c) any other service which the Licensee has contracted with a Commissioner to provide as a Commissioner Requested Service.		with Licence conditions, maintaining whatever records are required.
	3. A service is also a Commissioner Requested Service if, and to the extent that, not being a service within paragraph 2: (a) it is a service which the Licensee may be required to provide to a Commissioner under the terms of a contract which has been entered into between them, and (b) the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either (c) the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or (d) the Commissioner, not earlier than the expiry of the [28th] day after making that request to the Licensee, has given to Monitor and to the Licensee a notice in accordance with paragraph 4, and Monitor, after giving the Licensee the opportunity to make representations, has issued a direction in writing in accordance with paragraph 5.	CFO	Definition noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.

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	4. A notice in accordance with this paragraph is a notice: (a) in writing, (b) stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and (c) setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.	CFO	Definition noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.
	5 A direction in accordance with this paragraph is a direction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 3(b) is unreasonable.	CFO	Definition noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.
	6. The Licensee shall give Monitor not less than [28] days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.	CFO	The Commissioning Manager provides a single point of contract for contractual arrangements with commissioners and does ensure that all changes in CRS contracts are recorded and brought to the attention of the responsible Director. The Director will ensure that NHS Improvement is notified.
	7. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until Monitor issues either: (a) a direction of the sort referred to in paragraph 8, or (b) a notice in writing to the Licensee stating that it has decided not to issue such a direction.	CFO	The Commissioning Manager provides a single point of contact for contractual arrangements with commissioners and does ensure that all changes in CRS contracts are recorded and brought to the attention of the responsible Director. The Chief Finance Officer will ensure that all CRS services are maintained until appropriate agreement with NHS Improvement, previously Monitor.

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	8. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then for that period the service shall continue to be a Commissioner Requested Service.	CFO	Noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.
	9. No service which the Licensee is subject to a contractual or other legally enforceable obligation to provide shall be regarded as a Commissioner Requested Service and, as a consequence, no Condition in Section 5 shall be of any application, during any period for which there is in force a direction in writing by Monitor given for the purposes of this condition and of any equivalent condition in any other current licence issued under the 2012 Act stating that no health care service provided for the purposes of the NHS is to be regarded as a Commissioner Requested Service.	CFO	Noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.
	10. A service shall cease to be a Commissioner Requested Service if: (a) all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service, or (b) Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service; or (c) it is a Commissioner Requested Service by virtue only of paragraph 2(a) above and 3 years have elapsed since the commencement of this Licence; or (d) it is a Commissioner Requested Service by virtue only of paragraph 2(b) above and either 3 years have elapsed since 1 April 2013 or 1 year has elapsed since the commencement of this Licence, whichever is the later; or (e) the contractual obligation pursuant to which the service is provided has expired and Monitor has issued a notice pursuant to paragraph 7(b) in relation to the service; or	CFO	Noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.

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	(f) the period specified in a direction by Monitor of the sort referred to in paragraph 8 in relation to the service has expired.		
	11. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.	CFO	The Commissioning Manager provides a single point of contact for contractual arrangements with commissioners and does ensure that a record is maintained of all designated Commissioner Requested Services. A schedule of such services will be provided on request.
	12. Within [28] days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to Monitor in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.	CFO	The Commissioning Manager will ensure that all changes in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, are notified to Monitor in accordance with Licence conditions.
	13. Unless it is proposes to cease providing the service, the Licensee shall not make any application to Monitor for a determination in accordance with paragraph 10(b): (a) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(a) above, in the period of 3 years since the commencement of this Licence or (b) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(b), in the period until the later of 1 April 2016 or 1 year from the commencement of this Licence.	CFO	Noted and understood. The Commissioning Manager does act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.
	14. In this Condition "NHS contract" has the meaning given to that term in Section 9 of the 2006 Act.	CFO	Noted and understood. The Commissioning Manager will act as the single point of contact for all information on CRS services and will ensure compliance with Licence conditions, maintaining whatever records are required.
Section 2 Pricing These conditions will apply to all licensees providing services that are covered by the National Tariff document.			
P1	**Recording of information**		

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	1. If required in writing by Monitor, and only in relation to periods from the date of that requirement, the Licensee shall: (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, and (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.	CFO	The Trust has a costing system and the relevant expertise to obtain, record and maintain sufficient information to meet the requirements of the Licence. .
	2. From the time of publication by Monitor of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information broken down in accordance with those Currencies by allocating to a record for each such Currency all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency and by similarly treating other relevant information.	CFO	When reporting requirements are published by NHS Improvement, the Deputy Chief Finance Officer shall be responsible for ensuring that costs and other relevant information are recorded.
	3. In the allocation of costs and other relevant information to Approved Reporting Currencies in accordance with paragraph 2 the Licensee shall use the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.	CFO	The Board is aware of this requirement and will ensure compliance with the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.
	4. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by Monitor the Licensee shall procure that each of those sub-contractors: (a) obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems	CFO	Sub-contractors are used in service delivery (Healthcare at Home and BUPA Homecare RBH, DCH and UHS) and to support RTT and diagnostic standards, these are all recognised providers of NHS services and will therefore be used to and able to comply with costing requirements. Sub-contractors are also required to meet the conditions precedent of the main commissioner contract, which are: • Evidence of CQC Registration for the Provider and all

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	and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and (b) provides that information to Monitor in a timely manner.		its Sub-contractors (permitted and mandatory) • Evidence of Monitor's Licence [where required] for the Provider and all its Sub-contractors (permitted and mandatory) • Copy of all contracts with Sub-contractors (permitted and mandatory) signed, dated and in a form approved by the Coordinating Commissioner • Evidence of appropriate Indemnity Arrangements If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England and Improvement, the Deputy Chief Finance Officer and Commissioning Manager shall ensure that if such information is provided as required.
	5. Records required to be maintained by this Condition shall be kept for not less than six years.	CFO	The Board is aware of this requirement and the Chief Finance Officer will ensure that records are maintained.
	6. In this Condition: "the Approved Guidance" means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs by reference to Approved Reporting Currencies as may be published by Monitor; "Approved Reporting Currencies" means such categories of cost and other relevant information as may be published by Monitor; "other relevant information" means such information, which may include quality and outcomes data, as may be required by Monitor for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act.	CFO	Definitions noted and understood.
P2	**Provision of Information**		

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	1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for the purpose of performing its functions under Chapter 4 in Part 3 of the 2012 Act. (See G1)	CIO	The Board is aware of these requirements and has established the functions and resources in the Information Department to enable compliance with these 4 conditions
	2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as Monitor may require.	CIO	
	3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that: (a) in the case of information or a report, it is accurate, complete and not misleading; (b) in the case of a document, it is a true copy of the document requested; and	CIO	
	4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	CIO	
P3	**Assurance report on submissions to Monitor**		
	1. If required in writing by Monitor the Licensee shall, as soon as reasonably practicable, obtain and submit to Monitor an assurance report in relation to a submission of the sort described in paragraph 2 which complies with the requirements of paragraph 3.	CFO	The Board is aware of these requirements. The Chief Finance Officer will be responsible for commissioning and providing an assurance report if required by NHS Improvement, previously Monitor.

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	2. The descriptions of submissions in relation to which a report may be required under paragraph 1 are: (a) submissions of information furnished to Monitor pursuant to Condition P2, and (b) submissions of information to third parties designated by Monitor as persons from or through whom cost information may be obtained for the purposes of setting or verifying the National Tariff or of developing non-tariff pricing guidance.	CFO	The Board is aware of these requirements. The Chief Finance Officer will be responsible for commissioning and providing an assurance report if required by NHS England and Improvement, previously Monitor.
	3. An assurance report shall meet the requirements of this paragraph if all of the following conditions are met: (a) it is prepared by a person approved in writing by Monitor or qualified to act as auditor of an NHS foundation trust in accordance with paragraph 23(4) in Schedule 7 to the 2006 Act; (b) it expresses a view on whether the submission to which it relates: (i) is based on cost records which have been maintained in a manner which complies with paragraph 2 in Condition P1; (ii) is based on costs which have been analysed in a manner which complies with paragraph 3 in Condition P1, and iii) provides a true and fair assessment of the information it contains.	CFO	The Board is aware of these requirements. The Chief Finance Officer will be responsible for commissioning and providing an assurance report if required by NHS England and Improvement, previously Monitor.
P4	**Compliance with the National Tariff**		
	1. Except as approved in writing by Monitor, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by Monitor, in accordance with section 116 of the 2012 Act.	CFO	The Board is aware of these requirements and has previously informed NHS England and Improvement, previously Monitor of the agreement of contracts with its local commissioners which include historically agreed transitional funding in addition to the income calculated in

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			accordance with national tariffs. The Chief Finance Officer is responsible for maintaining records of income which enables this analysis to be provided both to the Board and to NHS England and Improvement, previously Monitor.
	2. Without prejudice to the generality of paragraph 1, except as approved in writing by Monitor, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by Monitor in accordance with, section 116 of the 2012 Act, wherever applicable.	CFO	See above
P5	**Constructive engagement concerning local tariff modifications**		
	1. The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the 2012 Act, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.	CFO	The Board is aware of this requirement and has regular and constructive dialogue with commissioners.
Section 3 Choice and Competition apply to all licence holders			
C1	**The right of patients to make choices**		
	1. Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found.	COO	Noted and understood.
	2. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.	COO	Noted and understood.
	3. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly	COO	Noted and understood.

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	favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.		
	4. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	COO	Noted and understood. Supported by the Trust's Managing Conflicts of Interest policy.
C2	**Competition oversight**		
	1. The Licensee shall not: (a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, or (b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, to the extent that it is against the interests of people who use health care services.	CSTO	The Board is aware of this requirement and will take legal advice before entering into any agreement which may not comply with competition regulations. This has been reviewed as part of merger and compliance achieved.
Section 4 Integrated care apply to all licence holders			
IC1	**Provision of integrated care**		
	1. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others with a view to achieving one or more of the objectives referred to in paragraph 4.	COO	Noted and understood. The Trust is part of local and national networks and has SLA's for provision of shared services with other NHS Trusts.

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	2. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of health-related services or social care services by others with a view to achieving one or more of the objectives referred to in paragraph 4.	COO	Noted and understood. In addition, there is an agreed multi-agency Pan Dorset Quality Standards and Leaving Hospital Policy.
	3. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling it to co-operate with other providers of health care services for the purposes of the NHS with a view to achieving one or more of the objectives referred to in paragraph 4.	COO	Noted and understood. The Trust works in partnership across a number of areas to deliver the best outcomes for patients eg, Dorset ICS and the Dorset Cancer partnership. In addition, the organisation is an active member of the Dorset System Leadership Team.
	4. The objectives referred to in paragraphs 1, 2 and 3 are: (a) improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, (b) reducing inequalities between persons with respect to their ability to access those services, and (c) reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.	COO	Board will comply. The Board is aware of these objectives and will apply.
	5. The Licensee shall have regard to such guidance as may have been issued by Monitor from time to time concerning actions or behaviours that might reasonably be regarded as against the interests of people who use health care services for the purposes of paragraphs 1, 2 or 3 of this Condition.	COO	The Board is aware that NHS England and Improvement, previously Monitor and the Care Quality Commission may specify a requirement at appropriate times. The Trust will respond in accordance with the provisions of such guidance.
Section 5 Continuity of Service apply to all licence holders that provide Commissioner Requested Services			
CoS1 Continuing provision of Commissioner Requested Services			

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	1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.	CFO	The Board is aware of this requirement. The Commissioning Manager will ensure that records of CRS services are maintained. The Board, before making any decision to cease or materially change any CRS service will ensure that the conditions in this section are complied with.
	2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G9(1)(b), Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.	CFO	The Board is aware of this requirement and will comply.
	3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except: (a) with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or (b) at any time when this condition applies by virtue of Condition G9(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or (c) if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by Monitor for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.	CFO	The Board is aware of this requirement and its authorisation is required before there is any significant change to the provision of CRS services. The Commissioning Manager does maintain register of CRS services and will ensure compliance with relevant conditions, reporting any potential breaches to Chief Finance Officer.

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	4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within [28] days of the alteration, shall give to Monitor notice in writing of the occurrence of the alteration with a summary of its nature.	CFO	The Chief Finance Officer is responsible for ensuring that NHS England and Improvement, previously Monitor is informed of any significant change including changes to CRS services. The Commissioning Manager does maintain register of CRS services and will ensure compliance with relevant conditions, reporting any potential breaches to the Chief Finance Officer
	5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in: (a) the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or (b) if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or (c) at any time when this Condition applies by virtue of Condition G9(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.	CFO	Definition noted and understood.
CoS2 Restriction on the disposal of assets			
	1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")	CFO/CIO	The Board is aware of this requirement and the Chief Finance Officer/Chief Informatics Officer is accountable to the Board for maintaining information systems which comply with the requirements of the organisation and the

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	2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.	CFO/CIO	requirements of NHS England and Improvement, previously Monitor, and other key external stakeholders.
	3 The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.	CFO/CIO	The Trust maintains an Asset Register which is continuously updated. It records the required information for all assets including those required for the provision of CRS services. The quality of this register is assured by Trust officers and internal and external audit. The Chief Finance Officer/Chief Informatics Officer will produce an Annual Report for the Finance and Performance Committee summarising the assets of the Trust, identifying those required for the provision of CRS services. The Trust's SFIs require Board authorisation.
	4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.	CFO	The Board is aware of this requirement. The ability of the Trust to continue as a going concern is reviewed annually by the Audit Committee, Finance and Performance Committee and by the Board. The Board would inform its external auditors and NHS England and Improvement, previously Monitor, if it was concerned about its ability to do so.
	5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except: (a) with the consent in writing of Monitor, and (b) in accordance with the paragraphs 6 to 8 of this Condition.	CFO	If the Board were concerned about the Trust's ability to continue as a going concern they would seek advice and consent from NHS England and Improvement, previously Monitor even if a formal notice had not been issued and would ensure that the organisation complied with conditions 6-8.
	6. The Licensee shall furnish Monitor with such information as Monitor may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.	CFO	The Board is aware of this requirement and will ensure compliance.
	7. Where consent by Monitor for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.	CFO	The Board is aware of this requirement and will ensure compliance.
	8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:	CFO	The Board is aware of this requirement and will ensure compliance.

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	(a) Monitor has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to: (i) transactions of a specified description; or (ii) the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or (b) the Licensee is required by the Care Quality Commission to dispose of a relevant asset.		
	9. In this Condition: "disposal" means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;	CFO	Definition noted and understood.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	"relevant asset", means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced; "relinquishment of control", includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.		
	10. The Licensee shall have regard to such guidance as may be issued from time to time by Monitor regarding: (a) the manner in which asset registers should be established, maintained and updated, and (b) property, including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.	CFO	The Board is aware of this requirement and the Chief Finance Officer is accountable to the Board for maintaining information systems which comply with the requirements of the organisation and the requirements of NHS England and Improvement, previously Monitor, and other key external stakeholders.
CoS3 Standards of corporate governance and financial management			
	1. The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as: (a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and (b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.	CFO/CEO	The Board is aware and will comply with this condition. The Trust will ensure governance and reporting arrangements are in place to maintain the capacity to deliver the Commissioner Requested Services. These will be subject to annual, quarterly (monthly) report to NHS Improvement, previously Monitor. The Trust will give assurance over its status as a going concern through its quarterly reporting and annual self-certification to NHS England and Improvement, previously Monitor.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
			For the year in question, after making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. This is based on the public sector interpretation as defined within the Government's Financial Reporting Manual and the Foundation Trust Annual Reporting Manual. Assurance is via the Trust's performance management reporting framework, the mandatory in year and annual reporting as required by NHS England and Improvement, previously Monitor, the Board certification process and regular external governance review.
	2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: (a) such guidance as Monitor may issue from time to time concerning systems and standards of corporate governance and financial management; (b) the Licensee's rating using the risk rating methodology published by Monitor from time to time, and (c) the desirability of that rating being not less than the level regarded by Monitor as acceptable under the provisions of that methodology.	CFO/CNO	The Board is aware and will comply with this condition. The Trust complies with the principles of corporate governance, the Code of Governance and its Constitution. The Trust will act on any new guidance or code of practice issued by NHS England and Improvement, previously Monitor as appropriate. Assurance is via the Board certification process and annual external governance review. The risk ratings will be calculated using NHS England and Improvement's, previously Monitor's methodology and notification made to that organisation.
CoS4 Undertaking from the ultimate controller			
	1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the	CFO	The Board is aware of this requirement and will ensure via the Chief Finance Officer that this requirement is built into standard contracts / agreements with an ultimate controller.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	Licensee, in the form specified by Monitor, that the ultimate controller ("the Covenantor"): (a) will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the 2012 Act or this Licence, and (b) will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to Monitor.		
	2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.	CFO	The Board is aware of this requirement and will ensure via the Chief Finance Officer that this requirement is built into standard contracts / agreements with ultimate controller.
	3. The Licensee shall: (a) deliver to Monitor a copy of each such undertaking within seven days of obtaining it; (b) inform Monitor immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and (c) comply with any request which may be made by Monitor to enforce any such undertaking.	CFO	The Board is aware of this requirement and will ensure via the Chief Finance Officer that NHS England and Improvement, previously Monitor is informed.
	4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:	CFO	Definition noted and understood.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	(a) directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and (b) that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.		
	5. A person is not an ultimate controller if they are: (a) a health service body, within the meaning of section 9 of the 2006 Act; (b) a Governor or Director of the Licensee and the Licensee is an NHS foundation trust; (c) any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or (d) a trustee of the Licensee and the Licensee is a charity.	CFO	Definition noted and understood.
CoS5 Risk pool levy			
	1. The Licensee shall pay to Monitor any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.	CFO	The Board will comply with any requirements imposed by NHS England and Improvement, previously Monitor in accordance with the legislation.
	2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by Monitor.	CFO	The Board will comply with any requirements imposed by NHS England and Improvement, previously Monitor in accordance with the legislation.
CoS6 Co-operation in the event of financial stress			
	1. The obligations in paragraph 2 shall apply if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the	CFO	The Board is aware of this requirement and will ensure compliance with this section.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	Licensee to carry on as a going concern.		
	2. When this paragraph applies the Licensee shall: (a) provide such information as Monitor may direct to Commissioners and to such other persons as Monitor may direct; (b) allow such persons as Monitor may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and (c) co-operate with such persons as Monitor may appoint to assist in the management of the Licensee's affairs, business and property.	CEO	The Board is aware of this requirement and will ensure compliance with this section.
CoS7 Availability of resources			
	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.	CEO	The Board is aware of this requirement and has governance processes in place via its committees to ensure compliance
	2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	CEO (CFO)	The Board is aware of this requirement and will comply with this condition
	3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it	CFO	The Board is aware of this requirement and will include its approval on the Governance cycle of the Audit Committee and the Board. The Chief Finance Officer will be required to provide assurance and supporting evidence that the Board is able to confirm the relevant certificate at the same time and in the same way as evidence is provided to confirm going concern status.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services". (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".		
	4. The Licensee shall submit to Monitor with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	CFO	The Board is aware of this requirement and will include its approval on the Governance cycle of the Audit Governance Committee and the Board. The Chief Finance Officer will be required to provide assurance and supporting evidence that the Board is able to confirm the relevant certificate at the same time and in the same way as evidence is provided to confirm going concern status.
	5. The statement submitted to Monitor in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.	CFO	The Board is aware of this requirement and will include its approval on the Governance cycle of the Audit Committee and the Board.
	6. The Licensee shall inform Monitor immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.	CFO	The Board is aware of this requirement and will inform NHS Improvement, previously Monitor of any change in their expectations / forecasts.
	7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.	CFO	The Certificate will be published as part of the Annual Report and Accounts.
	8. In this Condition: "distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;	CFO	Definition noted and understood.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	"Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts; "Required Resources" means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.		
Section 6 NHS Foundation Trust Conditions will apply only to NHS foundation trusts.			
FT1 Information to update the register of NHS foundation trusts			
	1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	CEO	The Board is aware of these obligations and will comply with this condition.
	2. The Licensee shall ensure that Monitor has available to it written and electronic copies of the following documents: (a) the current version of Licensee's constitution; (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and (c) the Licensee's most recently published annual report, and for that purpose shall provide to Monitor written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in	CEO (Co Sec) CFO CFO	The Board is aware of these obligations and will comply with this condition. These documents are lodged with NHS England and Improvement, previously Monitor. Processes are already in place to ensure compliance. Processes are already in place to ensure compliance.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	sub-paragraphs (b) and (c) within 28 days of being published.		
	3. Subject to paragraph 4, the Licensee shall provide to Monitor written and electronic copies of any document that is required by Monitor for the purpose of Section 39 of the 2006 Act within 28 days of the receipt of the original document by the Licensee.	CEO (ALL)	The Board is aware of this obligation and will comply with this condition.
	4. The obligation in paragraph 3 shall not apply to: (a) any document provided pursuant to paragraph 2; (b) any document originating from Monitor; or (c) any document required by law to be provided to Monitor by another person.	CEO	The Board notes the limitations on this condition.
	5. The Licensee shall comply with any direction issued by Monitor concerning the format in which electronic copies of documents are to be made available or provided.	CEO (ALL)	The Board is aware of these requirements and shall comply.
	6. When submitting a document to Monitor for the purposes of this Condition, the Licensee shall provide to Monitor a short written statement describing the document and specifying its electronic format and advising Monitor that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act**.**	CEO (ALL)	The Board is aware of these requirements and shall comply.
FT2 Payment to Monitor in respect of registration and related costs			
	1. The obligations in the following paragraph of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	CFO	The Board is aware of this requirement and will comply with NHS England and Improvement's, previously Monitor's requirements.
	2. Whenever Monitor determines in accordance with section 50 of the 2006 Act that the Licensee must pay to Monitor a fee in respect of Monitor's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to Monitor within 28 days of the fee being notified to the Licensee by Monitor in writing.	CFO	The Board is aware of this requirement and will comply with NHS England and Improvement's, previously Monitor's requirements.
FT3 Provision of information to advisory panel			

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	1. The obligation in the following paragraph of this Condition applies if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	CFO	The Board is aware of this requirement and will comply with NHS England and Improvement's, previously Monitor's requirements.
	2. The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the 2006 Act.	CFO	The Board is aware of this requirement and will comply with NHS England and Improvement's, previously Monitor's requirements.
FT4 NHS foundation trust governance arrangements			
	1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	CEO	The Board is aware of this condition.
	2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	CEO	The Board is aware of this condition.
	3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and (b) comply with the following paragraphs of this Condition.	CEO	The Board is aware and will comply with this condition. The Trust complies with the principles of corporate governance, the Code of Governance and its Constitution. The Trust will act on any new guidance or code of practice issued by NHS England and Improvement as appropriate.
	4. The Licensee shall establish and implement: (a) effective board and committee structures; (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) clear reporting lines and accountabilities throughout its organisation.	CEO CEO (ALL) CEO/COO (CoSec)	The Board is aware and will comply with this condition. The board and committee structures are reviewed in line with NHS England and Improvement's, previously Monitor's code of governance. The reservations and delegations of powers and SFIs are set out and all committees have terms of reference. The Trust maintains a clear map of its organisational structure and this is communicated widely.
	5. The Licensee shall establish and effectively implement systems and/or processes:		The Board is aware and will comply with this condition.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	CEO	Effective systems shall be overseen via the Board and its committee
	(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;	CEO	Timely and effective scrutiny and oversight shall be achieved by means of approved Board and committee governance cycles
	(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	COO/CPO	Compliance and exceptions to compliance on all health care standards relevant to the Trust shall be presented to the Board. The Board shall receive an annual assurance of compliance with the Quality Governance Framework.
	(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	CEO (CNO)	Information for decision-making shall be disseminated via the approved Board committee and governance cycles and SFIs and management accounting processes.
	(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	CEO	Information is disseminated to Board and committees with approved governance cycles.
	(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	CNO	Material risks shall be identified and managed as part of the Board Assurance Framework, as overseen by the Board and its committees. The Board shall receive and approve an annual assurance framework. The assurance framework shall be regularly updated and reported.
	(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	CEO	The Board receives regular Integrated Performance Reporting/Board Assurance and risk reports
	(h) to ensure compliance with all applicable legal requirements.	Co Sec	All legal requirements in regards to the licence and FT governance will be complied with.
	6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:		The Board notes and will comply with this condition.

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	CEO (CNO)	The Board has identified responsibilities for the Chief Nursing Officer and Chief Medical Officer and non-executives. The Board and the Quality Committee consider quality indicators and quality impact assessments in decision making The Board and the Quality Committee consider quality indicators and quality impact assessments in decision making The Board uses its auditors to scrutinise and report on data quality of the quality indicators The Board holds public meetings, hears patient stories, has listening events and offers a number of patient/public forums/groups and uses the output to improve its services. The accountability for quality is clearly articulated in the Trust's structures, philosophy and reporting. Staff are regularly updated on their quality responsibilities.
	(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	CEO (CNO)	
	(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;	CEO (CNO)	
	(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	CEO (CNO)	
	(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	CNO	
	(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	CNO	
	7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified	CEO (CPO)	The Board is aware and will comply with this condition. The composition of the Board has been agreed and is working effectively. The composition of the Board of the new organisation was presented in January 2021. Effectiveness

CONDITIONS		LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
	to ensure compliance with the Conditions of this Licence.		will be reviewed regularly by means of the Annual Governance review, supported by a Board Development Plan, the latter of which has been in place since October 2020..
	8. The Licensee shall submit to Monitor within three months of the end of each financial year: (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and (b) if required in writing by Monitor, a statement from its auditors either: (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.	CFO	The Board is aware of this requirement and will comply with NHS England and Improvement's, previously Monitor's requirements. The Chief Finance Officer is responsible for ensuring compliance and already has confirmed process in place.
Section 7 Interpretation and Definitions			
D1 Interpretation and Definitions			
	1. In this Licence, except where the context requires otherwise, words or expressions set out in the left hand column of the following table have the meaning set out next to them in the right hand column of the table. "the 2006 Act" | the National Health Service Act 2006 c.41;		

CONDITIONS				LEAD EXEC	NARRATIVE OF ASSESSMENT/ASSURANCE OF COMPLIANCE
		"the 2008 Act"	the Health and Social Care Act 2008 c.14;		
		"the 2009 Act"	the Health Act 2009 c.21;		
		"the 2012 Act"	the Health and Social Care Act 2012 c.7;		
		"the Care Quality Commission"	the Care Quality Commission established under section 1 of the 2008 Act;		
		"clinical commissioning group"	a body corporate established pursuant to section 1F and Chapter A of Part 2 of the 2006 Act;		
		Commissioner Requested Service"	a service of the sort described in paragraph 2 or 3 of condition G9 which has not ceased to be such a service in accordance with paragraph 9 of that condition;		
		"Commissioners"	includes the NHS Commissioning Board and any clinical commissioning group;		
		"Director"	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, or (ii) a company constituted under the Companies Act 2006;		
		"Governor"	includes any person who, in any organisation, performs the functions of, or functions equivalent or trust as specified by statute;		
		"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act and the 2012 Act;		
		"NHS Commissioning Board"	the body corporate established under section 1E of, and Schedule A1 to, the 2006 Act;		
		"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act.		
	2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.				
	3. Unless the context requires otherwise, words or expressions which are defined in the 2012 Act shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.				
	4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.				

ANNEX 1

REFERENCES

Reference	Extract/ website link	Condition ref
Health and Social Care Act 2012		
Section 96(2)	Monitor may only exercise a function to which this section applies—	G1, G2, G3, G5

Reference	Extract/ website link	Condition ref
	(a) for the purpose of regulating the price payable for the provision of health care services for the purposes of the NHS; (b) for the purpose of preventing anti-competitive behaviour in the provision of health care services for those purposes which is against the interests of people who use such services; (c) for the purpose of protecting and promoting the right of patients to make choices with respect to treatment or other health care services provided for the purposes of the NHS; (d) for the purpose of ensuring the continued provision of health care services for the purposes of the NHS; (e) for the purpose of enabling health care services provided for the purposes of the NHS to be provided in an integrated way where Monitor considers that this would achieve one or more of the objectives referred to in subsection; (f) for the purpose of enabling the provision of health care services provided for the purposes of the NHS to be integrated with the provision of health-related services or social care services where Monitor considers that this would achieve one or more of the objectives referred to in subsection; (g) for the purpose of enabling co-operation between providers of health care services for the purposes of the NHS where Monitor considers that this would achieve one or more of the objectives referred to in subsection; (h) for purposes connected with the governance of persons providing health care services for the purposes of the NHS; (i) for purposes connected with Monitor's functions in relation to the register of NHS foundation trusts required to be maintained under section 39 of the National Health Service Act 2006; (j) for purposes connected with the operation of the licensing regime established by this Chapter; (k) for such purposes as may be prescribed for the purpose of enabling Monitor to discharge its duties under section 62. (3) The objectives referred to in subsection (2)(e), (f) and (g) are— (a) improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, (b) reducing inequalities between persons with respect to their ability to access those services, and (c) reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.	
Chapter 4 (Pricing) Part 3	http://www.legislation.gov.uk/ukpga/2012/7/part/3/chapter/4/enacted	P1, P2
Section 116	http://www.legislation.gov.uk/ukpga/2012/7/section/116	P4
Section 124	http://www.legislation.gov.uk/ukpga/2012/7/section/124	P5
Section 135(2)	In order to raise money for investment in a fund it establishes under this section, Monitor may impose requirements on providers or commissioners.	CoS5

Reference	Extract/ website link	Condition ref
Section 139(1)	The power under section 135(2) includes, in particular, power to impose a levy on providers for each financial year.	CoS5
Section 143(10)	If the whole or part of the amount which a person is liable to pay is not paid by the date by which it is required to be paid, the unpaid balance carries interest at the rate for the time being specified in section 17 of the Judgments Act 1838; and the unpaid balance and accrued interest are recoverable summarily as a civil debt (but this does not affect any other method of recovery).	CoS5
National Health Act 2006		
Section 9	http://www.legislation.gov.uk/ukpga/2006/41/section/9	G9, CoS4
Paragraph 23(4) Schedule 7	But a person may not be appointed as auditor unless he (or, in the case of a firm, each of its members) is a member of one or more of the following bodies— (a) the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998 (c. 18), (b) any other body of accountants established in the United Kingdom and approved by the regulator for the purposes of this paragraph.	P2
Section 39	http://www.legislation.gov.uk/ukpga/2006/41/section/39	FT1, FT2, FT3
Section 50	An authorisation may require an NHS foundation trust to pay a reasonable annual fee to the regulator.	FT2
Company Directors' Disqualification Act 1986	http://www.legislation.gov.uk/ukpga/1986/46/contents	G4.5
Section 1, Insolvency Act 1986	http://www.legislation.gov.uk/ukpga/1986/45/contents	G4.5
Terms of Authorisation condition 7(1)	The Trust is required to provide for the purposes of the health service in England the goods and services listed in Schedule 2 in the volumes or amounts specified therein ("**mandatory goods and services"**) which goods and services in the volumes or amounts specified are to be provided pursuant to a legally binding contract or contracts between the Trust and one or more of the commissioning bodies, or on the understanding that the Trust and the relevant commissioning body or bodies will conclude a legally binding contract or contracts for the provision of said goods and services in the volumes or amounts specified within 12 months of the date on which this authorisation comes into force. This requirement includes an obligation to provide any ancillary services, accommodation and other facilities related to said goods and services and which are generally accepted to be required for the effective, efficient and economic provision of said goods and services in the volumes or amounts specified.	G9

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 10.6

Subject:	Draft 2020/21 Code of Governance Comply or Explain

Prepared by:	Executive Directors and Carrie Stone, Company Secretary
Presented by:	Debbie Fleming, Chief Executive

Purpose of paper:	To present for scrutiny the Board assessment assuring compliance or otherwise with Monitor's (now NHS Improvement) revised Code of Governance – July 2014
Background:	The draft compliance report was scrutinised by the Audit Committee on 18 March 2021 prior to presentation to the Board and ahead of the required explanations for the Trust's Annual Report.
Key points for members:	As part of the Trust's conditions as a Foundation Trust the Board of Directors is required to give explanation in the Annual Report for any non-compliance of Monitor's Code of Governance. The Trust is currently reporting for the period 2020/21 and the current assessment is compliance of all elements of the code which are applicable to the Trust
Options and decisions required:	To approve the current assessment of compliance with the code.
Recommendations:	The Board is asked to approve the report and assessment of compliance.
Next steps:	Extracts of the comply or explain document will be included in the UHD 2020/21 Annual Report.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well-Led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	18/03/2021

`UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

CODE OF GOVERNANCE COMPLY/EXPLAIN FOR 2020/21 ANNUAL REPORT

(*WORKING DOCUMENT for scrutiny to Audit Committee March 2021 & then to BoD for Approval March 2021)*

SECTION A: LEADERSHIP

A.1 The role of the board of directors

Main Principles		How Applied
A.1.a	Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation trust.	The directors believe that it is essential that the trust should be both led and controlled by an effective board of directors. The board of directors has adopted a formal statement of its powers, duties and responsibilities within the annual report.
A.1.b.	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 organisation so as to maximise the benefits for the members of the trust as a whole and for the public.	The board of directors collectively and each director individually will act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

Supporting Principles		How Applied
A.1.c.	The role of the board of directors is to provide entrepreneurial leadership of the NHS foundation trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.	The board of directors shall provide entrepreneurial leadership and ensure that an effective system of internal processes, procedures and controls is in place at all times. Such a system shall be used to identify and manage risks that threaten the fulfilment of business objectives.
A.1.d.	The board of directors is responsible for ensuring compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.	The board of directors shall ensure compliance with statutory requirements and contractual obligations and its licence, its constitution and mandatory guidance issued by Monitor, now NHS Improvement (NHSI).

Supporting Principles		How Applied
A.1.e.	The board of directors should develop and articulate a clear "vision" for the trust. This should be a formally agreed statement of the organisation's purpose and intended outcomes which can be used as a basis for the organisation's overall strategy, planning and other decisions.	The board of directors shall develop and articulate a clear vision for the trust. This agreed vision shall be written for the strategies and planning processes and will be used as a basis for the organisation's overall strategy planning and other decisions.
A.1.f.	The board of directors should set the NHS foundation trust's strategic aims at least annually taking into consideration the views of the council of governors, ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.	Taking into consideration the council of governors' view through the full council, the board of directors shall agree business and strategic plans for the trust that shall be reviewed against performance and refreshed at least annually (see governance cycle) with a view to ensuring that the necessary financial and human resources are in place for the trust to meet its main priorities and objectives. The operational plan is shared with the council of governors annually. As part of the work leading up to merger on 1 October 2020, the Trust agreed its strategic objectives for the new organisation. In developing the new organisation the Trust set out its vision, mission and values, taking into account the views of the two Councils of Governors and the clinical leadership of the two legacy Foundation Trusts. The Vision and Values were approved by the Board in October 2020. The strategic objectives were subsequently reviewed against a new Board Assurance Framework (BAF). The BAF was produced in line with the review and was endorsed by the Shadow Interim Board in September 2020. An accountability framework for the new organisation was developed and endorsed by the Shadow Interim Board. The board of directors shall evaluate critically on a regular basis its own performance. Both executive and non-executive directors undertake an annual appraisal.

Supporting Principles		How Applied
A.1.g.	The board of directors as a whole is responsible for ensuring the quality and safety of health care services, education, training and research delivered by the NHS foundation trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies.	The board of directors ensures the quality and safety of health care services, education, training, and research delivered by the trust and applies the principles of clinical governance set out by the Department of Health, the Care Quality Commission and NHSI's quality governance framework. There is a schedule of matters reserved for the board's decision.
A.1.h.	The board of directors should also ensure that the NHS foundation trust functions effectively, efficiently and economically.	The board of directors ensures the Trust operates effectively, efficiently and economically. Performance is overseen by the Finance and Performance Committee where regular reports on productivity and efficiency, operational performance and financial performance are considered.
A.1.i.	The board of directors should set the NHS foundation trust's vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met.	The board of directors shall publish the Trust's mission, vision, values and standards of conduct within its annual/operational plan, business and strategic plans and the annual report. The operational plan is shared with the council of governors at a public meeting and local stakeholders. Members and patients can access the Trust's vision, values and standards of conduct via the website.
A.1.j.	All directors must take decisions objectively in the best interests of the NHS foundation trust and avoid conflicts of interest.	Avoiding conflict of interests, directors shall take decisions objectively in the interests of the Trust.
A.1.k.	All members of the board of directors have joint responsibility for every decision of the board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the chief executive as the accounting officer.	Recognising the responsibilities of the CEO as the accounting officer the board of directors shall operate as a unitary board. The non-executive and executive directors share the same liability for board decisions.
A.1.l.	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.	The board of directors expects and receives constructive challenge from all of its directors and help to develop proposals on priorities, risk management, values, standards and strategy.

Supporting Principles		How Applied
A.1.m.	As part of their role as members of a unitary board, all directors have a duty to ensure appropriate challenge is made. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. Non-executive directors are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing executive directors, and in succession planning.	The non-executive directors are aware of the duty to ensure challenge. The non-executives will also through receiving adequate information, monitor the reporting of performance (financial, clinical quality, governance and risk) ensuring mechanisms are robust and scrutinise the performance of the executive management in meeting the agreed goals and objectives. The board of directors has an appointments and remuneration committee (Register D27) consisting of non-executive directors to determine the levels and remuneration of executive directors. The board convenes the committee for appointment/renewal and where necessary removal of executives on an ad-hoc basis.

Code Provisions	Compliance Y/N	Evidence or Non Compliance Explanation

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.1.	The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors (as described in A.5). This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	YES	All in place: • Reservations and delegation of powers (Register D12) • Council of governors roles and responsibilities (Register E1) • Statement (dispute procedure) explaining how any disagreements between the council of governors and the board of directors will be resolved. • Board responsibility/operating/decision statement (Register B1/refer to annual report) • Statement board of directors/council of governors engagement policy October 2020 (Register D7) • Governance cycles (Register D17 & E12a)
A.1.2.	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent directors (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	YES	All details held within the annual report. (Register B2) Meetings and attendance registers for board and council. (Register B2 & D6)
A.1.3.	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	YES	The Trust has a statement which is included within the annual report.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.4.	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	YES	The Trust has the following reporting systems: • Trust Management Group • Board (BoD, Finance & Performance, Workforce Strategy, Quality, Audit, Transformation and Sustainability Committees) • Integrated Performance Report • ¼ Care Group Performance Reviews • Submissions to NHSI (or as required) • CQC
A.1.5.	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice for example from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	YES	Progress and delivery of key performance targets are assessed by monthly reporting against a range of metrics. If necessary the board would seek external independent advice to provide an adequate and reliable level of assurance. The annual internal audit work plan is developed taking into account key quality indicators and the Trust's risk register.
A.1.6.	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where, within the structure of the organisation, consideration of clinical governance matters occurs.	YES	The Trust has a quality committee that considers clinical governance and clinical improvement matters. The committee is chaired by a non-executive director and reports to the board of directors. The executive leads for clinical governance are the Chief Medical Officer and Chief Nursing Officer. The Trust has an operational Quality Governance group chaired by the Chief Medical Officer and this group reports into the quality committee.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.7.	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	YES	The chief executive, as the accounting officer, has confirmed in writing to the chairman her understanding of the responsibilities as set out in the memorandum in a letter dated 15 December 2020.
A.1.8.	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (*The Nolan Principles*).	YES	The trust has a mission and vision and values statements for all staff. The values were developed using appreciative inquiry to listen to staff and patients in order to understand what they valued most. The board of directors subsequently approved the Values in October 2020. The board of directors approve and sign up to the trust's code of conduct which includes the Nolan principles. (Register D1)

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.9.	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	YES	The board of directors approved and signed up to the Trust's code of conduct. (Register D1) The board of directors meetings are split into two sessions – the first being held in public. Agendas, minutes and supporting papers to the public part of the board meetings are available on the Trust's website. The agenda for the private meeting of the board meeting is also published on the website. Draft part 1 minutes of the board are shared with the council of governors when available and approved, private part 2 minutes (redacted if necessary). The chairman and chief executive provide a briefing to the governors on areas as appropriate from the private part 2 board of directors meetings.
A.1.10.	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	YES	The Trust holds liability insurance for the directors. It is not intended to extend this insurance to cover governors as it is felt that the risks of liability are very small.

A.2 Division of responsibilities

Main Principles		How Applied
A.2.a	There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the boards of directors and the council of governors, and the executive responsibility for the running of the NHS foundation trust's affairs. No one individual should have unfettered powers of decision.	The responsibilities are clearly defined within the constitution and powers of delegation. No one person has unfettered powers.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.2.1.	The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the board of directors.	YES	The chairman and chief executive's clear division of responsibility is set out in a public statement supported by job descriptions.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.2.2.	The roles of chairperson and chief executive must not be undertaken by the same individual.	YES	The roles of chairman and chief executive are not undertaken by the same individual.

A.3 The chairperson

Main Principles		How Applied
A.3.a	The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.	The chairman shall lead the board of directors and the council of governors. The board of directors and council of governors shall be subject to performance review. The chairman shall invite contributions to setting the agendas for both the board and council.

Supporting Principles		How Applied
A.3.b.	The chairperson is responsible for leading on setting the agenda for the board of directors and the council of governors and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	The chairman sets the agenda for the board of directors and council of governors in line with the governance cycle and current business affairs of the Trust and adequate time is available for discussion of all agenda items, in particular strategic issues.
A.3.c.	The chairperson is responsible for ensuring that the board and council work together effectively.	The chairman shall ensure that the board and council work effectively through informal and formal communication routes.
A.3.d.	The chairperson is also responsible for ensuring that directors and governors receive accurate, timely and clear information which enables them to perform their duties effectively. The chairperson should take steps to ensure that governors have the skills and knowledge they require to undertake their role.	The chairman shall ensure that the agenda and papers for both parties are available in line with the requirements of the constitution. The chairman shall take steps to ensure that governors have the skills and knowledge they require to undertake their role**.** This will include access to a comprehensive induction process and development training events.
A.3.e.	The chairperson should promote effective and open communication with patients, service users, members, staff, the public and other stakeholders.	The chairman shall ensure there is open and effective communications through the Trust's communication strategy which includes newsletters, briefings and reporting.

Supporting Principles		How Applied
A.3.f.	The chairperson should also promote a culture of openness and debate by facilitating the effective contribution of non-executive directors, in particular and ensuring constructive relations between executive and non-executive directors.	The chairman shall promote a culture of openness and debate by facilitating effective contribution and constructive and productive relations between executive and non–executive directors and board and council. There is a link between the non-executive director committee chairmen and the lead executive director for that committee. This arrangement means that non-executive directors and executive directors establish relationships based on appropriate advice, challenge and support. Governors are able to observe part 1 of the board and ask questions of the board of directors. They are also provided with a briefing after part 2 of the board meeting and receive the approved part 2 minutes. Executives and non-executives shall be invited to attend the council of governor meetings and selected governor groups.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.3.1	The chairperson should, on appointment by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	YES	Criteria met.

A.4 Non-executive directors

Main Principles		How Applied
A.4.a	As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.	Non-executive directors are aware they should constructively challenge and help develop proposals on strategy. Non-executives will promote the functioning of a unitary board. The non-executive and executive directors share the same liability for board decisions. The board of directors expects constructive challenge from all of its directors and help to develop proposals on priorities, risk management, values, standards and strategy.

Supporting Principles		How Applied
A.4.b.	Non-executive directors should scrutinise the performance of management in meeting agreed goals and objectives, and monitor the reporting of performance. They should satisfy themselves on the integrity of financial information and that financial controls and systems of risk management are robust and defensible. They are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing executive directors, and in succession planning.	The non-executive directors are aware of the duty to ensure challenge. The non-executives will also through receiving adequate information, monitor the reporting of performance (financial, clinical quality, governance and risk) ensuring mechanisms are robust and scrutinise the performance of the executive management in meeting the agreed goals and objectives. The board of directors has an appointments and remuneration committee (Register D27) consisting of non-executive directors to determine the levels and remuneration of executive directors and convenes a committee meeting for appointment/renewal and where necessary removal of executives on an ad-hoc basis**.**

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	YES	Senior independent director appointment is made in consultation with council of governors. Senior independent director's job description. (Register D24 and Constitution: Annex 7).
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate.	YES	The chairman meets with non-executive directors without executives present. The senior independent director meets with the non-executive directors without the chairman present. This is included in the performance processes agreed by the council of governors.
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	YES	All directors are aware of responsibilities and mechanisms. Details of concerns or actions are recorded in the board minutes.

A.5 Governors

Main Principles	How Applied

A.5.a	The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.	The council of governors receive performance reports and scrutinises possible and actual breaches of the provider licence. Following elections to the Council of Governors for the new organisation, governors were invited to nominate themselves to observe the Board committees, to strengthen their duty to hold non-executive directors to account. The terms of reference of each committee includes the attendance of one governor in an observer role. Strategy and the priorities and objectives of the trust shall be the responsibility of the board of directors.
A.5.b.	The council of governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.	The Trust shall have a council of governors comprising: • 17 elected • 5 appointed • 5 staff The governors shall be issued with and sign a code of conduct. (Register E2)
A.5.c.	Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.	Governors regularly feedback informally about the Trust and its vision and performance to members, the public and stakeholder organisations. The council of governors has a membership and engagement recruitment group that agrees a programme of events and engagement opportunities. Governors will also have their own column within the staff and member newsletter.

Supporting Principles		How Applied
A.5.d.	Governors should discuss and agree with the board of directors how they will undertake these and any other additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the local community and emerging best practice.	The council of governors shall agree its roles and responsibilities including additional roles. (Register E1)
A.5.e.	Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors must be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.	The council of governors shall be presented with, the annual report and accounts and annual plan at a general meeting. The council of governors shall be consulted on the development of forward plans and any significant changes to delivery of the Trust's business plan through the council of governors.
A.5.f.	Governors should use their voting rights (including those described in A.5.14 and A.5.15) to hold the non-executive directors individually and collectively to account and act in the best interest of patients, members and the public. If the council of governors does withhold consent for a major decision, it must justify its reasons to the chair and the other non-executive directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust. The council of governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.	The governors voting rights are set out in the constitution including partial reference to code provisions A.5.14 and A.5.15. Governors are aware of their roles and responsibilities reported in the Trust's constitution which is provided to governors at induction. The governors have to sign on appointment a register of interests, eligibility to vote declaration and a code of conduct which includes the Nolan principles.

Code provision	Compliance Y/N	Evidence or Non Compliance Explanation

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.1.	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	YES	See Annex 5 of the constitution. The Council of Governors meeting schedule and governance cycle indicates meeting four times a year. Meetings are held early evening to accommodate the majority of governors.
A.5.2.	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the council of governors should be reviewed regularly as described in provision B.6.5.	YES	See Annex 3 of the constitution. The council has 27 members and the roles, structure and composition of the council are set out in the constitution which will be the subject of regular revision.
A.5.3.	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	YES	The annual report identifies members of the council of governors and the supporting details. Council record of attendance is maintained by the Corporate Governance Manager: Committees and Governors (Register B5) and an annual register will be available on the website. The Trust will identify a lead governor in April 2021. The role and responsibilities have been agreed.
A.5.4.	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	YES	The constitution includes roles and responsibilities of the council of governors and is available on the website.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.5.	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant director present at the meeting about the affairs of the NHS foundation trust.	YES	The chairman is responsible for leadership of both the board of directors and the council of governors. The council of governors' agenda, minutes and annual report for attendance of executive and non-executive directors demonstrates the attendance of the chief executive and relevant executive directors, at the council of governors meeting. The Senior Independent Director attends the council of governors' meetings.
A.5.6.	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the *new provider licence* or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	YES	See engagement policy and board and council dispute statement. (Register D7 and D7a) The Trust has appointed a senior independent director which is endorsed by the council of governors.
A.5.7.	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	YES	There is a governance cycle for the Council of Governors. The agenda is set by the chairman of the council of governors in line with the constitution. Individual governors have the opportunity to pose questions to the board of directors and add items to the council agendas. Agendas, papers and other information are provided to the governors in a timely manner with clear and unambiguous language.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.8.	The council of governors should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	YES	See constitution clause 24. Board of directors and council of governors' engagement policy and dispute statement. (Register D7 and D7a)
A.5.9.	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example clinical statistical data and operational data.	YES	See council of governors' agenda, minutes and governance cycle. A performance report is presented to the governors at their meeting.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.10.	The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.	YES	The council of governors hold non-executive directors to account for performance of the board of directors through the performance reporting. The Governor's Nominations, Remuneration and Evaluation Committee (NREC) will receive the outcome of the chairman and non-executive director appraisals in July 2021. The council also receives informally, reports from the non-executive director chairmen of board committees and a nominated governor for each board committee observes the meetings.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.11.	The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the *NHS Foundation Trust Annual Reporting Manual*: (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report.	YES	The governors receive, once laid before parliament: (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report.
A.5.12.	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	YES	The governors are provided with an agenda before all meetings of the board of directors and receive a briefing on part 2 matters. Governors are provided with the minutes of private sessions (redacted where necessary) of board meetings, following their approval. Governors recognise and respect the confidentiality of the "part 2" information.
A.5.13.	The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust's or directors' performance.	YES	Directors accept the council of governors may require their attendance at a meeting of the council.
A.5.14.	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way.	Not applicable	The right to refer a question to the independent panel for advising governors is not used. NHS Improvement advised in January 2017 that the panel had been disbanded as no substantive questions had been put to the panel in over three years.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.15.	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These new voting powers require: • More than half of the members of the board of directors who vote and more than half of the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust. • More than half of governors who vote to approve a significant transaction. • More than half of all governors to approve an application by a trust for a merger, acquisition, separation or dissolution. • More than half of governors who vote, to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income. • Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions. NHS foundation trusts are permitted to decide themselves what constitutes a "significant transaction" and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.	YES	These new rights and voting powers from the 2012 Act are enshrined within the constitution.

SECTION B: EFFECTIVENESS

B.1 The composition of the board

Main Principles		How Applied
B.1.a.	The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.	The board of directors and its committees will have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.

Supporting Principles		How Applied
B.1.b.	The board of directors should be of sufficient size that the requirements of the organisation can be met and that changes to the board's composition and that of its committees can be managed without undue disruption, and should not be so large as to be unwieldy.	The board comprises of the non-executive Chairman, 7 non-executive and 8 executive directors.
B.1.c.	The board of directors should include an appropriate combination of executive and non-executive directors (and in particular, independent non-executive directors) such that no individual or small group of individuals can dominate the board's decision taking.	The board of directors has an appropriate combination of executive and non-executive directors. Power and information shall not be concentrated in one or two individuals and there shall be strong presence on the board of directors of both executive and non-executive directors.
B.1.d.	All directors should be able to exercise one full vote, with the chairperson having a second or casting vote on occasions where voting is tied.	All directors are able to exercise one full vote, with the chairman having a second or casting vote on occasions where voting is tied. This is enshrined within the constitution.

Supporting Principles		How Applied
B.1.e.	The value of ensuring that committee membership is refreshed and that undue reliance is not placed on particular individuals should be taken into account in deciding chairpersonship and the membership of committees. The value of appointing a non-executive director with a clinical background to the board of directors should be taken into account by the council of governors.	This shall be taken into account when deciding chairmanship and membership of committees. These entitlements shall be clear in the terms of reference of the board committees of: • audit committee; • appointments and remuneration committee; • finance and performance committee; • quality committee; • workforce strategy committee; • transformation committee; • sustainability committee. The council has appointed a non-executive director with clinical experience.
B.1.f.	Only the committee chairperson and committee members are entitled to be present at meetings of the nominations, audit or remuneration committees, but others may attend by invitation of the particular committee.	The terms of reference for the nominations, audit and remuneration committees ensure only the committee chairman and committee members are entitled to be present at the meeting, but others may attend by invitation of the particular committee.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
B.1.1.	The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director: • has been an employee of the NHS foundation trust within the last five years; • has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust; • has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme; • has close family ties with any of the NHS foundation trust's advisers, directors or senior employees; • holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; • has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or • is an appointed representative of the NHS foundation trust's university medical or dental school.	YES	Refer to annual report

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
B.1.2.	At least half the board of directors, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	YES	The board comprises of 8 executive directors and 7 non-executive directors and a non-executive Chairman. (Total 8 non-executives who are deemed independent)
B.1.3.	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	YES	No individual does.
B.1.4.	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	YES	The Annual Report and public statements will be published on the website following confirmation they have been laid before Parliament. (Register C1 & C2)

B.2 Appointments to the board

Main Principles		How Applied
B.2.a.	There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence.	The board of directors accepts that there should be a formal, rigorous and transparent procedure for the appointment of new directors. The Trust shall conform with legislation in appointing to the board of directors and on election of the council of governors. The council of governors has formalised and adopted terms of reference for a nominations, remuneration and evaluations committee.

Supporting Principles		How Applied
B.2.b	The search for candidates for the board of directors should be conducted, and appointments made, on merit, against objective criteria and with due regard for the benefits of diversity on the board and the requirements of the trust.	Board of directors appointments shall be made on merit based on objective criteria and terms of reference for the appointments committee and nominations, remuneration and evaluations committee.
B.2.c.	The board of directors and the council of governors should also satisfy themselves that plans are in place for orderly succession for appointments to the board, so as to maintain an appropriate balance of skills and experience within the NHS foundation trust and on the board.	The board of directors shall be satisfied through a regular board evaluation process. The Chairman, Non Executive Director and Chief Executive appointments were approved by the Council of Governors at the meeting held on 4 March 2021

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.1.	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.	YES	See terms of reference for the appointments and remuneration committee and nominations, remuneration and evaluations committee. (Register D27 & E13)

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.2	Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations	YES	The "fit and proper" persons test is installed within the constitution. The Board approved a Fit and Proper Persons Policy in 2020 for the new organisation. **For governors** A declaration is made on entering elections and taking up governorship. An annual declaration form is issued to governors. DBS checks for new governors are undertaken. **For directors (or equivalent)** Declaration made in signing contract of employment. Also evidenced by the signed end of year declaration form issued to all directors (or equivalent) – issued and held by the company secretary on behalf of the trust. DBS checks for new directors are undertaken and thereafter every three years.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.3.	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	YES	There are two committees: One for the appointment of chairman and non-executive directors: council of governors – nominations, remuneration and evaluation committee. (see ToR Register E13) One for the appointment of the executive directors: board of directors – appointments and remuneration committee. (see ToR Register D27) Both committees for their respective appointments evaluate the balance of skills, knowledge and experience of the board in preparing to make appointments to the board of directors.
B.2.4.	The chairperson or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.	YES	See terms of reference for nominations, remuneration and evaluations committee and appointments and remuneration committee (NREC). (Register E13 & D27) - for the appointment of non-executive directors the chairman chairs the NREC - for the appointment of a chairman the senior independent director chairs NREC.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.5.	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.	YES	See terms of reference for nominations, remuneration and evaluations committee and council of governors agendas and minutes. (Register E13) Process for the nomination of the chairman and non-executive directors has been agreed with the council of governors in March 2021.
B.2.6.	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	YES	See terms of reference for nominations, remuneration and evaluations committee. (Register E13)
B.2.7.	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	YES	See terms of reference for nominations, remuneration and evaluations committee. (Register E13)
B.2.8.	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive directors.	YES	The process followed will be described when required. (Register B7 & E13)
B.2.9.	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	YES	See terms of reference for nominations, remuneration and evaluations committee and appointments committee. (Register E13 & D26)

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.10.	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	YES	Statement within annual report An annual report of the nominations, remuneration and evaluations committee for the organisation shall be produced. (Register B8) The terms of reference of the committee are available on the website. The terms of reference of the appointments & remuneration committee are available on the website.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.11.	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	YES	Refer to constitution. Suitable candidates for executive director posts will be identified as part of the appointment process identified by the chairman and non-executive directors in the terms of reference of the appointments and remuneration committee. (See C.1.2 above).
B.2.12.	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	YES	See clause 26 of the constitution and council of governors' agendas and minutes on the appointment of the chief executive.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.	YES	See terms of reference for nominations, remuneration and evaluations committee (Register E13) and council of governors' agendas and minutes. Process for the nomination of the chairman and non-executive directors has been agreed with the council of governors.

B.3 Commitment

Main Principles		How Applied
B.3.a	All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.	The directors' contract of employment or contract of service sets out the requirement that all directors allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.3.1.	For the appointment of a chairperson, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chairperson of an NHS foundation trust, should be the substantive chairperson of another NHS foundation trust.	YES	See terms of reference for nominations, remuneration and evaluations committee. (Register E13) See annual report for any disclosures in regards to the chairman's any other significant duties.
B.3.2.	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	YES	Terms and conditions available for inspection from the Chief People Officer Nominations, remunerations and evaluation committee lead the process to ensure non-executive directors undertake that they have sufficient time to meet other commitments and significant commitments are disclosed before appointment.
B.3.3.	The board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.	YES	Executive directors comply.

B.4. Development

Main Principles		How Applied
B.4.a.	All directors and governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and governors should make every effort to participate in training that is offered.	Directors and governors are required to complete a comprehensive induction process. Directors are subject to individual annual appraisal and the council shall be subject to a collective annual evaluation. Both directors and governors participate in training that is offered.

Supporting Principles		How Applied
B.4.b.	The chairperson should ensure that directors and governors continually update their skills, knowledge and familiarity with the NHS foundation trust and its obligations to fulfil their role both on the board, the council of governors and on committees. The NHS foundation trust should provide the necessary resources for developing and updating its directors' and governors' skills, knowledge and capabilities.	All directors and governors shall have access to the advice and services of the company secretary, who shall be responsible for ensuring the board and council procedures are followed, and to securing independent professional advice, if required, at the Trust's expense. The trust provides the necessary resources for developing and updating the board and council skills, knowledge and capabilities.
B.4.c.	To function effectively, all directors need appropriate knowledge of the NHS foundation trust and access to its operations and staff.	All directors are given a comprehensive induction to the Trust and have access to its operations and staff.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.4.1.	The chairperson should ensure that new directors and governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.	YES	Induction programme, including a hospital tour with the Chief Nursing Officer. (Register D2 & E3) Directors have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.
B.4.2.	The chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the board.	YES	The chairman shall meet with each director and agree training and development needs relating to their role on the board.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.4.3.	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	YES	The governors receive a comprehensive induction programme. The council is subject to an annual review of its collective performance. The council has a development programme to ensure it has the skills and knowledge to discharge its duties appropriately. Ad hoc training sessions are also arranged as required.

B.5 Information and support

Main Principles		How Applied
B.5.a.	The board of directors and the council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties. Statutory requirements on the provision of information from the board of directors to the council of governors are provided in *Your statutory duties: A reference guide for NHS foundation trust governors*.	The board of directors and council of governors shall be supplied in a timely manner with such information in a form and of a quality appropriate for them to discharge their respective duties. For the council of governors this includes the statutory requirements.

Supporting Principles	How Applied

Supporting Principles		How Applied
B.5.b.	The chairperson is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and governors should seek clarification or detail where necessary.	The board shall receive a steady flow of information to enable it to discharge its duties, including a monthly report detailing current and forecast on financial and operations performance. Board papers shall be generally distributed not less than five days in advance of the relevant meeting to allow the directors fully to prepare for meetings, and minutes of committee meetings shall be circulated to all directors. The board shall be kept fully informed of developments within the trust through regular seminar presentations by management. The council of governors shall receive a steady flow of information to enable it to discharge its duties, including reports detailing the overall current and forecast financial and operational performance. Council of governors' papers shall be generally distributed not less than five days in advance of the relevant meeting to allow the governors fully to prepare for meetings, and minutes of committee meetings are circulated to all.

Supporting Principles		How Applied
B.5.c	The responsibilities of the chairperson include ensuring good information flows across the board, the council of governors and their committees, between directors and governors, and between senior management and non-executive directors, as well as facilitating appropriate induction and assisting with professional development as required.	The board shall receive regular updates on council of governors' views, via joint board and council development events and informal governor briefing attendance. All governors and directors receive an induction programme. Induction programmes for newly-appointed directors shall be devised to ensure that directors spend time with managers and visits to operational areas shall be included. Directors shall be subject to individual annual appraisals. The council of governors shall be subject to collective annual appraisals. There is an engagement policy in place for the board of directors and council of governors.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.5.1.	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	YES	The board and council are provided with agendas and supporting papers relevant to their need for knowledge and to the decisions they have to make. See the engagement policy, annual operational plan and annual report. The board has access to employees of the hospital as required to discharge their duties.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.5.2.	The board of directors, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	YES	The board of directors are aware of their obligations and commitments to the roles of executive or non-executive roles of the trust. The board will appoint where necessary relevant advisors where required. Information is supplied to the board of directors when requested: see board papers and minutes/action lists. Non-executive directors can and will utilise external assurance as required, particularly through the Audit Committee.
B.5.3.	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	YES	Independent advice available on request. The board has access to external sources of advice.
B.5.4.	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	YES	Support and resources in place for board of directors and council of governors. Budgets held by board and company secretary team.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.5.5.	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of an NHS foundation trust as they would in other similar roles.	YES	The non-executive directors receive agendas, papers and other correspondence in a timely and effective manner in line with the constitution. They are aware of their responsibilities to challenge recommendations or decisions of the board and utilise their full skills and experience. Non-executives can ask the board of directors for further information or reports that they consider useful.
B.5.6.	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	YES	The operational plan is reported to the finance and performance committee which includes governor attendance. The council of governors receives the operational plan in draft and subsequently final version. The board of directors is invited to attend the council of governors meetings. The annual report will contain a statement on how this requirement is undertaken.
B.5.7.	Where appropriate, the board of directors should take account of the views of the council of governors on the forward plan in a timely manner and communicate to the council of governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.	YES	The board of directors will consider and take account of the views of the council of governors on the NHS foundation trust's forward plan and communicate why they have or have not been incorporated.

Relevant statutory requirements	Compliance Y/N	Evidence or Non Compliance Explanation

B.5.8.	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan.	YES	The forward plan of the Trust is discussed with the council of governors. The board of directors has regard for the views of the council of governors on the Trust forward plans through these mechanisms.

B.6. Evaluation

Main Principles		How Applied
B.6.a.	The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.	The board of directors shall undertakeundertakes a formal and rigorous annual evaluation of its own performance and that of its committees and directors.
B.6.b.	The outcomes of the evaluation of the executive directors should be reported to the board of directors. The chief executive should take the lead on the evaluation of the executive directors.	The outcome shall be reported to the board of directors. The chief executive shall take the lead on the performance appraisal of the executive directors.
B.6.c.	The council of governors, which is responsible for the appointment and re-appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chairperson and the non-executives, with the chairperson and the non-executives. The outcomes of the evaluation of the non-executive directors should be agreed with them by the chairperson. The outcomes of the evaluation of the chairperson should be agreed by him or her with the senior independent director. The outcomes of the evaluation of the non-executive directors and the chairperson should be reported to the governors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chairperson.	The council of governors shall agree the process for the evaluation of the chairman and non-executives and the outcomes shall be reported to and agreed by the governors. The senior independent director shall lead the chairman's evaluation process.
B.6.d.	The council of governors should assess its own collective performance and its impact on the NHS foundation trust.	The council of governors shall assess its own collective performance and identify areas for development.

Supporting Principles	How Applied

Supporting Principles		How Applied
B.6.e	Evaluation of the board of directors should consider the balance of skills, experience, independence and knowledge of the NHS foundation trust on the board, its diversity, including gender, how the board works together as a unit, and other factors relevant to its effectiveness. This should be reported to the council of governors with a specific focus on what changes are needed for improvement.	Regular evaluation of the board shall be undertaken and the council shall be made aware of the outcomes.
B.6.f.	Individual evaluation of directors should aim to show whether each director continues to contribute effectively and to demonstrate commitment and has the relevant skills for the role (including commitment of time for board and committee meetings and any other duties) going forwards.	The chairman shall act on the outcome of appraisals which identify individual and collective development needs for the board and non-executive directors. The chairman shall report to the council of governors on improvement needs of the non-executive directors. The chief executive will undertake the appraisal of the executive directors and report the outcomes to the appointments and remuneration committee.
B.6.g.	The chairperson should act on the results of the performance evaluation by recognising the strengths and addressing the weaknesses of the board, identifying individual and collective development needs, and, where appropriate, proposing new members be appointed to the board or seeking the resignation of directors.	The chairman shall act on the outcome of appraisals, which identify individual and collective development needs and where necessary will propose new members be appointed to the board of directors or seek the resignation of directors.
B.6.h.	The focus of the chairperson's appraisal will be his/her performance as leader of the board of directors and the council of governors. The appraisal should carefully consider that performance against pre-defined objectives that support the design and delivery of the NHS foundation trust's priorities and strategy described in its forward plan.	The chairman shall have an annual appraisal based on his performance as leader of the board of directors and council of governors. The appraisal shall be based on the pre-defined objectives of the previous year's outcomes and in line with the trust's strategic priorities and objectives within the annual operational plan.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.6.1.	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.	YES	The annual report will refer to the process of performance evaluation. The board will use external assessors on a regular basis. A statement shall be made within the annual report.
B.6.2.	Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	YES	The evaluation of the board will be externally facilitated at least every three years.
B.6.3.	The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors.	YES	The senior independent director leads the performance evaluation of the chairman, within a framework agreed by the council of governors and taking into account the views of directors and governors.
B.6.4.	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	YES	There is an agreed performance review process (Register D4a). The outcomes of the evaluation are the basis of development programmes for the future.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.6.5.	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors. • communicating with their member constituencies and the public and transmitting their views to the board of directors; and • contributing to the development of forward plans of NHS foundation trusts. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Monitor's publication: *Your statutory duties: A reference guide for NHS foundation trust governors*.	YES	A review of the council of governor's collective performance shall be undertaken and the outcomes reported in the public part of a Council of Governors meeting.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.6.6.	There should be a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	YES	The trust has a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This has been shared with governors. The process also provides for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. The Trust has provision within its constitution and its code of conduct for governors that provides for requesting an independent assessor where there is a disagreement as to whether the proposal to remove a governor is justified.

B.7 Re-appointment of directors and re-election of governors

Main Principles		How Applied
B.7.a.	All non-executive directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The performance of executive directors of the board should be subject to regular appraisal and review. The council of governors should ensure planned and progressive refreshing of the non-executive directors.	The re-appointment of non-executive directors shall be determined by the constitution noting Monitor's code of governance. Governors shall have three year or two year tenure at the end of which their seats will be up for election. Governors can stand for a maximum of nine years at the trust.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.7.1.	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g., two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.	YES	Non-executive directors and the chairman are nominated by the nominations, remuneration and evaluations committee for reappointment by the council of governors in line with the code of governance. The chairman reports to the nominations, remuneration and evaluations committee and council of governors on the performance evaluation of the non-executive directors considered for reappointment. See terms of reference for the nominations, remuneration and evaluations committee. (Register E13) There shall be a rigorous review of non-executive directors who exceed six years in their role including that of their independence. This is not applicable at the present time, given the new organisation.
B.7.2.	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	YES	See model rules of election within the constitution. NOTE The Trust's model rules of election do not include the requirement to place the number of meetings each governor has attended and other such events. However the Trust shall publish this information in the annual report.

Relevant statutory requirements	Compliance Y/N	Evidence or Non Compliance Explanation

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.7.3	Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors.	YES	See Terms of Reference for Nominations, Remuneration and Evaluations Committee. (Register E13) Re-appointments of non-executive directors shall take place through the nominations, remuneration and evaluations committee and council of governors. All other executive director posts are appointed through the appointments and remuneration committee. (Register D27)
B.7.4	Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	YES	Non-executive directors and chairman are nominated by nominations, remuneration and evaluations committee for appointment by the council of governors in line with the code of governance. The chairman reports to the nominations, remuneration and evaluations committee and council of governors on the performance evaluation of the non-executive directors. See terms of reference for nominations, remuneration and evaluations committee. (Register E13)
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	YES	Refer to model rules of election within the constitution. Refer to register of governors.

B.8 Resignation of directors

Main Principles		How Applied
B.8.a.	The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate succession planning.	The board of directors retain the necessary skills to ensure ongoing compliance with the NHS foundation trust with its licence, its constitution, mandatory guidance issued by NHSI, relevant statutory requirements and contractual obligations. The board through the chairman and senior independent director shall work with the council of governors to ensure appropriate succession planning for non-executive directors. The composition of the board is reviewed when a new post is required to be filled.

Code provision	Compliance Y/N	Evidence or Non Compliance Explanation

B.8.1.	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	YES	The appointments and remuneration committee will not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment. See appointments and remuneration committee terms of reference. (Register D27) See nominations, remuneration and evaluation committee terms of reference (CEO position only). (Register E13)

SECTION C. ACCOUNTABILITY

C.1 Financial, quality and operational reporting

Main Principles		**How Applied**
C.1.a.	The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.	The board of directors will present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.

Supporting Principles	**How Applied**

C.1.b.	The responsibility of the board of directors to present a fair, balanced and understandable assessment extends to all public statements and reports to regulators and inspectors, as well as information required to be presented by statutory requirements.	The UHD communications team is developing a communications and engagement strategy. The board of directors shall endorse this and the emerging closer working relationship with the communication and engagement teams in the Our Dorset Integrated Care System through our own communications team as we seek to implement the Clinical Services Review. Our communications team also works closely with NHS England and Improvement regional and national communications teams on public statements and media engagement. This allows us to build on what works best taking the best practices forward. This includes setting out four enabling factors for successful engagement: a strong strategic narrative, engaging managers, nurturing the employee voice and organisational integrity.
C.1.c.	The board of directors should establish arrangements that will enable it to ensure that the information presented is fair, balanced and understandable.	External communication activities are overseen by the Associate Director of Communications, reporting to the director of workforce and organisational development. Public messages such as media statements are approved as appropriate by an executive director in line with the trust's media policy. Our external website can be tailored by users to ensure it is easily accessible by all.

Code provision	Compliance Y/N	Evidence or Non Compliance Explanation

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.1.1.	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	YES	See relevant annual report sections: • board of director's responsibilities • statement from external auditors • annual governance statement
C.1.2.	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	YES	Refer to annual report, audit committee agenda and finance and performance committee agenda.
C.1.3.	At least annually and in a timely manner, the board of directors should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance. Further requirements are included in the *NHS Foundation Trust Annual Reporting Manual.*	YES	Refer to the trust's operational plan Refer to annual report (from the chief executive supported by the Chief Finance Officer).

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.1.4.	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.	YES YES	Board of directors aware of duty. Board of directors aware of duty.

C.2 Risk management and internal control

Main Principles		How Applied
C.2.a.	The board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.	The board of directors has a risk management structure. The board assurance framework is produced with links to the strategic objectives. The board receives regular updates on the trust risk register. All new red risks are reported to the Board of directors and the strategic risks faced by the trust are considered at every board meeting. The Risk Management Strategy approved by the board in 2020 contains the risk appetite of the board. The strategy supports delivery of the Trust's corporate objectives and describes the organisation's approach to the identification, assessment and management of risk.
C.2.b.	The board of directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHS foundation trust's assets, and service quality. The board should report on internal control through the Annual Governance Statement (formerly the Statement on Internal Control) in the annual report.	The board of directors shall maintain a sound system of internal control. The processes are considered by the audit committee and approved by the board of directors and are published as part of the annual report.

Supporting Principles		How Applied
C.2.c.	An internal audit function can assist a trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluating and continually improving the effectiveness of its risk management and internal control processes.	The externally sourced internal audit function assists the trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluating and continually improving the effectiveness of its risk management and internal control processes.

C.2.d.	If a trust has an internal audit function, the head of that function should have a direct reporting line to the board or to the audit committee to bring the requisite degree of independence and objectivity to the role.	N/A The internal audit is externally sourced with reports to the audit and governance committee with the internal audit director reporting to the director of finance.

Code provision		**Compliance Y/N**	**Evidence or Non Compliance Explanation**
C.2.1.	The board of directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	YES	The Trust through its audit committee ensures that its risk management and control systems are subject to regular independent audit. Auditors report their findings to the council of governors and through the council to members. Any exceptions are reported to the board of directors.
C.2.2.	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	YES	The trust does have an internal audit function and appropriate details are provided in the annual report by the director of finance.

C.3 Audit committee and auditors

Main Principles	**How Applied**

C.3.a.	The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors. Monitor's publications, *Audit Code for NHS Foundation Trusts* and *Your statutory duties: A reference guide for NHS foundation trust governors*, provide further guidance.	The board of directors has appointed an audit committee to ensure compliance with corporate reporting, risk management and internal control principles. Following an agreed tendering process the council of governors, approved the appointment of KPMG in October 2017 as the external auditors for a three year period. Nominated governors were fully involved in the selection process at all stages. The committee reviews the performance of auditors on an annual basis. The key elements include a review of performance in relation to the contracted service specification, the standard of audits conducted, the recording of any adjustments, the timeliness of reporting, the availability of the Auditor for discussion and meetings on key issues, and the quality of reporting to the audit committee, the board of directors and the council of governors. The committee has agreed a policy for the use of external auditors for non-audit work and would directly approve such work. The audit committee ensures full compliance with the NHS Code for NHS Foundation Trusts.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.1.	The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively; including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.	YES	Four independent non-executive directors (excluding the chairman) are members of the audit committee. One member of the committee has recent and relevant financial experience. The audit committee shall produce an annual report of its work.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.2.	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly. It should include details of how it will: • Monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them; • Review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; • Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements; • Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; • Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and • Report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.	YES	See audit committee terms of reference which are published on the website. (Register B15) A policy statement on external audit providing non-audit services was endorsed by the Shadow Interim Board of Directors in June 2020. The policy will be reviewed in 2023. An annual report of the audit committee shall be submitted to council of governors including the terms of reference for review. Ad-hoc issues would be reported to the council as required. The chairman of the audit committee provides an update to governors on an annual basis.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.3.	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.	YES	Following agreement across all five Dorset health bodies, a procurement exercise was undertaken for the provision of external audit services. (Register D16 The appointment of external auditors, KMPG for a three year period from April 2018) The Chief Finance Officer is satisfied with the effectiveness of the external audit process and provides council with details of how the Trust monitors their performance from input from Trust staff that have regular contact with the auditors.
C.3.4.	The audit committee should make a report to the council of governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the council of governors to consider whether or not to re-appoint them. The audit committee should also make recommendation to the council of governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.	YES	Appointment of the auditors has been made. Performance shall be evaluated at the same time as remuneration is reviewed, as part of the annual review of performance.
C.3.5.	If the council of governors does not accept the audit committee's recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	YES	Would do so in the event.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.6.	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.	YES	The council agreed a tendering process for the appointment of external auditors from April 2018 and approved the appointment of KPMG as the external auditors for a three year period, in October 2017.
C.3.7.	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	N/A	Would do so in the event.
C.3.8.	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	YES	The audit committee will review the arrangements and the process used in reaction to each freedom to speak up report, as per its terms of reference and governance cycle. The job description for the freedom to speak up guardian is based on the guidelines provided by the National Guardian's Office. In November the guardian presented the annual Board commitment to Sir Robert Francis principles and the declaration of behaviour, alongside the bi-annual report.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.9.	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	YES	The annual report contains a description of the work on the committee in discharging its responsibilities.

SECTION D: REMUNERATION

D.1 The level and components of remuneration

Main Principles		How Applied
D.1.a.	Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead the NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.	Trust shall look to work within benchmarking parameters when setting levels of remuneration. The appointments and remuneration committee shall review the VSM guidance annually/when published.

Supporting Principles		How Applied
D.1.b.	Any performance-related elements of executive directors' remuneration should be stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any competencies required and specified within the job description for the post.	N/A
D.1.c.	The remuneration committee should decide if a proportion of executive director's remuneration should be structured so as to link reward to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration levels with no corresponding improvement in performance.	The appointments and remuneration committee has decided not to link remuneration to corporate and individual performance but will keep this decision under review.
D.1.d.	The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS foundation trust, especially when determining annual salary increases.	The appointments and remuneration committee shall be aware of employment conditions elsewhere in the trust when determining annual salary increases.

Code provision	Compliance Y/N	Evidence or Non Compliance Explanation

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
D.1.1.	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: i) The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	YES	Performance related pay eligibility considered and decided it will not apply within the Trust however this will be kept under review.
D.1.2.	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	YES	Levels of remuneration for the chairman and non-executive directors are approved by the council of governors and reflect time commitments and responsibilities.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
D.1.3.	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	YES	Currently N/A. Refer to the appointments and remuneration committee terms of reference.
D.1.4.	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	YES	Refer to appointments and remuneration committee terms of reference and trust recruitment processes.

D.2 Procedure

Main Principles		How Applied
D.2.a.	There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.	The appointments and remuneration committee shall comprise of non-executive directors and will consider executive remuneration. The outcome of which shall be published in the annual report.

Supporting Principles		How Applied
D.2.b.	The remuneration committee should consult the chairperson and/or chief executive about its proposals relating to the remuneration of other executive directors.	The appointments and remuneration committee shall consult with the chief executive on remuneration proposals for other directors.

D.2.c.	The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.	The appointments and remuneration committee may appoint independent consultants.
D.2.d.	Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.	The appointments and remuneration committee shall observe this duty of care.

Code provision		**Compliance Y/N**	**Evidence or Non Compliance Explanation**
D.2.1.	The board of directors should establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	YES	Refer to Trust appointments and remuneration committee terms of reference. Membership of the committee is all non-executive directors and the trust chairman. Remuneration consultants were instructed to provide an opinion on the remuneration of the Executive Directors of the new Foundation Trust.
D.2.2.	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	YES	The appointments and remuneration committee has determined that the definition of 'senior management' should be limited to board members only. All other staff remuneration is covered by the NHS Agenda for Change pay structure.

D.2.3.	The council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	YES	See council of governors/nominations, remuneration and evaluations committee papers. The remuneration of the chairman was considered with external advice ahead of the current chairman's appointment in March 2021. External advice will be sought when making material change to the remuneration.

Relevant statutory requirements		**Compliance Y/N**	**Evidence or Non Compliance Explanation**
D.2.4.	The council of governors is responsible for setting the remuneration of nonexecutive directors and the chairperson.	YES	The council of governors approve the remuneration of the chairman and non-executive directors on an annual basis.

SECTION E. RELATIONS WITH STAKEHOLDERS

E.1 Dialogue with members, patients and the local community

Main Principles		How Applied
E.1.a.	The board of directors should appropriately consult and involve members, patients and the local community.	The board of directors shall appropriately consult as required.
E.1.b.	The council of governors must represent the interests of trust members and the public.	The council of governors represent the interests of trust members and the public.
E.1.c.	Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.	The board of directors as a whole will take responsibility to ensure that regular and open dialogue with its stakeholders takes place.

Supporting Principles		How Applied
E.1.d.	The board of directors should keep in touch with the opinion of members, patients and the local community in whatever ways are most practical and efficient. There must be a members' meeting at least annually.	Our board of directors meeting starts with a patient story to ensure the voices of patients are heard. The council of governors has a membership and engagement group and part of their work is to hold events to gather public opinion, including at our Trust open day. This engagement will be developed by the group. The communications team share media headlines with the board of directors to ensure they are kept in touch with public opinion and highlight anything that they board of directors needs to be aware of. There is a members meeting held annually.

Supporting Principles		How Applied
E.1.e.	The chairperson (and the senior independent director and other directors as appropriate) should maintain regular contact with governors to understand their issues and concerns.	The board of directors through formal and informal routes maintains sufficient contact with governors to understand their issues and concerns.
E.1.f.	NHS foundation trusts should use an open annual meeting and open board meetings, both of which trusts are required to hold, to encourage stakeholder engagement.	The trust uses the annual members (open) meeting and open board meetings to encourage stakeholder engagement.
E.1.g.	Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public regarding the trust, its vision, performance and material strategic proposals made by the trust board.	Governors seek the views of members and the public on material issues or changes being discussed by the trust. Governors provide information and feedback to members and the public regarding the trust, its vision, performance and material strategic proposals made by the trust board.
E.1.h.	It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that will enable them to fulfil their duty to represent the interests of members and the public.	The governors produce a membership strategy which is supported by the trust. The governors have a membership and engagement group. The trust holds annual membership meetings. The trust involves the governors on material strategic proposals through the full council meetings.

Code provision	Compliance Y/N	Evidence or Non Compliance Explanation

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.1.	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	YES	The UHD communications team is developing a communications and engagement strategy that sets out our key audiences and stakeholders and how the boards of directors will communicate with them. The ambition of the strategy is to continually seek closer working relationships with key external stakeholders and partners within the healthcare community through the Our Dorset Integrated Care System as we seek to implement the Clinical Services Review.
E.1.2.	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g., Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).	YES	Stakeholder engagement will be an integral part of our communications and engagement strategy. (see C.1.b). Refer to constitution.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.3.	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	YES	Council of governors' minutes are available to board members. Council of governors invite board of directors to their meetings. The senior independent director attends sufficient meetings (minimum of the full council meetings and the annual members' meeting). Council of governors invited to meet board of directors, present questions to the board at their monthly meetings and attend a briefing after the part two of the meeting. A weekly e-mail is provided to governors.
E.1.4.	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	YES	Contact processes on website, staff and membership newsletter and within the annual report.
E.1.5.	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	YES	Board engagement with council of governors policy statement. (Register D7) The annual report states how many council of governors meetings the board of directors have attended during the year.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.6.	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	YES	An annual membership report is presented to the board of directors as part of the annual operational plan and annual report.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.7.	The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	YES	Board members and the annual meeting are open to the public. The constitution provides for members of the public to be excluded from a meeting for special reasons.
E.1.8.	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting.	YES	The Trust holds such a meeting annually.

E.2 Co-operation with third parties with roles in relation to NHS foundation trusts

Main Principles		How Applied
E.2.a.	The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.	The board of directors shall ensure the trust co-operates with relevant organisations. The board shall receive an annual report on the effectiveness of third party processes and relationships.

Supporting Principles		How Applied
E.2.b.	The board of directors should enter a dialogue at an appropriate level with a range of third party stakeholders and other interested organisations with roles in relation to NHS foundation trusts based on the mutual understanding of objectives.	The board of directors shall enter a dialogue at an appropriate level with a range of third party stakeholder and other interested organisations with roles in relation to NHS foundation trusts based on the mutual understanding of objectives and maintain a register of third party organisations and their objectives in relation to the trust.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.2.1.	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	YES	Working schedule maintained by Associate Director of communications (Register D19)
E.2.2.	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	YES	Working schedule maintained by Associate Director of communications which will be presented to the Board in March 2021, given the establishment of the new organisation. (Register D19)

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 31 March 2021

Agenda item: 10.7

Subject:	Annual Review of effectiveness of third-party processes and relationships 2020/21

Prepared by:	James Donald, Acting Associate Director of Communications
Presented by:	Debbie Fleming, Chief Executive

Purpose of paper:	To present a schedule of third parties which UHD has a duty to cooperate with and the nature of the trust's relationship with those organisations, in compliance with the NHS England and NHS Improvement Code of Governance Comply/Explain framework. The Board is asked to review the effectiveness of these processes and relationships as set out in the attached paper and where necessary, note any further actions to improve them.
Key points for Board members:	This document sets out the details of third parties which UHD has a duty to co-operate. The list is indicative and not exhaustive. Where appropriate, it is split into third parties with a remit specific to healthcare and those with a more general remit, such as the local safeguarding boards. NHSEI guidance states that the board of directors should be clear as to the specific third-party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third-party bodies in order to discharge their statutory duties. The board of directors should also ensure that effective mechanisms are in place to co-operate with relevant third-party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.
Recommendations:	For scrutiny

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	• Continue to provide strong and effective leadership for the two organisations, during this time of significant change. • Ensure that we continue to provide safe, high quality care for patients. • Continue the work to bring together the two organisations – developing shared vision and values, designing the new structure, establishing robust governance arrangements and agreeing the timescales/process for bringing teams together.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	Date

SCHEDULE OF THIRD PARTIES 2020/21

This list is indicative and not exhaustive. Where appropriate, it is split into third parties with a remit specific to healthcare and those with a more general remit. N.B. the list may change from time to time.

Key to responsibilities:

Chief Executive Officer (CEO)
Chief Nursing Officer (CNO)
Chief Medical Officer (CMO)
Chief Finance Officer (CFO)
Chief Operating Officer (COO)
Chief People Officer (CPO)
Chief Strategy and Transformation Officer (CSTO)
Chief Informatics and IT Officer (CIIO)

Relevant NHS England and NHS Improvement Code of Governance guidance:

E.2.1 The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.

E.2.2 The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.

1. Bodies with statutory enforcement powers

NHS England and NHS Improvement does not reasonably expect to be involved with the resolution of issues covered by such bodies, except where persistent failures may indicate fundamental governance failings and a breach of authorisation.

	FORM AND SCOPE OF COOPERATION
Statutory remit specific to healthcare	
Care Quality Commission (CQC) (CNO)	UHD will comply with the CQC standards and maintain its registration. UHD will comply with requests from the CQC and if issues regarding compliance are identified will work with the CQC to address these.
Public Health England (PHE) (COO)	UHD will comply with directions from PHE to respond to health hazards and emergencies. UHD will work with partner agencies to anticipate and prepare for emerging and future threats with regard to public health.
Human Fertilization and Embryology Authority (HFEA) (CMO)	UHD does not currently provide any services which would be regulated by the HFEA.
NHS England and NHS Improvement (NHSEI) (CEO/CFO)	UHD submits board-approved plans to NHSEI and reports in line with requirements.

Regulators of Individual Health Professionals: 1. General Chiropractic Council (CMO/CNO) 2. General Dental Council (CMO/CNO) 3. General Medical Council (CMO) 4. General Optical Council (CMO) 5. General Osteopathic Council (CMO/CNO) 6. General Pharmaceutical Council (COO) 7. The Health and Care Professions Council (CMO/CNO) 8. Nursing and Midwifery Council (CNO)	There are currently eight regulators of individual health professionals covering a range of professions which UHD is linked with. UHD would cooperate with the regulators with regard to fitness to practice of an individual.
General statutory remit	
The Charity Commission (CFO)	UHD is registered with the Charity Commission and sends them our Annual Report and Accounts each year within the specified timescale.
Equality and Human Rights Commission (CPO)	UHD will comply with its legal duties with regard to equality and human rights and will cooperate with the Equality and Human Rights Commission when they are undertaking their statutory remit in protecting and monitoring human rights and equality.
Environment Agency (CSTO)	UHD will comply with the requirements of the Environment Agency with regard to protecting the environment and dealing with clinical and non-clinical waste.
Fire and Rescue Authorities (CSTO)	UHD is subject to statutory fire checks and would consider any recommendations by the Fire and Rescue Authorities about changes to buildings or operations to prevent fires.

Dorset Police (COO)	Dorset Police provides cover for the hospitals. The Trust has a local security manager, and there are various other points of contact through the hospital.
Health and Safety Executive (HSE) (CNO)	UHD will comply with policy from the HSE with regard to the safety of its staff, patients and members of the public on UHD premises. UHD will report reportable incidents to the HSE (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, RIDDOR). UHD will cooperate with any investigation undertaken by the HSE and implement the recommendations of such an investigation.
HM Revenue and Customs (CFO)	UHD is aware of its responsibilities to HM Revenues and Customs and will comply with all appropriate requirements
Human Tissue Authority (HTA) (COO)	UHD holds a licence with the HTA. The Trust submits an annual report showing audit results. The trust may be inspected without notice.
Information Commissioner (CIIO)	The Information Commissioner oversees and enforces compliance with the Data Protection Act 1998 and Freedom of Information Act 2000. UHD has an approved publication scheme and responds to requests under these Acts within the statutory timeframes. If a serious data loss/breach occurs, UHD is required to inform the Information Commissioner.
Local planning authorities (CSTO): 1. BCP Council local planning authority 2. Dorset Council highways agency	UHD will work with local planning authorities on all appropriate development activities, and has a single point of contact for major planning applications through the estates office.

Public Accounts Committee (CEO/CFO)	The Public Accounts Committee has the power to call any Accounting Officer of a public body before it. UHD's Accounting Officer would cooperate with any such request from the Public Accounts Committee.
Secretary of State for Health and Social Care (CEO)	NHS Foundation Trusts are not generally subject to direction by the Secretary of State for Health. However, there may be directions issued from time to time which would be applicable to UHD which would be implemented appropriately.

2. Bodies with a statutory role but no enforcement powers

Commissioners: 1. Dorset Clinical Commissioning Group (COO/CFO) 2. NHS England and NHS Improvement (commissioners of specialist services) (COO/CFO)	UHD is required to meet its contractual obligations to its commissioners.
Health and Wellbeing Boards (HWB): 1. Bournemouth, Christchurch and Poole HWB (CEO) 2. Dorset Council HWB (CEO) 3. Hampshire County Council HWB (CEO)	HWB take on their statutory function from April 2013. UHD will collaborate with local HWBs to understand local needs, and address the broader determinants of health and wellbeing.
BCP Safeguarding Adult Board (CNO) Dorset Safeguarding Adult Board (CNO) Dorset Safeguarding Children Partnership (CNO)	UHD will work closely with Dorset and BCP partners to improve the safety and well-being of adults/children who might be at risk of harm.
Public Health England (PHE) (CNO)	UHD will work closely with the local PHE authority to deliver improvements in public health outcomes for the local population

NHS Blood and Transplant (COO)	UHD complies with advice and best practice guidance provided by NHS Blood and Transplant.
Parliamentary and Health Service Ombudsman (CEO/CMO)	UHD will consider recommendations made by the Parliamentary and Health Service Ombudsman where we have been unable to resolve a complaint locally.
Co-operation and Competition Panel (CCP) (CEO/CFO)	UHD will cooperate with any investigation undertaken by the CCP.
Care Quality Commission (CMO/CNO)	UHD complies with the Mental Health Act as appropriate to its patients, and is aware of its responsibility to the Commission.
NHS Digital (CIIO)	UHD will report data to NHS Digital as required to do so by Schedule 6 of our Authorisation.
Overview and Scrutiny Committees (OSC): • BCP Council OSC (CEO) • Dorset Council OSC (CEO) • Hampshire County Council OSC (CEO) •	UHD will consult with the relevant Overview and Scrutiny Committees before making any material changes to services and will provide the Committee with information if it is requested.
Healthwatch Dorset (CNO)	UHD will work with Healthwatch Dorset to understand and respond to the views of the local community with regard to healthcare, and will accommodate 'enter and view' visits
General Remit	
Ofsted (CPO)	UHD would comply with requests from Ofsted for information relating to an inspection.
HM Inspectorate of Prisons (CNO/CMO)	UHD would comply with requests from HM Inspectorate of Prisons for information relating to an inspection.

National Audit Office (NAO) (CFO)	UHD would comply with requests from the NAO for information relating to an audit.

3. Bodies with no statutory role but a legitimate interest

NHSEI expects that NHS foundation trusts will generally cooperate with such bodies and a failure to cooperate may, under certain circumstances, constitute a breach of authorisation.

Clinical Pathology Accreditation (UK) Ltd (CMO)	A private organisation which provides a nationally recognised accreditation for clinical laboratories.
Committees, working groups and forums advising the Department of Health and Social Care on topics across health and social care (CNO/CMO)	UHD would consider the key recommendations from such groups and would identify appropriate changes to clinical practice which would improve the quality of care and patient outcomes.
Confidential enquiries, including: • The National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CMO) • The Centre for Maternal and Child Health Enquiries (CMO) • The National Confidential Enquiry into Patient Outcome and Death (CMO)	UHD would consider the key findings and recommendations from the reports and would identify appropriate changes to clinical practice which would improve the quality of care and patient outcomes.
Health Education England Wessex (CPO) Health Education England South West (CPO)	UHD will maintain a relationship with the Local Training and Education Board (LETB) to ensure we are working to best practice with regard to education, training and workforce planning in the fields of medicine, dentistry, pharmacy and healthcare science.

Medicines and Healthcare Products Regulatory Agency (MHRA) (COO)	UHD will work with and pay heed to the advice of MHRA
National screening programme teams (CMO)	UHD will work with and pay heed to advice from the national breast, cervical and bowel cancer screening teams. UHD manages the Dorset Bowel Cancer Screening Program.
NHS Business Services Authority (NHSBSA) (CFO)	The NHS Business Services Authority is responsible for policy and operational matters relating to prevention, detection and investigation of fraud and corruption. UHD will work with the Local Counter Fraud Specialist (LCFS) or NHS Protect (NHSBSA) to investigate and recover losses in cases of fraud or corruption.
NHS Resolution (CMO)	UHD is a member of the NHS Resolution Risk Pooling Schemes and as such undertakes NHS Resolution assessments which are a mandatory part of the scheme. UHD also complies with appropriate requests from NHS Resolution with regard to its claims management and liaises with them to bring a satisfactory resolution to the claim.
Other local NHS provider trusts, including: • Dorset County Hospital NHS Foundation Trust • Dorset Healthcare University NHS Foundation Trust	UHD works collaboratively with other local provider trusts as appropriate to meet the needs of patients within the local community

Royal Colleges, including: • Royal College of Anaesthetists (CMO) • Royal College of GPs (CMO) • Royal College of Midwives (CNO) • Royal College of Nursing (CNO) • Royal College of Obstetricians and Gynaecologists (CMO) • Royal College of Ophthalmologists (CMO) • Royal College of Paediatrics and Child Health (CMO) • Royal College of Pathologists (CMO) • Royal College of Physicians (CMO) • Royal College of Psychiatrists (CMO) • Royal College of Radiologists (CMO) • Royal College of Speech and Language Therapists (CNO) • Royal College of Surgeons (CMO)	UHD considers the key recommendations from the Royal Colleges and identify appropriate changes to clinical practice which would improve the quality of care and patient outcomes.
UK Genetics Testing Network (CMO/COO)	UHD will worth with and pay heed to the advice of the UK Genetic Testing Network
Universities and post-graduate Deaneries (CMO/CNO/ COP)	UHD is a university hospital trust and has a close relationship with a number of local universities, including our partner Bournemouth University and Southampton University, and offers professional education and training in conjunction with a range of universities and professional bodies. The trust enjoys a strong relationship with the Wessex Deanery.