University Hospitals Dorset NHS Foundation Trust

Council of Governors Meeting – Part 1

Monday 29 July 2024

14:30 – 16:00

Boardrooms, Poole Hospital

& via Microsoft Teams

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

The meeting of the University Hospitals Dorset NHS Foundation Trust Council of Governors will be held at 14:30 on Monday 29 July 2024 in the Boardrooms at Poole Hospital and via Microsoft Teams.

If you are unable to attend please notify the Company Secretary Team by sending an email to: company.secretary-team@uhd.nhs.uk

Rob Whiteman
Trust Chair

AGENDA – PART 1

14:30 on Monday 29 July 2024

Time	Item		Method	Purpose	Lead
14:30	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	2	Declaration of Interests	**Verbal**		**Chair**
14:32	**3**	**MINUTES**			
	3.1	For Accuracy and to Agree: Minutes of the Council of Governors Meeting held on 31 May 2024	**Paper**	**Approval**	**Chair**
	3.2	Matters Arising – Action List	**Paper**	**Review**	**Chair**
14:35	**4**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
	4.1	Chair's Update	**Verbal**	**Information**	**Chair**
	4.2	Chief Executive's Update	**Verbal**	**Information**	**CEO**
14:45	**5**	**INTEGRATED PERFORMANCE REPORT, RISK AND OPERATIONAL PLAN**			
	5.1	Board Assurance Framework – 2023/24	**Paper**	**Information**	**CSTO**
	5.2	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Information**	**Chief Officers**
	5.3	Summary of Operational Plan	**Paper**	**Information**	**CSTO**
	5.4	Wayfinding	**Verbal**	**Information**	**Transformation Team**
15:05	**6**	**GOVERNANCE**			
	6.1	Trust Constitution - update	**Paper**	**Approval**	**Chair**
	6.2	Annual Audit Committee Review of Effectiveness and consultation on Terms of Reference	**Paper**	**Review**	**Audit Committee Chair**
	6.3	Review of the terms of reference of the Nominations, Remuneration and Evaluations Committee	**Paper**	**Approval**	**Chair**
	6.4	Code of Conduct update	**Paper**	**Decision**	**CoSec**

15:20	**7**	**FREEDOM TO SPEAK UP**			
	7.1	Freedom To Speak Up	**Paper**	**Information**	**FTSU Guardian**
15:30	**8**	**COMMITTEES AND GOVERNOR GROUPS UPDATE**			
	8.1	Council of Governors 2024/25 Events Calendar	**Paper**	**Approval**	**Chair**

	8.2	Feedback from Council of Governors Informal Groups:
		• Constitution Review Group
		• Effectiveness Group
		  ○ Governors' Pledges
		• Membership and Engagement Group
		  ○ Staff Governor Leaflet
		• Quality Group
			Paper [R]	**Review**	**Group members**

	8.3	Feedback from Governor Observers	**Verbal**	**Information**	**Governors Observers**
15:55	**9**	Urgent Motions or Questions	**Verbal**		**Chair**
	10	Any Other Business	**Verbal**		**Chair**
16:00		**Date of Next Council of Governors Meeting:** Thursday 3 October 2024			

* late paper
[R] Associated item in Reading Room

This meeting is being recorded for minutes of the meeting to be produced.
The recording will be deleted after the minutes of the meeting have been approved.

Items for Next Council of Governors Part 1 Agenda – October 2024

Standing Reports

- Chair's Update
- Chief Executive's Update
- Integrated Performance Report
- Feedback from the Nominations, Remuneration and Evaluation Committee
- Updates from the Council of Governor Groups
- Feedback from Governor Observers

Annual Reports

- Quality Account (six months review)
- Annual Patient Experience Report (to include Complaints)
- Report on the Annual Members' Meeting

List of abbreviations:

CEO – Chief Executive Officer
CFO –Chief Finance Officer
CNO – Chief Nursing Officer
CoSec – Company Secretary Team
CSTO – Chief Strategy and Transformation Officer

Other abbreviations

CDEL – Capital Delegated Expenditure Limit
CIP – Cost Improvement Programme
ED – Emergency Department
HSMR – Hospital Standardised Mortality Ratio
ICB – Integrated Care Board
ICS – Integrated Care System
ITU – Intensive Therapy Unit
MSG – Mortality Surveillance Group
NHSE/I – NHS England/Improvement
#NOF – Fractured neck of femur
OPEL – Operational Pressures Escalation Levels
SMR – Standardised Mortality Ratio
SWAST – South West Ambulance Service NHS Foundation Trust

AGENDA – PART 2 PRIVATE MEETING

16:15 on Wednesday 29 July 2024

Time		Item	Method	Purpose	Lead
16:15	**11**	Welcome, Introduction, Apologies & Quorum	**Verbal**		**Chair**
	12	Declaration of Interests	**Verbal**		**Chair**
16:20	**13**	**MINUTES**			
	13.1	For Accuracy and to Agree: Minutes of the Council of Governors Meeting held on 31 May 2024	**Paper**	**Approval**	**Chair**
	13.2	Matters Arising – Action List	**Paper**	**Review**	**Chair**
16:25	**14**	**GOVERNANCE**			
	14.1	Update from the Part 2 meeting of the Board of Directors held on 3 July 2024	**Verbal**	**Information**	**Chair**
16:50	**15**	Any Other Business	**Verbal**		**Chair**
16:55	**16**	Reflections on the Meeting	**Verbal**		**Chair**
17:00	**17**	**Date of Next Council of Governors Meeting:** Thursday 3 October 2024.			

* late paper

This meeting is being recorded for minutes of the meeting to be produced.
The recording will be deleted after the minutes of the meeting have been approved.

Items for Next Council of Governors Part 2 Agenda – October 2024

Standing Items

- Update from Nominations, Remuneration and Evaluations Committee
- Update from Board Part 2 meeting

Annual Reports

- Annual Effectiveness of External Audit Process

List of abbreviations:

CEO – Chief Executive Officer
CFO –Chief Finance Officer
CNO – Chief Nursing Officer
CoSec – Company Secretary Team

Other abbreviations

CDEL – Capital Delegated Expenditure Limit
CIP – Cost Improvement Programme
ED – Emergency Department
HSMR – Hospital Standardised Mortality Ratio
ICB – Integrated Care Board
ICS – Integrated Care System
ITU – Intensive Therapy Unit
MSG – Mortality Surveillance Group
NHSE/I – NHS England/Improvement
#NOF – Fractured neck of femur
OPEL – Operational Pressures Escalation Levels
SDEC – Same Day Emergency Care
SHMI – Summary Hospital-Level Mortality Indicator
SMR – Standardised Mortality Ratio
SWAST – South West Ambulance Service NHS Foundation Trust

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

EXTRAORDINARY MEETING OF THE COUNCIL OF GOVERNORS PART 1

Minutes of the Extraordinary Part 1 meeting of the Council of Governors held on Friday 31 May 2024 at 9:30 in the Committee Room at Royal Bournemouth Hospital and via Microsoft Teams

Present:	Rob Whiteman	Trust Chair *(chair)*
	Colin Blebta	Public Governor: Bournemouth
	Robert Bufton	Public Governor: Poole and Rest of Dorset
	Sharon Collett	Public Governor: Bournemouth, Lead Governor
	Steve Dickens	Public Governor: Christchurch, East Dorset and Rest of England
	Beryl Ezzard	Appointed Governor: Dorset Council
	Rob Flux	Staff Governor: Administrative, Clerical and Management
	Paul Hilliard	Appointed Governor: BCP Council
	Elizabeth McDermott	Public Governor: Bournemouth
	Keith Mitchell	Public Governor: Bournemouth
	Jeremy Scrivens	Public Governor: Christchurch, East Dorset and Rest of England
	Diane Smelt	Public Governor: Bournemouth
	Carrie Stone	Public Governor: Poole and Rest of Dorset, Deputy Lead Governor
	Kani Trehorn	Staff Governor: Nursing, Midwifery and Healthcare Assistants
	Michele Whitehurst	Public Governor: Poole and Rest of Dorset, Lead Governor
In attendance	Jonathan Brown	KPMG, External Audit
	Ewan Gauvin	Acting Deputy Company Secretary
	Judy Gillow	Non-Executive Director, Senior Independent Director
	Siobhan Harrington	Chief Executive Officer
	Oluwatobi Olopade	KPMG, External Audit
	Tina Ricketts	Chief People Officer
	Klaudia Zwolinska	Corporate Governance Assistant *(minutes)*
	2 members of the public	

CoG053/24	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting, particularly Dr Deniz Cetinkaya, Public Governor for the Bournemouth constituency and Dr Shelley Thompson, Appointed Governor from Bournemouth University. They were attending the meeting as observers, with their induction scheduled for 6 June 2024. The Trust Chair invited everyone to introduce themselves. Apologies were received from the following members: • Colin Hamilton, Staff Governor for Estates and Ancillary Services • Andrew McLeod, Public Governor for Poole and Rest of Dorset Apologies had also been received from Richard Renaut, Chief Strategy and Transformation Officer and Yasmin Dossabhoy, Associate Director of Corporate Governance. The meeting was declared quorate.
CoG054/24	**Declarations of Interest** No existing interests in the matters to be considered were declared. In addition, no further interests were declared.

CoG055/24	**For Accuracy and to Agree: Minutes of the Council of Governors Meeting held on 4 April 2024** The minutes of the Council of Governors Meeting Part 1 held on 4 April 2024 were APPROVED as an accurate record, subject to correcting a typo in the action section on the bottom of page 9 (*change from filling to filing*).
CoG056/24	**Matters Arising – Action List** **CoG031/24** - *To clarify whether the reference in the informatics section of the IPR (April 2024 meeting) to the number of incorrect filings related to individual pieces of paper or to the number of patient records affected* – Pete Papworth would provide an update at the July 2024 Council of Governors meeting. Action remained OPEN. **CoG038/24** - *To share the UHD Charity presentation and list of available funds with the Council of Governors* – The presentation and the list of available funds were shared with the Governors on 9 April 2024. Action CLOSED. All remaining actions were CLOSED.
CoG057/24	**Convening of Annual Members' Meeting** Rob Whiteman informed the Council that since the papers had been published, Klaudia Zwolinska had explored more suitable options for the Annual Members' Meeting (AMM) based on the received feedback and invited her to share the details. Klaudia Zwolinska presented the proposed changes to the AMM, highlighting the following: • New date and time – 12 September 2024 at 11am • New venue – St. Saviour's Church in Bournemouth Klaudia Zwolinska also acknowledged the incorrect date on the draft AMM agenda, which had been rectified since the paper's publication. Diane Smelt referenced the ongoing review of the Trust Constitution and commented on the lack of an agenda item related to that at the AMM. Klaudia Zwolinska explained the circumstances in which members would be required to approve changes to the Constitution. Otherwise, the amended Constitution would be presented to the members at the annual members' meeting for awareness. Rob Whiteman provided an update on the work of the Constitution Review Group, highlighting the significant progress made and what to expect at the end of this exercise. He welcomed any comments from the Group members. Robert Bufton and Carrie Stone agreed that the process had been intense, the Constitution had been reviewed in detail, and a substantial portion of the work had been completed. The Council discussed the timing for this year's AMM, noting that the proposed time may not be conducive to encouraging students and young people to attend. Rob Whiteman emphasised the importance of engaging the above age groups; however, based on the local demographic, the proposed time would maximise attendance generally. The Council also considered the potential topic for the Understanding Health Talk following the AMM. The Council of Governors APPROVED the Convening of Annual Members' Meeting.
CoG058/24	**Annual Review of the Register of Interests** Rob Whiteman presented the Annual Review of the Register of Interests and invited Ewan Gauvin to provide any additional comments. Ewan Gauvin informed the Council that since the publication of the register of interests, a few more declarations from Governors had been submitted. This included from Public Governor Diane Smelt, who had declared her involvement in a number of patient engagement groups and various projects at Bournemouth University. The updated register would be published on the Trust's website. Ewan Gauvin asked those Governors who had not submitted their declaration yet to do so as soon as possible. Michele Whitehurst sought clarity on whether those Governors who were also University Hospitals Dorset (UHD) Volunteers, needed to declare this. Ewan Gauvin believed that

	Governors who had submitted the form to date had declared their volunteer role at the Trust if applicable and the recommendation was to do so for consistency. Expanding on Michele Whitehurst's question, Diane Smelt commented that the advice she had received in the past had not always been clear. For transparency, she had declared all her activities, thereby reinforcing the need for clear communication in declarations. The Council of Governors APPROVED the Annual Review of the Register of Interests
CoG059/24	**2024/25 Annual Plan** Siobhan Harrington presented the 2024/25 Annual Plan, highlighting the following aspects: • It had been a challenging planning process as the national guidance was announced later than anticipated; • There were ambitious plans to achieve for the next 12 months; • The Patient First improvement methodology would be used across the Trust to bring teams together and to improve the key areas included in the plan. These improvements needed to be aligned with how the services were changing across the Trust; • All the providers in Dorset had agreed to a 5% cost improvement programme; • The Trust aimed to deliver 109% of its activity compared to 2019/20 to improve patient waiting times, assuming there would be no industrial action. Since then, junior doctors had announced a further round of five days of industrial action; • Improving productivity and reducing agency spend across the Trust would support achieving the 109% target. Siobhan Harrington added that the Plan was being used for objective setting in appraisals across the Trust. Michele Whitehurst noticed that car parking was not mentioned in the Estates Masterplan. Siobhan Harrington welcomed this feedback and reassured the Council of Governors that the team was fully committed to the ongoing work on car parking, which included the recent travel survey and the plans to use the current car parking options to benefit staff and patients as a part of the people ready strategy. Rob Whiteman outlined the existing available options for staff parking across Bournemouth and Poole Hospitals sites and the plans for temporary parking arrangements on Wessex Fields while the work on the further multi-storey parking proposal was ongoing. He also mentioned ideas to encourage staff to use different means of transport, including shuttle buses between sites and extending car sharing schemes. Regarding the Patient Experience Strategy and Patient Safety Incident Response Plan, Michele Whitehurst asked whether these documents were available to the public. Siobhan Harrington confirmed this and said she would circulate both documents to members of the Council of Governors. **ACTION:** To share the Patient Experience Strategy and Patient Safety Incident Response Plan with the Council of Governors. **Siobhan Harrington.** Sharon Collett commented positively on the presentational appearance in the Annual Plan and its link to the appraisal and objectives, applying to everyone in the organisation ("golden thread"). Robert Bufton suggested adding some context to the number of Trust members by including the total population served by the Trust to showcase the proportionate membership level. Kani Trehorn wanted to know by how much the Trust was aiming to reduce agency spending and level of savings this would generate. Siobhan Harrington invited Tina Ricketts to highlight the plan, which included: • Collaborative bank staff arrangements across the system; • Work in progress in relation to agency rates;

	• Using workforce systems, including health roster for medical workforce across three NHS trusts, to allow the identification of any vacant shifts ahead of time by setting up better rules when allocating workforce; • Working on the workforce reporting system providing regular updates where additional staff support was needed; • The agency reduction plan would become a regular agenda item for the People and Culture Committee from June 2024. To follow up on Sharon Collett's point, Sandy Wilson asked whether the "golden thread" covered everyone in the organisation. Siobhan Harrington confirmed it did and added that the appraisal structure and paperwork were aligned to the Patient First triangle. The method would stay the same for the next five years, focusing on the essential areas for the Trust simultaneously. The Council of Governors NOTED the 2024/25 Annual Plan.
CoG060/24	**Informal Governor Groups Membership Update** Rob Whiteman presented the paper in relation to the Informal Governor Groups membership update. Robert Bufton was curious about how the Groups' membership had been established. Klaudia Zwolinska reminded Governors of the process, which began at the August 2023 meeting. She highlighted the role of the Company Secretary Team, who facilitated the Groups' membership by collecting the Governors' expressions of interest through a Microsoft Form questionnaire. She also provided a detailed update on how specific Groups' membership had been expanded since the 2023 review. The Council of Governors APPROVED the Informal Governor Groups Membership Update.
CoG061/24	**Rotation of Governor Observers at the Committees** Rob Whiteman presented the paper regarding the rotation of Governors' observers at the Committees, emphasising the collaborative nature of the review process. He stressed that it was important to give Governors as many opportunities as possible to observe NEDs, especially in the areas where Governors had a particular interest. The Council of Governors felt that this was the right time to reflect and review the current arrangements, and their input was crucial in this process. The Effectiveness Group had considered two alternatives for Governors' observers, which were explained in detail in the paper. Rob Whiteman welcomed the Governors' comments on these options and their input on the preferred one. Robert Bufton supported the first option with a standing observer for a certain period and with the second slot being open for the remaining Governors. However, he suggested allowing Governors to "tune in" on Microsoft Teams and listen to as many Committees as they wanted without attending in-person meetings and without actively partaking. The Council discussed the idea proposed by Robert Bufton, with Diane Smelt supporting this option. Judy Gillow was invited to comment from her perspective as a Committee chair; she was also keen on having one Governor invited on a standing basis proposed in the paper as this would help the Governor in question to develop relationships and understand the function of the Committee, with the other Governor observer being on a rotational basis. Steve Dickens highlighted that the concept of having all of the Governors able to join on Teams had not been discussed by the Effectiveness Group. Notwithstanding this, he believed that having a nominated Governor able to observe for a dedicated three to six month period, with other Governors able to observe as they wanted to would complement this. Kani Trehorn preferred there to be an option for Governors to contribute to the Board Committee meetings if possible. Rob Whiteman summarised the Governors' feedback, which concluded into a proposal to approve option one, explained in the meeting papers, with the addition of the Governors being allowed to observe any Committees they wished to. It was strongly emphasised that ground rules and discipline had to be established to enable the

	Committee to conduct its business effectively. Klaudia Zwolinska added that the Committee's terms of reference would require amendment to facilitate this. Judy Gillow supported this proposal and reiterated that the terms of engagement were required to establish the ground rules. The approach would need to be re-evaluated regularly, starting initially at six months. In terms of the ground rules, Carrie Stone suggested that Governors should have their cameras and microphone off during the meeting, especially if taking place on Teams only. Sharon Collett enquired how the permanent Governors would be selected to sit on the Committee. It was proposed that an expression of interest would be required to be submitted, and the Council of Governors would decide based on that. Rob Whiteman outlined the process as follows: • Governors to provide the Company Secretary Team with their expression of interest as to which Committee they would like to be a permanent observer; • The Company Secretary Team would try to assign every Governor to their first choice (in the case of many Governors wanting to sit on one Committee, the Council of Governors would make the final decision); • The recommendation would be presented to the Council of Governors for approval; • Other Governors would have the opportunity to "tune in" to the meetings. **ACTION:** To invite Governors to submit expressions of interest in being permanent observers at Board Committee meetings. **Company Secretary Team**. Beryl Ezzard emphasised that quoracy at the Committee meetings was crucial. Rob Whiteman explained that only Executive Directors and NEDs were formal members, and the quoracy was based on their attendance only. The Trust Chair emphasised that minimising changes to the meeting schedule for 2025 was essential. The Council of Governors APPROVED the Rotation of Governor Observers at the Committees.
CoG062/24	**Any Other Business** Rob Whiteman raised that there had been a conversation, prior to the beginning of the meeting, about the upcoming industrial action. It was proposed that Governors would receive an update on it as a part of the Board Part 2 meeting feedback. The Council of Governors approved a public event at Probus in Ferndown led by Steve Dickens on 12 June 2024. It was agreed that the Council of Governors meeting would be brought forward to 3 July 2024 so that the meeting did not take place on the same day as the General Election. There being no further business, the meeting was closed.
	The date and time of the next meeting of the Council of Governors was announced as being held on 3 July 2024.

Council of Governors Part 1 Action List - July 2024						
Minute Ref.	**Meeting Date**	**Action**	**Lead**	**Due Date**	**Progress**	**Status**
CoG031/24	04/04/2024	To clarify whether the reference in the informatics section of the IPR (April 2024 meeting) to the number of incorrect filings related to individual pieces of paper or to the number of patient records affected.	Pete Papworth	~~May-24~~ Jul-24	**July 2024:** Update provided by Sarah Hill, Assistant Director IT Development & Health Records: *In relation to the incorrect filing – in the example 110 is the number on the slice and this means that for 110 patients they had a piece of paper in their notes that did not belong to them.*	Complete
CoG059/24	31/05/2024	To share the Patient Experience Strategy and Patient Safety Strategy with the Council of Governors	Siobhan Harrington	Jul-24	**July 2024:** Both documents were shared with the Council of Governors on 17 July 2024.	Complete
CoG061/24	31/05/2024	To invite Governors to submit expressions of interest in being permanent observers at Board Committee meetings.	Company Secretary Team	Oct-24	**July 2024:** The Committees' Terms of Reference are in the process of being updated. The Company Secretary Team will shortly be inviting expressions of interest from Governors to be semi-permanent observers at Board Committee meetings with the proposals to be presented to the Council of Governors at its October 2024 meeting.	In progress

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 5.1

Subject:	Board Assurance Framework (BAF) 2023/24 and 2024/25
Prepared by:	Richard Renaut, Chief Strategy and Transformation Officer
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	The whole BAF (assurance of process)
Purpose of paper:	Information
Executive Summary:	The Board has refreshed and updated the Board Assurance Framework process for both 2023/2024 and 2024/2025. This follows best practice reviews and Board workshops to align the process more closely with strategic objectives and operational governance. **Review of BAF 2023/2024:** • The Board agreed on nine strategic objectives, forming nine BAF risks. • An additional risk for the Electronic Patient Record (EPR) was added mid-year due to its strategic importance. • Introduction of Strategy Deployment Reviews (SDRs) structured around achieving the strategic objectives with monthly 90-minute reviews between the Executive team and each care group. • The review of the refreshed BAF was undertaken by the Audit Committee and shared with the Board of Directors. The good progress on establishing the process was noted. Suggestions for further improvements included: ❖ Continued focus on "horizon scanning" for larger systematic risks, and ongoing review of the risk register and strategic objectives.

	❖ Development of clinical, workforce, and digital strategies will generate further horizon scanning, potentially adding more Board Assurance Framework risks throughout the year. ❖ Quarterly updates to committees and six-monthly updates to the Board, with the item at the beginning of meetings to retain a strategic outlook. **2024/2025:** • Five strategic objectives set, with ten breakthrough objectives, each summarised in a "BAF on a page." • Highest risk areas include Electronic Health Record (risk rating 20), Reconfiguration (16), and Recurrent Financial Surplus (16). • No major changes in headline risk ratings in the first quarter, with progress and manageable risk levels noted. • The detailed BAF summary on a page are attached, provided a summary of the issues, controls and assurances. Of note the counter measures summary (CMS) work, especially around EHR and financial sustainability, have seen significant progress in the first quarter of the year.
Background:	The Board Assurance Framework was refreshed for 2023/24 and reviewed in early 2024/25.
Key Recommendations:	To note the Board Assurance Framework 2024/25 and 2023/24.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
BAF Board Workshop Audit Committee Board Annual plan approval	Feb 2023 May 2024 July 2024	Improved BAF framework from April 2023 Updated Agreed plan and objectives

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)		
	Commercial confidentiality	☐
	Patient confidentiality	☐
	Staff confidentiality	☐
	Other exceptional reason	☐

Board Assurance Framework - Plan on a Page 2024/25

NHS
University Hospitals Dorset
NHS Foundation Trust

Team UHD
Our 5 objectives
2024-25

Population and system
See our patients sooner

Workforce
Be a great place to work

Patient experience
Improve patient experience, listen and act

Quality outcomes and safety
Save lives, improve patient safety

Sustainable services
Use every NHS pound wisely

TITLE	BAF Risk 1 - Risk of not achieving 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance.													
Ref	2072	If the Trust does not deliver its weighted value elective activity plan (109% of 2019/20 baseline) there will be a loss of elective recovery funding to the Trust and the length of waits for patients and/or volume of patients waiting to be seen will increase providing a poor patient and staff experience and increasing the potential for harm.												
Strategic Priority	Population and System Working	Risk Score 2023/24												
Review Date	14/3/25	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Operating Officer	12	12	12	12									3
Lead Committee	Finance & Performance Committee													
Risk Rating		Likelihood			4	Consequence			3	Gaps in Controls			Minor	

Context	Controls	Gaps in Controls or Assurances
The Trust's 2024/25 Operational plan outlines a trajectory to deliver 109% elective recovery of activity against the baseline year 2019/20. Elective Recovery Funding will be awarded to Dorset ICS on achievement of 103% weighted value elective activity and the System has assumed additional benefit to its financial operational plan by achieving above 103%. Increasing elective activity will enable the Trust to reduce its RTT waiting list and the length of waits for patients. This is a key Strategic breakthrough objective within the Patient First Improvement Programme of the Trust.	• Activity plans for each Care Group to provide a forward plan against the Trust trajectory. • Activity planning tool created to map delivery of elective activity to the operational plan and understand any gaps at point of delivery level (First OPA, Day case, Elective Inpatient) • Activity tracking tool provides a weekly update of activity delivered against the target at Care Group and Directorate level so that remedial actions can be put in place where specialties are off plan. • Full award of elective recovery funding has been assumed to allow the Care Groups to seek funding to schedule additional activity. • Productivity programmes: Outpatients, theatres, length of stay, endoscopy and radiology • Patient First Planned Care Improvement programme • Strategy Deployment Reviews • Operational Delivery Group • Contracts with Independent Sector Providers	**Gaps in controls** None identified

PROGRESS – 19 July 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks (12 and above)	How are these challenges being managed
[19/7/2024] The provisional data for June 2024 indicates that the activity delivered by the Trust year to date (108.1%) met the threshold of 103% and operational plan trajectory. Productivity opportunities modelled and data packs have been provided to the Care Groups. Process mining project for outpatients underway and interventions in delivery stage. Care Groups have commenced scheduling additional elective activity from May 2024. Demand and capacity modelling tools being enacted by specialities.	• Impact of Industrial Action on provision of services – Junior Doctors' IA end June/July • Cancer demand is above planned levels and may increase further due to national awareness campaigns and high-profile cases including among the Royal family. April 2024 saw a 9.5% increase in referrals on 23/24 compared to 0.5% increase in 23/24 compared to 22/23. This trend is continuing int May 2024. • Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting. (Risk 1395) • Therapy Staffing (1303) • Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates (1292) • Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NCTR patients (1053) • Lack of substantive consultants in restorative dentistry and delay to patient consultant-led reconstructive treatments (2000) • Increased waiting list for SACT treatment/ Capacity on Day units (1697)	Planned Care Improvement programme in place as a Corporate Project and underpinned by 5 action plans for: outpatients, cancer, data and validation optimisation, diagnostics and theatres. Monitoring group – Operational Delivery Group. Monthly update on delivery at Trust Management Group. Ongoing recruitment to vacancies and insourcing.

TITLE	BAF RISK 2: Risk of not meeting the patient national constitutional standards for Emergency Care													
Ref	14601429	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation (under Review) Ambulance handover delays - risk to patient harm, performance and organisational reputation (under Review)												
Strategic Priority	Population and System Working	Risk Score 2023/24												
Review Date	17/5/24	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Operating Officer	12	12	12	12									6
Lead Committee	FPC													
Risk Rating		Likelihood	3	Consequence	4	Gaps in Controls		Moderate						

Context – Free text	Controls	Gaps in Controls or Assurances
The Delivery plan for Recovering Urgent and Emergency Care Services published January 2023 by NHSE set out the requirement for "*Patients being seen more quickly in emergency departments: with the ambition to improve to *76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25*". *The UHD trajectory for the 24/25 operational plan requires delivery of 78% performance by March 2025. UHD was one of the top 20 most improved Trusts nationally and has received a letter from NHSE acknowledging this improvement – along with a one of £1m capital allocation.	• This is a key Strategic breakthrough objective within the Patient First Improvement Programme of the Trust. • Requirement to monitor and report against National Standard • Daily Performance reporting against metrics to Execs • Daily operational meetings to support UEC flow and challenges 7 days a week • Timed Admissions Process (TAD) evoked (Push model) • Compliance with Trust and ED Escalation plans/SOPs • IPS optimisation with clinically led weekly review in place • Diagnostic delays standards (blood tests/x-ray and CT) • 'Surge Management' criteria and plan • Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy. • 4-hour performance metrics linked to ED escalation • Escalation email/text process along with ED shift report template improvement • MIU and UTC Type 3 ED attendances being reported • Daily Breach Review Meetings • 20 Additional beds funded in 24/25 • 2024/25 capacity plan agreed and Health of the Ward amended to reflect changes and align with the national reporting specification.	**Performance Monitoring and Reporting**: • Gaps in assurance for sustainable delivery of 4-hour standard. • Type 3 data from MIU and UTC remains a manual process: needs to be automated for new standards **ED and Hospital Processes** • Plans to deliver effective change require review and challenge to ensure continual improvement. • SDEC pathways not in place 12 hours a day 7 days a week across all services. • Admitted performance particularly challenging in June due to IPC (Norovirus & COVID 19). **Workforce** • Gaps in recruitment remain a key challenge – pulling consultants onto nights and reducing senior decision maker cover. NOTE: Consultant consultation has been launched. • Capacity across the organisation to respond to the issues and take necessary action, including change management capacity. **External Factors** • UEC growth and NCtR numbers contribute to reduced patient flow and performance • Local Health and Social Care System schemes and delivery to support UEC access

PROGRESS – 1st July 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
UHD was one of the top 20 most improved Trusts nationally and has received a letter from NHSE acknowledging this improvement – along with a one of £1m capital allocation. • Performance against the 4-hour standard for June 2024 was 72.2% against a plan of 73%	• 24/25 operational plan requires delivery of 78% performance • ED middle grade staffing continues to be a significant challenge. • SDEC Services not 12 hours a day, 7 days a week in key specialties • Challenges to sustain performance overnight and at weekends resulting in long waits and inability to recover performance. • Demand on UTC primary care capacity • Some reduction in No Criteria to Reside numbers at a system level, but	• SDECs released from being bedded. • SDEC workstream refreshed to develop opportunities and reduce variation and inconsistency cross specialty and site. • Focused work with BI ensures a full suite of data to support recovery – reporting now going to UEC Programme Board • ED medical staff template funded in budget setting 23/24 – recruiting, ongoing gaps in middle grade tier.

• All SDECs areas released from escalation as well as TIU cross site as attendance avoidance services. • Focused curiosity and oversight on improving 4 hour awareness and delivery • Revision of legacy action plans to develop single working plan complete. • A revised fortnightly UEC Programme Board has been launched to promote Trust-wide engagement and ensure plans are being robustly monitored.	remains just below 200 • Changes to discharge transport have reduced the hours of service. Now not available overnight and reduced timings at weekends. Currently being evaluated with the intention of addressing with evidence of the impact to flow.	• Surgical SDEC now 7 days. Medical plans delivering weekend service from November 2023 one in three, clear ask for more. • UHD UEC Programme board established - aligning to patient first methodology and patient pathways. • ECIST review and Criteria to Admit Audit complete, and second audit undertaken to develop opportunities. Action plan in place.

TITLE	BAF Risk 3 – Risk of not significantly improving staff experience and retention over the next 3 years (and not being in the NHS staff survey results top 20% of comparator trusts).														
Associated significant risks	**1221** Medical Staffing Shortages – Older Person Services – Staffing (15) **1933** Medical Staffing Shortages – ED – Staffing (12) **1771** Radiology Staffing Shortages – Staffing (12) **1283** Radiotherapy Staffing Shortages – Staffing (12) **1202** Medical Staffind – Womens' Health – Staffing (12)														
Review Date	26/6/24		Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CPO		12	12	12										8
Lead Committee	PCC														
Risk Rating			Likelihood	3	Consequence	4	Gaps in Controls		Moderate						

Context – *Free text*	Controls	Gaps in Controls or Assurances
The NHS relies on its workforce to deliver patient centred care and services. There is evidence that staff working within the NHS are tired, feeling burnt out and also demoralised by national pay concerns which has led to industrial action across the NHS and has further impacted on staff morale, satisfaction and retention. UHD also has a major transformation programme which requires some staff to move sites. Risk 1492 – Vacancy rates have fallen across the organisation and the joining rate has been higher than turnover rate for 15 months. There is a significant focus on reducing vacancies, improving rostering and staff planning/utilisation, and eliminating high-cost agency. Staff are our biggest asset and key to the success of our services and organisation and in achieving our aim of being a great place to work.	People & Culture Strategy Recruitment & Retention Plan Patient First Programme People Ready strand of TCT Programme Health and wellbeing staff offer, occupational health service standards Access to proactive and preventative services Staff survey (local and national) action plans Annual Leave procedures Flexible Working policy Staff sickness absence policy Recruitment and Retention policy CQC well led key lines of enquiry Agency reduction plan	Refresh of the People & Culture Strategy Reliance on the temporary workforce Better exit interview information that is reviewed locally and triangulated with other data Stay questionnaire survey data to aid retention Medical staffing rostering ongoing. Appraisal compliance Job planning compliance

PROGRESS

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
Risk 1493- Risk description sickness absence levels continue to reduce over the 12-month rolling period but levels are not reducing consistently month on month with some variations. Staff networks support staff engagement and the current high completion rate for the staff survey is encouraging. Staff support through the Occupational Health and Psychological Support and Counselling Service (PSC) along with stress assessment tools are in place and in use Staff data cleanse has been completed in terms of confirming staff in post	Attracting recruiting and retaining staff who feel supported and optimistic about the changes in buildings, services and sites and not worried about the personal impact for them. Managing the scale of the changes including staff consultations continues. Stress / anxiety / depression remains one of top 5 reasons despite comparison data showing a decrease compared to previous years. Recording on this reason for absence does not distinguish about workplace stress	People Ready Strand of TCT now in place The roll-out of sickness absence training for leaders continues to take place. Audits to ensure assessment tools and support are being used for staff off with stress, anxiety and depression in line with our policies Demonstrating the return on investment for health and well-being support and reviewing regularly the services provided and

against the correct budget linesnin ESR Ward template reviews complete with agreement given at Trust Management Group. Risk 1811 – Positive progress has been made with recruiting to the templates with the care groups and leads. Theatre vacancies have reduced from 18% to 10% with a further reduction anticipated. The amount of over time worked across UHD theatres has reduced.	or home external stressors Reliance on the temporary workforce - improvement required in rostering practice at ward and department level and making sure that people are rostering in advance, managing leave, managing unused hours to standard system of operation. The same applies to Health Rota and Job planning for medical staff	communicating these effectively. Agency Reduction Plan in place. Roster performance stats shared with more training being developed to improve understanding and better forward planning. Change to shift request reasons implemented and a heightened focus. Patient First corporate project to focus on E roster and Health rota.

TITLE	BAF Risk 4 – Risk that not every team is empowered to make improvements using patient feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.														
Ref	1920	Risk that the Trust does not have adequate systems and processes in place to promote, gather, triangulate and utilise patient feedback consistently across UHD. It is therefore recognised that this may result in missed opportunities for learning and improvement in patient experience.													
Strategic Priority	Patient Experience	Risk Score													
Review Date			Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CNO	L=3 S=2 RR=6	6	6	6	6									6
Lead Committee	QC														
Risk Rating	6	Likelihood	3	Consequence	2	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The NHS Constitution set out a clear message that the NHS should put patients and the public at the heart of everything it does. The NHS must be more responsive to the needs and the wishes of the public, all of whom will use its services at some point in their lives (NHSE 2016). UHD needs to ensure that the public, patient and carer voices are at the centre of our healthcare services, from planning to delivery. More recently, the legal duty to *involve* has extended to provider services. (NHSE 2023). Service providers will collect results of FFT, analyse them and see if any action is needed. Providers are also encouraged to inform patients about comments and suggestions they have received and include actions they have taken in response. (NHSE 2013). UHD is developing a unified patient experience service to ensure that we • Encourage and support patients and carers to 'tell their stories' • Use these stories to pinpoint those parts of the care pathway where the users' experience is most powerfully shaped • working with patients, carers and frontline staff to redesign these experiences rather than just systems and processes • Empower teams to make continuous improvement by engaging with patients in a meaningful way	• Statutory Duty to involve patients • FFT surveillance • CQC National Survey Programme • NICE Guidance Quality Standard 15 • NHSE Patient Experience Framework • UHD Patient Engagement Strategy • UHD Patient Experience Group • Monitoring of complaints trends • Care group governance meetings • Quality reporting - IPR • UHD QI reporting/projects • CQC KLOE • National patient safety strategy – patient safety partners	Response rates of FFT in UHD is not significantly high therefore does not give a true representation of our patient's experiences. Not all patients are aware of how to give patient feedback Not all services are getting patient feedback due to low response rates Those teams that are getting FFT/HYS data there is limited assurance regarding meaningful continuous quality improvement Limited assurance that QI that takes place is continuous. Not all services are receiving patient experience data consistently across our care groups.

PROGRESS – 19th July 24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
1. Patient experience strategy continues to be driven	1. Ensuring staff understand the	1. Continue to work with the senior clinical and

through Patient Experience Group (PEG), working alongside our care group and reported in Quarterly reports. 2. We are continuing to increase awarness of the Have your say (HYS) survey which has been designed with core questions and additional questions driven by departments. Now published on website and linked to FFT SMS messaging. 3. Number of FFT returns remains static but have increased since UHD SMS text messaging service commenced. Rating of Very Good/ Good remains over the upper control. 4. A focus through PEG on FFT returns which are low and those that continue to be received from more services. 5. There continues to be improvements in the 55-day complaints and now receiving feedback from complainants. 6. Progress has been made with BI and Agile to collect FFT responses, though not completed aligned the BI team are working through the current issues. 7. National Inpatient Survey for 2023 to be published in August 2024 with an opportunity for further learning to be shared.	strategic direction of patient experience and all work is aligned. 2. HYS data transfer to BI for inclusion on dashboard. BI and Patient Experience team working on this. 3. Working toward 'every contact has a SMS'- different platforms for CT/MRI and Pathology still need to be joined. ED still not online through Agyle. 4. Problems with accuracy of data as patients often do not know which outpatient clinic they visit 5. Platform being developed, need it to be interactive and useable 6. New format of report which has always been well received at Quality committee 7. Understanding and capturing the QI work undertaken by services in relation to improving patient experience by feedback .	ward leads embedding the strategy, ensuring that improvement is aligned to one or more of the strategies principles. 2. Seeing some returns, but accuracy of location continues to require improving- BI and Patient Experience team working together an ensuring that all areas are represented. 3. Patient Experience team working with BI to ensure the data can be transferred from the warehouse. Change request outstanding for Agyle- near completion. Soliton consent resolved and awaiting BI to build into system, which continues. 4. Patient Experience team working with BI to ensure FFT for OPD is coded to speciality. 5. Patient Experience team with BI developing the experience platform further. 6. Feedback on new way of reporting positive and linkage to the strategy clearer. 7. Encouraging care groups to ensure that is shared and captured at directorate / care group level and feeding through to the PEG group for cascade and sharing of good practice.

TITLE	BAF Risk 5 – Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next 3 years													
Ref	1922	If the Trust does not fully implement and embed an effective Trust wide learning from deaths process, then there is a risk that patient safety and patient care will be sub-optimal increasing the risk of avoidable deaths and an above expected HSMR.												
Strategic Priority	Quality	Risk Score												
			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CMO	L=2 S=4 RR=8	8	8	8										6
Lead Committee	QC														
Risk Rating	8	Likelihood	2	Consequence	4	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
HSMR has been steady rising over the last 3 years There is variation across our sites	UHD Learning from Deaths Policy UHD Medical Examiners Policy LERN policy and toolkit	Audit of M&M meetings (2022/23) identified inconsistent approach to mortality governance across UHD Compliance with mortality case note reviews not consistent

PROGRESS – 30/6/24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
MSG ToR and Learning from Deaths policy (and supporting Toolkit) to be reviewed – Medical Director for Quality leading. New Mortality dashboard now live New mortality metrics available via HED, training provided. Review of MSG in progress – new structure to start in June. Risk rating remains the same due to identified gaps in controls and assurances.	eLearning from deaths process rolled out across UHD but not all cases reviewed as per policy. Decision made to amend policy and triage cases selected for full case note (emortality) review. Aim is to focus on reviewing less cases but with more detail on key areas and opportunities for learning and improvement. Work on going to strengthen Care Group mortality governance processes. Reconfigured Trust Mortality Group to start in June 24.	Resource requirement to support redevelopment of eMortality system now agreed (May 24) and project specification now developed. Positive engagement from clinical stakeholders, BI team, Patient safety, ME, bereavement and IT developers. List of key requirements to be developed to enable project plan established. Design work started (JUne 24) Discussion to be held with IT Systems team to consider long term support for emortality system as admin and tech support will be essential for effective implementation and sustainability. Recognised this is a Trust wide essential system and a priority for Patient First objective

TITLE	BAF Risk 6 – If insufficient resources are in place for the implementation and continuation of PSIRF then there is a risk the Trust will not learn from patient safety events and will not reduce patient harm events.														
Ref	**2079**														
Strategic Priority	**Quality**	**Risk Score**													
Review Date		**new**	**Apr**	**May**	**Ju**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Target**
Executive Lead	**CMO**	**2079**	**9**	**9**	**9**										
Lead Committee	**QC**														
Risk Rating		Likelihood	3	Consequence	3	Gaps in Controls	**Moderate**								

Context – *Free text*	**Controls**	**Gaps in Controls or Assurances**
PSIRF plan approved Nov 23 but limited resources centrally and in Care Groups to implement the new systems and process needed to embed change. PSIRF requires a significant fundamental shift in the way patient safety events are discussed reviewed and investigated with the basis of learning directed at local level.	PSIRF Plan PSIRF Implementation programme PSIRF reporting templates and processes Care Group PSIRF Insight and Oversight Groups Well established LERN reporting culture Roll out of UHDPSaF	Gaps in Patient Safety team staffing – 2 Band 7 and 2 0.5 wte 8a post currently vacant although post holders have been appointed and should be in place by end of summer. Vacancies for patient safety administrators to validate the LERNs that are reported, Training has been on hold due to lack of resources and training packages for the intranet are being worked through Care Groups have yet to establish PSIRF Insight meetings and are struggling with resource to support. Risk management strategy and LERN Policy out of date and need revising to align to patient first and PSIRF PSIRF Toolkit not yet in place PSIRF guidance documents to be produced PSIRF dashboard and counter measure summaries being developed but not yet in place. Safety strategy to be developed Gaps in ward action plans for key PSIRF priorities – falls and pressure ulcers

PROGRESS 30/6/24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
PSIRF Plan agreed PSIRF training provided – 30 trained PSS investigators trained UHD PSIRF templates agreed and in use LFPSE has been implemented and incident reporting numbers remain consistent, Learn at lunch sessions are well attended	Additional training required to support implementation of PSIRF principles and methodology at local level e.g. safety huddles, After Action Reviews. Ward improvement plans for falls and pressure ulcers need to be consistently applied and updated across the Trust Standard agenda for Care Group PSIRF meetings being developed for pilot	Working with Care Groups to establish PSIRF meetings Exec support for Care Groups to look at appointing additional senior risk and governance role to support implementation (Care groups to self-fund) Development of Safety Strategy, Risk Strategy and PSIRF policy planned Working with Clinical Practice forum lead on processes to learn from falls and pressure ulcers. Working with Maternity leads to pilot use of After-action reviews Pilot with Critical care planned to focus on Just and

		Restorative Culture

BAF RISK 7	Risk of not returning to recurrent financial surplus from 2026/27
Strategic Priority	Sustainable Services
Risk Reference	1595
Review Date	Jun-24
Executive Lead	Chief Finance Officer
Lead Committee	Finance and Performance

RISK SCORE												
Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Target
16	16	16										8

Context	Controls	Gaps in Controls or Assurances
Whilst the Trust has set a balanced revenue budget for 2024/25, this contains significant financial risk. Specifically, the financial plan includes an Efficiency Improvement Programme of 5% equating to £42 million, a requirement to achieve elective recovery of 109%, operating within 20 funded escalation beds, and requires a 33% reduction in agency expenditure. In addition, each directorate holds a number of potential cost pressures which they are required to mitigate locally alongside these trust level requirements. At the end of June the Trust is reporting an adverse variance to plan of £1.2million. This has been caused by the Junior Doctors industrial action in June, with a financial impact of £1.0m. Efficiency schemes were on plan in June, and whilst agency remained above budget, there was a continued reduction in expenditure during June.	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, Financial Management Accountability Framework and other finance policies and procedures in place. • Monthly reporting to TMG, FPC and Board highlighting risks and mitigating actions. • Patient First 'driver' and 'watch' metrics agreed and monitored monthly. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery.	• Weaknesses in temporary staffing controls and roster management. Mitigation: External review of TSO, re-establishment of e-roster steering board, new e-form in development for approval of nursing/ HCA agency (Lead = CPO). • Incomplete medical job plans and inconsistent premium medical rates. Mitigation: Refreshed job planning policy, use of electronic systems, consistent rate card utilised through locums nest (Lead = CMO). • Weaknesses in the approval process for the opening of unfunded escalation capacity. Mitigation: New SOP approved to inform consistent escalation process, de-escalation plan developed and progressing (Lead = COO).

Progress

What is going well: action plan & future opportunities	Current challenges including future risks	How are these challenges being managed
• Budgets formally delegated and accepted. • Implementation of Patient First metrics and SDRs. • Detailed variance analysis and escalation of issues. • Embedding of Care Group financial governance.	• CIP identification and delivery. • Operational pressures/ escalation beds. • Productivity improvements supporting elective recovery. • Premium pay expenditure. • Industrial action.	• Patient First approach to Sustainable Services. • Senior finance and additional PMO support in place. • Enhanced business intelligence for temporary staffing. • Medium-Term Financial Plan being refined.

TITLE	BAF Risk 8 – Risk of not successfully and sustainably adopting the patient first approach across UHD													
Ref	1924	Risk that benefits of transformation, improvement and innovation are not realised												
Strategic Priority	Patient First Programme	Risk Score												
Review Date		new	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CEO	2992	12	12	12										6
Lead Committee	TMG														
Risk Rating		Likelihood			3		consequences		4		Gaps in controls		Moderate		

Context	Controls	Gaps in controls or assurance
The trust has made rapid progress in year 1 (2023/24) introducing Patient First at UHD, developing our strategy, agreeing our trust priorities and piloting Patient First training for both leaders and frontline teams. Year two (2024/25) builds on these foundations refining how we monitor our corporate projects, improving our TMG level strategy deployment reviews (SRD), extending SDR to care group and corporate functions and training more staff, teams and leaders so they can play their role in adopting Patient First at UHD.	PID (to ensure clarity on the scope) Programme pillars Steering board ToR Reporting to TMG, and assurance to BoD Patient First methodology A3 thinking methodology Annual patient first cycle linked to annual plan Maturity assessments to be completed 6 monthly now SDR in place	Moderate gaps in controls A full benefits realisation plan is required to align directly with strategic themes and corporate projects following completion of Phase 2

PROGRESS – 25 June 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
Training and resource plan for year 2 agreed PFSG May 24. Additional band 7 improvement facilitator role approved – recruitment summer 2024. Further cohorts of Patient First for Leaders, Patient First Improvement System and A3 training for staff delivered as per plan. Feedback and ongoing joint evaluation with BU inform continuous improvement of training. Execs supporting delivery. TMG level SDR now in place, Care Group level SDR piloted March '24. Board development sessions for NEDS to ensure non-executive directors are a) adequately briefed on progress and b) identify opportunities to engage in several continuous improvement activities with UHD staff. New resources including video shorts under development to support development of UHD Patient First Community of Practice. A3 training, "Let's have a Conversation" and "Patient First Open Forum" sessions	Key Risks: • Slippage of key milestones and deliverables resulting in programme delays and delayed delivery of outcomes (RPF004) • Patient First programme scope reduced, or time scale extended due to time constraints execs and operational teams (RPF006) • Failure to gain support from regulators resulting in uncertainty and potentially additional work pressures on staff (RPF 008) • Failure to decommission other activities not linked to True North and Breakthrough objectives (RPF007) • Failure to access robust business intelligence support resulting in failure to carry out analysis of the opportunities (RPF009) • Lack of ongoing programme management	Risk log reviewed monthly. Latest mitigations: • Year 2 programme and training plan agreed. • Additional support from PF team offered to Execs to strengthen corporate project templates. • UHD engaged with NHS IMPACT programme & network – Clinical Director visited UHD 5.4.24 • Scorecards development progressing – Exec involvement to help prioritise BI workload. • All Patient First training programmes revised and shortened following pilot phase in order to reduce need to release staff to attend off site training. New "in the workplace" coaching component added to PFIS training. • Execs supporting managers to prioritise staff attendance at PF training.

provide multiple opportunities for any UHD staff to get involved with Patient First and support further development and sharing of ideas/experience post PFIS / PfFL training.	resource and appropriate budget to drive implementation and roll out (RPF003) • Lack of ability to release staff for Patient First training leading to reduce skills transfer / lower value for money (RPF011) Key Issues: • Communication of Patient First purpose and benefits to staff is currently ineffective (RPF015) • Challenge of booking training venues for essential patient first training due to lack of capacity within UHD estate and lack of resource for external venues	• Patient First Community of Practice pillar under development to support staff access to patient first resources, training and facilitate ongoing engagement across hospitals. • Potential new on-site training facility at Christchurch under investigation

TITLE	BAF Risk 9 – Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals														
Ref	1784	Critical Path Management													
		Risk Score													
Review Date			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CSTO	1784	16	16	16										12
Lead Committee	FPC														
Risk Rating		Likelihood	4	Consequence	4	Gaps in Controls	Moderate								

Context	Controls	Gaps in Controls or Assurances
Taking lessons from previous relocations, such as the one in Bristol, we have recognized the importance of integrating and operating services as a unified entity at least 6 to 9 months prior to any move. As our build programs become more defined, our efforts need to shift towards the integration of teams. Therefore, as we approach the integration phase, our governance structure will be aligned with the four phases of reconfiguration, with a greater emphasis on preparing services for reconfiguration rather than solely focusing on the build program. The Acute Reconfiguration Capital Group will be renamed the Build Ready Group and ensure delivery of the buildings and manage risks. The Reconfiguration Oversight Group will be transformed into the Service Ready and Move Group and manage the critical path to being ready for treating patients in our reconfigured services. There will also be potential challenges associated with the hygiene factors such as staff rest areas and transport and we will need to have effective governance and communications in place to manage this.	**Prevention** Evidence of effective governance: • Speciality level plans in place • Meeting structure, attendance, escalation and resolution from speciality steering groups into CG and then Service Ready Group (SRG) • Service Reviews to assess readiness for moves with actions followed up by Care Groups • Robust critical path timeline that clearly articulates deliverables and interdependencies between specific deliverables • Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration) • Focus on Critical Path actions **Detection:** Internal Audit, NHP Scrutiny/Governance, external Gateway process, result of Service Review findings and progress on critical path actions. Go/No Go checklist and criteria	Moderate gaps: Development of Service reviews and associated scorecard. Focus on critical path actions during 2024. Changes to the build programme and interdependency with the reconfiguration programme Assurance that actions identified at speciality, CG and during Speciality reviews are completed Effective Working Groups in place to manage the hygiene factors (e.g Travel Working Group and Improving Staff Experience Group)
PROGRESS – 26 June 2024		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
• Scored reduced to 16 (Likelihood reduced from 5 to 4) as transition to new governance complete and working well • Transforming Care Together Group has now met on 3 occasions to provide assurance • Care Group reporting strengthened and new focus on critical path actions from January 2024. Red actions escalated to SRG and also to TMG SDR. • Service review process well underway with 36 services now	Risk score reduced to 16 in August 2023 as revised governance and service review process now in place. However, issue remains the same with biggest risk being capacity and capability to implement integration plans, actions identified by service reviews and actions identified by SRG and CG TSG's. Progress variable access different specialties with operational pressures taking precedence. Now focusing on those Phase 2 service that are moving into the BEACH in Spring 2025. Maternity/NICU currently in enhanced	Monthly meetings (BRG, SRG, Care Grp TSG's) that reviews and escalated any barriers and delays. Linking of operational and integration plans via COO. External support and Internal Audit

reviewed. 8 services rated red to date and will be reviewed again in 3 months to review progress. • Service Review schedule amended to prioritise services moving in April 2025 (Phase 2 services) • People Ready Group agreed and in place from June 2024 • Gateway review process agreed for Phase 2 services • Agreed for go/no go checklist and QIA to be used for all Move Early service to ensure consistency and most services now moved (Surgical beds and Haem complete. TIU in June) • Maternity/NICU in enhanced support as currently off track for move planning. • Transitional funds reviewed and monies to support operational delivery brought forward – current recruitment of operational change delivery resources to support capacity in Care Groups to deliver integration plans and service review actions • FBC A approved at Joint Investment Committee on 22.03.24 and Treasury approval on 08.05.24. FBC B submission date to be confirmed • Recent changes to parking permits and update to Staff Partnership Forum on travel actions. Recruitment for Transport and Travel Manager now commenced.	support. Unplanned costs that are not part of transitional funds and for any revenue costs not factored into budget remain a current challenge. Individual business cases to FPG on this e.g. Housekeeping. The beds gap is still a concern and option appraisal being developed on the impact and options for this on the Phase 3 moves (Nov 2025) People Ready Group now in place but workforce planning remain key risk for Service ready - some workforce plans still outstanding. Workforce review and triangulation now agreed for Phase 2 services to align with gateway process. From a build ready perspective, Building Safety Act is a key risk. Both Bournemouth and Poole main buildings (plus Parkstone House) fall within the parameters of the Building Safety Act and must comply. This will increase the programme time and cost for all projects which fall under Category A works. Possible delays to Junior Dr Mess could impact on critical path. Space also remains a challenge but space requests to be submitted by 1 April 2024 and space principles document agreed at TMG in May 2024. Scenario testing completed in March to understand impact and mitigations for build delays and operational readiness on overarching programme.	review of Reconfiguration Programme Internal Gateway Review process for Phase 2 service moves. External gateway assurance for Gateway 2 for Phase 2 moves

TITLE	BAF Risk 10 - Risk that the trusts Electronic Patient Record (EPR) not fit for purpose for UHD and this contributes to the 3 risks referenced below												
Ref	1950 1872 (20) 1378 (15)	**The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose** Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding Lack of Electronic results acknowledgement system											
Strategic Priority		Risk Score 2024/25											
Review Date	09/07/24	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Finance Officer	20	20	20	20									6
Lead Committee	FPC													
Risk Rating	20	Likelihood	4	Consequence	5	Gaps in Controls	High							

Context	Controls	Gaps in Controls or Assurances
UHD has an EPR (Graphnet) using 1990s computer code, to which few coders can now use. UHD is the sole remaining customer and the supplier will only support the system until April 2027. The Medical Staff Committee (MSC) at UHD have written as a body highlighting there are considerable clinical risks with Graphnet, and these are reflected in the Trust risk register. These risks are: i. Inhibited Patient Flow and increased length of stay, due to poor functionality (risk rating 20) ii. Lack of closed loop reporting of results, leading to delayed or missed diagnosis (risk rating 15) Clinicians are also highlighting the impact of reduced productivity as less patients are seen per clinic, theatre list and ward round due to the time taken navigating multiple disjointed, separate systems. Doctors in training rotating between Trusts see the difference and are less likely to want a career at UHD due to "unsafe, and labour-intensive IT systems."	The Electronic Health Record Programme (EHR) is moving forward where UHD will partner with Somerset and Dorset to procure a new system that will replace all the current key IT systems, an update was provided to the Board in January 2024. The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place: • Underpinning legal contracts with software suppliers • Immutable backups (i.e. cannot be affected by malware) • Staff training programmes • Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit • UHD wide Business Continuity Plan • Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state • Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state	• Substantial gaps in the functionality of our EPR ecosystem relating to the management of the workflow of diagnostic results and reports and assured clinical transactions generally (e.g. therapy input and interprofessional referrals). • No effective single user interface for clinicians to manage their core care processes. • Local departmental Business Continuity Plans are not yet in place – these are in development with a plan to develop by June 2024.

PROGRESS – 9th July 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
• Outline Business Case has been submitted to Region as the first stage in the external approval of the funding. • Current scope – Somerset Acute / Community / Mental Health and Dorset Acute / Mental Health. • Communication plan needs to be stepped up to increase the Trust wide communications, but this will be progressed once the business case is in the approval process. • Governance from OBC to contract award is agreed with new workstreams being setup before the end of July 2024.	Based on average times for events supplied by region the timeline for the EHR is now a risk for UHD. The OBC should be approved by Dorset and Somerset for passing to region by end-June. This then goes into a 5-month funding approval process after which procurement can commence. This is due for contract award October 2025 with a go live of April 2027. The election being announced may cause a delay in the above timeline due to the cabinet office approval required in the funding approval. At this point the belief is this is a delay to the LPP contract award so only a delay in pre market	• Single Dorset and Somerset Partnership Board with Chief Execs, SROs and the Programme Director has had their first meeting, regular dates now in the diary. • Single Dorset and Somerset EHR board is now in place and running monthly to keep decisions moving forward. • Somerset Programme director is leading the Business case and procurement process jointly. And Ethical remains supporting the Dorset Programme for readiness. • Weekly EHR Leadership meting to ensure workstreams are progressing as required. • New workstreams being identified to support the EHR

• Change Management review with Frontline Digitisation has taken place and an action plan has been shared to clarify where we are on the planning for the change. • Site visit to Sunderland happening on the 11th July with plans to visit Northern Ireland and Finland in August. • Work planned to upgrade the hardware and SQL version of the EPR environment so that the equipment will support the system to 2027. • Discussion with Graphnet to be scheduled to ensure that any learning the Trust needs to better support the system is arranged.	engagement elements. Graphnet / System C have confirmed their ability to support the EPR to the end of April 2027 to give us coverage until the EHR goes live. Region have offered some support from the DSS team to see if any other support can be looked at around this solution, meetings booked with DSS to investigate further options. The Trust has accepted the reduced service offered in the support of the EPR system from 1st April 2025 to end of April 2027. The DSS team from Region will also do a readiness review during their engagement with the Trust and wider partners.	programme up to contract award – these are joint Dorset and Somerset. • New governance in Informatics at UHD to support the wider digital programme but also to ensure the responsibility and drive for the EHR programme moving forward.

NHS
University Hospitals Dorset
NHS Foundation Trust

Team UHD
Our 7 objectives
2023-24

SEE OUR PATIENTS SOONER

BE A GREAT PLACE TO WORK

IMPROVE PATIENT EXPERIENCE BY ACTING ON FEEDBACK

SAVE LIVES BY IMPROVING PATIENT SAFETY

USE EVERY NHS POUND WISELY

START ON OUR PATIENT FIRST JOURNEY

WORK AS ONE TEAM, FIT FOR FUTURE CHANGES

TITLE	BAF Risk 1 - Risk of not meeting the patient national constitutional standards for Planned Care (No patients waiting more than 65 weeks on Referral to Treatment (RTT) pathway by March 2024)												
Ref	1074	Timely access to Planned Care - If we do not deliver on effective improvement plans to meet access standards then we will create patient safety risk, widen inequalities and be subject to regulatory action.											
Strategic Priority	**Population and System Working**	**Risk Score 2023/24**											
Review Date	14/3/24	**Apr**	**May**	**Ju**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Target**
Executive Lead	Chief Operating Officer	20	20	20	20	16	16	16	16	16	16	16	9	6
Lead Committee	Finance & Performance Committee													
Risk Rating		Likelihood			3	Consequence			3	Gaps in Controls			Moderate	

Context	Controls	Gaps in Controls or Assurances
NHSE 2023/24 operational planning priorities for planned (elective) care require Trusts to: • Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) • Deliver the system- specific activity targets UHD has set the following strategic target and stretch target for 2023/24: • To have no patients waiting in excess of 65 weeks on an RTT pathway to be seen and treated by 31 March 2024 • Stretch: To have 0 non admitted patients above 52 weeks by March 2024	• Annual Operational plan 23/24 and recovery trajectories. Revised in October 2023. • Planned Care Improvement programme to control variation and efficiency. • Trust Access policy and SOPs for waiting list management set out standard way of working. • Clinical prioritisation/risk stratification of waiting lists and harm review process for patients waiting beyond planned dates reduces the likelihood and impact of any delays for patients. • Planned Care and performance governance arrangements aligned to the Trust's Accountability Framework. • Elective Recovery Funding and activity plan agreed, which aims to control the level of reliance on temporary staffing and independent sector providers to provide necessary capacity • Single PAS to enable equitable and timely patient access. • Performance reports to track performance metrics and activity targets, with deep dive analysis of data where required.	**Gaps in controls** Significant reconfiguration programme and operational pressures impact on operational and improvement capacity to respond to the issues and take necessary action. *Mitigation: Alignment of Planned Care Improvement Programme, Patient First and Reconfiguration programme (Lead = COO)* Weaknesses in improvement plans to deliver an increase in activity levels at the level needed to support demand. *Mitigation: Full review of planned care improvement programme undertaken Electivity activity planning tool developed to support planning in 24/25 (Lead = COO)*

PROGRESS – 14 March 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
[11/04/2024] 6% reduction in the RTT waiting list in 2023/24 and maintained an improvement in 18 Week RTT performance at 62% compared to 53.8% in March 2023. A reduction in both RTT waits greater than 78 weeks and 65 weeks in March 2024 delivered, however the Trust was not able to recover against its trajectory to eliminate long waiters due to the in-year impacts of lost activity due to Industrial Action, workforce challenges and high non-elective bed occupancy. A review of the improvement actions for 2024/25 is now underway. Key actions: • Prioritising patients at risk of breaching >65 weeks before Sept 2024 • Elective Recovery Fund activity plan has been deployed focused on maintaining safe wait times. • Achieving a minimum of 104% elective activity. • Delivering on productivity improvement plans for outpatients, theatres, endoscopy, length of stay and radiology.	• Impact of Industrial Action on provision of services (Risk 1863) • Bed occupancy remains high and continues at times to impact on elective capacity (Risk 1053) • Cancer demand is above planned levels and may increase further due to national awareness campaigns and high-profile cases including among the Royal family (Risk 1386) • Radiographer staffing (Risk 1283) cellular pathology (Risk 1395) • High follow up waiting list backlog (Risk 1292) – ongoing reduction plan in place • Capacity to see or treat the volume of patients on PTL>18 weeks (1053) • Endoscopy capacity and demand (1393)	Planned Care Improvement programme in place as a Corporate Project and underpinned by 5 action plans for: outpatients, cancer, data and validation optimisation, diagnostics and theatres. Monitoring group – Operational Delivery Group. Monthly update on delivery at Trust Management Group. Risk appetite for maintaining a level of electives during IA agreed between COO/CNO/CMO. Ongoing recruitment to vacancies and insourcing.

TITLE	BAF RISK 2: Risk of not meeting the patient national constitutional standards for Emergency Care													
Ref	1460 Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation. 1429 Ambulance handover delays - risk to patient harm, performance and organisational reputation													
Strategic Priority	Population and System Working	Risk Score 2023/24												
Review Date	9/4/2024	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Operating Officer	20	20	20	20	20	20	20	20	20	20	20	20	6
Lead Committee	FPC													
Risk Rating		Likelihood	5	Conseq uence	4	Gaps in Controls		Moderate						

Context – Free text	Controls	Gaps in Controls or Assurances
The Delivery plan for Recovering Urgent and Emergency Care Services published January 2023 by NHSE set out the requirement for "*Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25*". UHD Trajectory developed to achieve 76% against the 4-hour standard, with increased scrutiny in March 24 nationally. 24/25 operational plan requires delivery of 78% performance by March 2025.	• Requirement to monitor and report against National Standard • Daily Performance reporting against metrics • Daily operational meetings to support UEC flow and challenges 7 days a week • Timed Admissions Process evoked (Push model) • Compliance with Trust and ED Escalation plans/SOPs • IPS optimisation • Diagnostic delays standards (blood tests/x-ray and CT) • 'Surge Management' criteria and plan • Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy. • 4 hour performance metrics linked to ED escalation • Escalation email/text process along with ED shift report template improvement • MIU and UTC Type 3 ED attendances being reported • Daily Breach Review Meetings	**Performance Monitoring and Reporting**: • Gaps in assurance for sustainable delivery of 4-hour standard. • Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards **ED and Hospital Processes** • Plans to deliver effective change and monitoring are not developed to maturity. • SDEC pathways not in place 12 hours a day 7 days a week across all services. **Workforce** • Gaps in recruitment remain a key challenge – pulling consultants onto nights and reducing senior decision maker cover. • Capacity across the organisation to respond to the issues and take necessary action, including change management capacity. **External Factors** • UEC growth and NCtR numbers contribute to reduced patient flow and performance

PROGRESS – 9th April 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
• Performance against the 4-hour standard for March 2024 was 70.2% against a plan of 76% • SDECs areas released from escalation • Focused curiosity and oversight improving 4 hour awareness and delivery • Executive-led weekly enhanced support meeting continues and has adopted the NHSE Tier 1 methodology. • Revision of legacy action plans to develop single working plan compete. • A revised fortnightly UEC Programme Board has been launched to promote Trust-wide engagement and ensure plans are being robustly monitored.	• 24/25 operational plan requires delivery of 78% performance • ED middle grade staffing continues to be a significant challenge. • SDEC Services not 12 hours a day, 7 days a week in key specialties • Unable to sustain performance overnight and at weekends resulting in long waits and inability to recover performance. • Demand on UTC primary care capacity • No reduction in No Criteria to Reside numbers at a system level (inc DCH and Community beds).	• UHD has completed our capacity de-escalation plan in March. This has seen SDECs released from being bedded but not delivered all objectives. • Focused work with BI ensures a full suite of data to support recovery – reporting now going to UEC Programme Board • ED medical staff template funded in budget setting 23/24 – recruiting, ongoing gaps in middle grade tier. • Surgical SDEC now 7 days. Medical plans delivering weekend service from November 2023 one in three, clear ask for more. • UHD UEC Programme board established - aligning to patient first methodology and patient pathways. • ECIST review and Criteria to Admit Audit agreed for April 24

TITLE	BAF Risk 3 – Risk of not significantly improving staff experience and retention over the next 3 years (and not being in the NHS staff survey results top 20% of comparator trusts).														
Associated significant risks	1492 1811 1493	Resourcing Pressures – Staffing (12) Staff Vacancies and skill mix deficit – Theatres (12) -to be reduced to 9 Absence, Burnout and PTSD (12)													
Review Date	05/2/24		Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CPO		12	12	12	12	12	12	12	12	12	12	12	12	8
Lead Committee	PCC														
Risk Rating		Likelihood	3	Consequence	4	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The NHS relies on its workforce to deliver patient centred care and services. There is evidence that staff working within the NHS are tired, feeling burnt out and also demoralised by national pay concerns which has led to industrial action across the NHS and has further impacted on staff morale, satisfaction and retention. UHD also has a major programme which requires some staff to move sites. Risk 1492 – Vacancy rates have fallen across the organisation and the joining rate has been higher than turnover rate for 15 months. There is a significant focus on reducing vacancies, improving rostering and staff planning/utilisation, and eliminating high-cost agency. Staff are our biggest asset and key to the success of our services and organisation and in achieving our aim of being a great place to work. Risk 1811 theatres – recruitment / induction of new starters is on-going. Risk to be reduced to 9 and reviewed at the end of March	Health and wellbeing staff offer, occupational health service standards, policies and procedures Access to proactive and preventative services (performance standards) Staff survey (local and national) action plans Return to work and Annual Leave procedures Flexible working policy Staff sickness absence policy Recruitment and retention policy CQC well led key lines of enquiry Staff survey standards Agency reduction plan	Refresh of the People & Culture Strategy Reliance on the temporary workforce Better exit information that is reviewed locally and triangulated with other data Stay questionnaire survey data to aid retention Medical staffing rostering ongoing. Workforce Baseline Data as part of the Patient First Corporate Project to improve confidence in workforce deployment, utilisation and planning.

PROGRESS – 5th February 2024		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
Risk 1493- Risk description sickness absence levels continue to reduce over the 12-month rolling period but levels are not reducing consistently month on month with some variations. Strong staff networks support staff engagement and the current high completion rate for the staff survey is encouraging.	Attracting recruiting and retaining staff who feel supported and optimistic about the changes in buildings, services and sites and not worried about the personal impact for them. Managing the scale of the changes including staff consultations continues. Pressure on HR operational staff to support organisational change consultations.	The roll-out of sickness absence training for leaders continues to take place. Audits to ensure assessment tools and support are being used for staff off with stress, anxiety and depression in line with our policies Demonstrating the return on investment for health and well-being support and reviewing

Staff support through the Occupational Health and Psychological Support and Counselling Service (PSC) along with stress assessment tools are in place and in use Staff on AFC contracts and medical and dental ESR data cleanse has been completed in terms of confirming staff in post is now an accurate portrayal of data in ESR Ward template reviews completes with agreement given at Trust Management Group. Risk 1811 – Positive progress has been made with recruiting to the templates with the care groups and leads. Theatre vacancies have reduced from 18% to 10% with a further reduction anticipated. The amount of over time worked across UHD theatres has reduced with the implementation of the enhanced rates which have proven to be of benefit to the staff, but first and foremost more patients are being seen for their surgery through theatres. The risk level is due to be reduced to 9 by Theatres and reviewed formally once again at the end of March 2024	New adverts now include the changes in sites to minimise associated turnover and costs. Stress / anxiety / depression remains one of top 5 reasons despite comparison data showing a decrease compared to previous years. Recording on this reason for absence does not distinguish about workplace stress or home external stressors The theatre template is continuing to be reviewed to meet the RTT and activity required to treat patients. Improvement required in rostering practice at ward and department level and making sure that people are rostering in advance, managing leave, managing unused hours to standard system of operation. The same applies to Health Rota and Job planning for medical staff	regularly the services provided and communicating these effectively. A staff ready stream is being set up under the Transforming Care Together programme Roster performance stats shared with more training being developed to improve understanding and better forward planning. Change to shift request reasons implemented and a heightened focus. Patient First corporate project to focus on E roster and Health rota.

TITLE	BAF Risk 4 – Risk that not every team is empowered to make improvements using patient feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.														
Ref	1920	Risk that the Trust does not have adequate systems and processes in place to promote, gather, triangulate and utilise patient feedback consistently across UHD. It is therefore recognised that this may result in missed opportunities for learning and improvement in patient experience.													
Strategic Priority	Patient Experience	Risk Score													
Review Date	30/6/23	new	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CNO	L=4 S=2 RR=8	8	8	8	8	8	8	8	8	8	8	6	6	6
Lead Committee	QC														
Risk Rating	6	Likelihood	3	Consequence	2	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The NHS Constitution set out a clear message that the NHS should put patients and the public at the heart of everything it does. The NHS must be more responsive to the needs and the wishes of the public, all of whom will use its services at some point in their lives (NHSE 2016). UHD needs to ensure that the public, patient and carer voices are at the centre of our healthcare services, from planning to delivery. More recently, the legal duty to *involve* has extended to provider services. (NHSE 2023). Service providers will collect results of FFT, analyse them and see if any action is needed. Providers are also encouraged to inform patients about comments and suggestions they have received and include actions they have taken in response. (NHSE 2013). UHD is developing a unified patient experience service to ensure that we • Encourage and support patients and carers to 'tell their stories' • Use these stories to pinpoint those parts of the care pathway where the users' experience is most powerfully shaped • working with patients, carers and frontline staff to redesign these experiences rather than just systems and processes • Empower teams to make continuous improvement by engaging with patients in a meaningful way	• Statutory Duty to involve patients • FFT surveillance • CQC National Survey Programme • NICE Guidance Quality Standard 15 • NHSE Patient Experience Framework • UHD Patient Engagement Strategy • UHD Patient Experience Group • Monitoring of complaints trends • Care group governance meetings • Quality reporting - IPR • UHD QI reporting/projects • CQC KLOE • National patient safety strategy – patient safety partners	Response rates of FFT in UHD is not significantly high therefore does not give a true representation of our patient's experiences. Not all patients are aware of how to give patient feedback Not all services are getting patient feedback due to low response rates Those teams that are getting FFT/HYS data there is limited assurance regarding meaningful continuous quality improvement Limited assurance that QI that takes place is continuous. Not all services are received patient experience data consistently across our care groups.

PROGRESS – 31/3/24		
What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed

1. Patient experience strategy is being driven through PEG and reported in Quarterly reports 2. Have your say survey has been designed with core questions and additional questions driven by departments, these can be adjusted to support continuous improvement. Now published on website and linked to SMS messaging. 3. Sustained and increased number of returns being realised since UHD SMS text messaging service commenced. Rating of Very Good/ Good remains over the upper control. 4. FFT returns being received from more services Number of zero returns dropped from 113 to 30. 5. BI developing the patient experience board to ward level dashboard with Patient First driver and watch metrics. HYS data now coded for reporting 6. Change the format of the Quarterly Patient Experience report to report on the Patient Experience strategy and Patient First metrics	1. Ensuring staff understand the strategic direction and all work is aligned. 2. HYS data transfer to BI for inclusion on dashboard. Data needing more detail for mapping. 3. Working toward 'every contact has a SMS'- different platforms for CT/MRI and Pathology still need to be joined. ED still not online through Agyle. 4. Problems with accuracy of data as patients often do not know which outpatient clinic they visit 5. Platform being developed, need it to be interactive and useable 6. New format of report which has always been well received at Quality committee .	1. Working with Strategic Nursing and professions forum, Ward leads embedding the strategy. 2. Seeing some returns, but accuracy of location needs improving- BI and PEXt working together. 3. PEx team working with BI to ensure the data can be transferred from the warehouse. Change request outstanding for Agyle- near completion. Soliton consent being checked- but data ready. 4. PEx team working with BI to ensure FFT for OPD is coded to speciality. Further discussion with BI/PExt care groups planned for Q1. 5. PExt with BI developing the platform further. 6. Feedback on new way of reporting positive.

TITLE	BAF Risk 5 – Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next 3 years													
Ref	1922	If the Trust does not fully implement and embed an effective Trust wide learning from deaths process, then there is a risk that patient safety and patient care will be sub-optimal increasing the risk of avoidable deaths and an above expected HSMR.												
Strategic Priority	Quality	Risk Score												
Review Date		New	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CMO	L=2 S=5 RR=10	10	10	10	10	10	10	8	8	8	8	8	8	6
Lead Committee	QC														
Risk Rating	10	Likelihood	2	Consequence	4	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
HSMR has been steady rising over the last 3 years There is variation across our sites	UHD Learning from Deaths Policy UHD Medical Examiners Policy LERN policy and toolkit	Audit of M&M meetings (2022/23) identified inconsistent approach to mortality governance across UHD Compliance with mortality case note reviews not consistent

PROGRESS – 31 March 24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
MSG ToR and Learning from Deaths policy (and supporting Toolkit) to be reviewed – Medical Director for Quality leading. New Mortality dashboard now live New mortality metrics available via HED, training provided. Review of MSG in progress – new structure to start in June. Risk rating (March) remains the same due to identified gaps in controls and assurances.	eLearning from deaths process rolled out across UHD (but not currently embedded) Inconsistent approach to mortality governance across UHD, new approach aligned with Care Group governance processes discussed and agreed. Due to start in June 24.	Resource requirement to support redevelopment of eMortality system raised at SDR 5/3/24 and to be raised at April meeting. Reconfiguration will reduce number of reviews required and increase quality and detail of ones completed.

TITLE	BAF Risk 6 – Risk of not managing patient safety in a manner that decreases unwarranted variation leading to worsening outcomes.														
Ref	1923	There is a risk that implementation of the new Learning from Patient safety Events (LFPSE) system will have a significant negative impact on reporting numbers and safety culture. There is a risk that there will be less reporting and therefore lost opportunities for learning and improvement. There is a risk that a lack of confidence and engagement in the new process will impact on the Trust safety culture and national staff survey results.													
Strategic Priority	Quality	Risk Score													
Review Date	30/6/23	new	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CMO	L=4 S=2 RR=8	8	8	8	8	8	8	8	8	8	6	6	6	6
Lead Committee	QC														
Risk Rating	8	Likelihood	4	Consequence	2	Gaps in Controls	low								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The definitions for reportable patient safety incidents will change with the introduction of LFPSE. Reportable incidents will not include external incidents, IG incidents, medical device incidents that do not result in patient harm, infection control breaches that do not result in patient harm, medication incidents that do not result in patient harm e.g., incorrect storage, incorrect CD counts etc. Decreasing the overall number of typically near miss or no harm events will impact on the Trust reporting profile. The change in the national definitions of levels of harm will also impact on baseline figures.	UHD Risk management strategy (and Governance structure) PSIRF Plan LERN Policy LFPSE Implementation plan and comms	LFPSE questions and taxonomy set nationally. Form design restricted by nationally mandated questions and Datix design. NRLS data will not be available after Sept 23 and no alternative national benchmark date will be able after this date. Data uploaded to LFPSE will be unvalidated when sent. Currently there is no information available on how Trust will be able to amend any incorrect records sent. I.e. staff can code incidents incorrectly without internal checks or validation.
PROGRESS – 31 March 24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
LFPSE went live 1/12/23 PSIRF approved by ICB at December Quality meeting PSIRF policy (and Toolkit) in draft and aim for discussion at Feb 24 CGG. Implementation of new model proposed for 01/04/23. PSIRF training for investigators booked for Feb and March 24	Patient safety incident investigator training in Feb/March 24. 30 staff attended first sessions. Investigators will need time to complete reviews – funding and capacity to be agreed. AAR training required to be rolled out Work improvement plans and training in safety huddles needed.	Comms plan for LFPSE and PSIRF in place. Pilot of UHD PSaF Restructure of Quality and Risk Team to support PSIRF AAR training plan to be developed

Patient safety culture focus in Core Brief Jan 24 UHD version of MaPSaF developed and in progress of roll out to Patient First early adopters (CC, XCH Day hospital, Stroke). Good support from Patient First Team (IN) Patient safety culture questions rolled out in People Pulse survey Jan 24 No reduction in reporting seen in Dec- March 24. New LERN forms introduced for non LFPSE incidents and new Restraint Form implemented. Training and education on going. 2023 Staff survey results show improvement in safety culture scores Risk rating reduced in Jan 24.		Plan to pilot PSIR plan in Surgical Care Group and Maternity in Q1 24/25

BAF RISK 7	Risk of not returning to recurrent financial surplus from 2026/27													
Strategic Priority	Sustainable Services													
Risk Reference	1595	RISK SCORE												
Review Date	December 2023		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TARGET
Executive Lead	Chief Finance Officer		16	16	16	16	16	16	16	16	16	16	16	16	8
Lead Committee	Finance and Performance														

Context – *Free text*	Controls	Gaps in Controls or Assurances
The Trust set a balanced revenue budget for 2023/24, which if delivered in full recurrently would leave a recurrent underlying deficit of £33m. At the end of March the Trust has reported a surplus of £0.065 million against a planned break-even position. However recurrent over spends, including an under delivery of the Efficiency Improvement Programme target, have been off-set by non recurrent under spends and additional non recurrent income. As a result, the Trusts underlying deficit has not improved and thus there remains a significant risk in relation to the recurrent underlying financial position of the Trust.	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, Financial Management Accountability Framework and other finance policies and procedures in place. • Monthly reporting to TMG, FPC and Board highlighting risks and mitigating actions. • Care Group and Corporate directorate quarterly performance reviews. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery.	• Weaknesses in temporary staffing controls. Mitigation: External review of TSO, re-establishment of e-roster steering board, new e-form in development for approval of nursing/ HCA agency (Lead = CPO). • Incomplete medical job plans and inconsistent premium medical rates. Mitigation: Refreshed job planning policy, use of electronic systems, review of premium rate card (Lead = CMO). • Weaknesses in the approval process for the opening of unfunded escalation capacity. Mitigation: New SOP approved to inform consistent escalation process, de-escalation plan developed and progressing (Lead = COO)

PROGRESS – 31 March 24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
• Budgets formally delegated and accepted. • CFO review of monthly budget variances. • Escalation meetings in place with Care Groups. • Patient First approach to financial sustainability.	• CIP identification and delivery. • Excess inflation (energy). • Operational pressures/ escalation beds. • Elective recovery. • Premium pay expenditure. • Industrial action.	• Patient First approach to Sustainable Services. • New PMO established to enhance CIP governance and accountability. • Medium-Term Financial Plan being refined.

TITLE	BAF Risk 8 – Risk of not successfully and sustainably adopting the patient first approach across UHD														
Ref	1924	Risk that benefits of transformation, improvement and innovation are not realised													
Strategic Priority	Patient First Programme	Risk Score													
Review Date	30/01/2024	new	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CEO	2992	9	9	9	9	9	9	16	16	12	12	12	**12**	6
Lead Committee	TMG														
Risk Rating		Likelihood	3	Consequence	4	Gaps in Controls	Moderate								

Trust has made good progress in delivery of year one of the programme: **Phase 1:** Organisational Readiness Assessment Complete [Jan 23] **Phase 2:** Strategy Development Complete **Phase 3:** Strategy Deployment Underway **Phase 4:** Organisational Improvement System Underway **Phase 5:** Leadership Behaviours and Development Underway **Phase 6:** Governance In preparation	PID (to ensure clarity on the scope) Programme pillars Steering board ToR Reporting to TMG, and assurance to BoD Patient First methodology A3 thinking methodology Annual patient first cycle linked to annual plan	Moderate gaps in controls A full benefits realisation plan is required to align directly with strategic themes and corporate projects following completion of Phase 2

PROGRESS – 11 March 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
Delivery of first cohorts of Patient First for Leaders, Patient First Improvement System and A3 training to be completed by end of March 2024. Evaluation of training programmes underway. Catchball#1 for all care groups completed (Dec'23) with scorecard development in progress ahead of Catchball#2 (Feb '24) Corporate SDR templates now under development for piloting 5.3.2024 Culture champions trained and undertaking appreciative enquiry activity with senior leaders and departmental teams. 2023 NHS staff survey record completion rate at 59%. Good attendance at regular Patient First: "Let's have a Conversation" sessions facilitated each month by our executive team to encourage engagement and involvement of all staff. Board development sessions for NEDS to ensure non-executive directors are a) adequately briefed on progress and b) identify opportunities to engage in several continuous improvement activities with UHD staff.	Key Risks: • Slippage of key milestones and deliverables resulting in programme delays and delayed delivery of outcomes (RPF004) • Patient First programme scope reduced, or time scale extended due to time constraints execs and operational teams (RPF006) • Failure to gain support from regulators resulting in uncertainty and potentially additional work pressures on staff (RPF 008) • Failure to decommission other activities not linked to True North and Breakthrough objectives (RPF007) • Failure to access robust business intelligence support resulting in failure to carry out analysis of the opportunities (RPF009) • Lack of ongoing programme management resource and appropriate budget to drive implementation and roll out (RPF003) • Lack of ability to release staff for Patient First training leading to reduce skills transfer / lower value for money (RPF011) Key Issues:	Risk log reviewed monthly. Latest mitigations: • Key future milestones to be agreed including 3 year plan for PFIS roll out. • Additional support from PF team offered to Execs toc complete corporate project templates ahead of corporate SDR • UHD engaged with NHS IMPACT programme & network – Clinical Director visit to UHD 5.4.24 • Completion by Execs of X matrix and meetings filter prioritised Q4 2024/25 • Work to develop scorecards now progressing well – draft corporate scorecards expected before start Q1 2024/25 • Risk increased - feasibility of reducing length of training programmes being explored due to trusts financial challenge • Execs supporting managers to prioritise staff attendance at PF training. • Patient First Communications plan to be reviewed March 2024. Work underway to support staff to access advice & share success.

Details and approval for year 2 consultancy support to be agreed March 2024	• Communication of Patient First purpose and benefits to staff is currently ineffective (RPF015)	

TITLE	BAF Risk 9 – Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals														
Ref	1784	Critical Path Management													
Strategic Priority	One Team	Risk Score													
Review Date	29/01/24		Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CSTO	1784	20	20	20	20	16	16	16	16	16	16	16	16	12
Lead Committee	FPC														
Risk Rating		Likelihood	4	Consequence	4	Gaps in Controls	Moderate								

Context	Controls	Gaps in Controls or Assurances
Taking lessons from previous relocations, such as the one in Bristol, we have recognized the importance of integrating and operating services as a unified entity at least 6 to 9 months prior to any move. As our build programs become more defined, our efforts need to shift towards the integration of teams. Therefore, as we approach the integration phase, our governance structure will be aligned with the four phases of reconfiguration, with a greater emphasis on preparing services for reconfiguration rather than solely focusing on the build program. The Acute Reconfiguration Capital Group will be renamed the Build Ready Group and ensure delivery of the buildings and manage risks. The Reconfiguration Oversight Group will be transformed into the Service Ready and Move Group and manage the critical path to being ready for treating patients in our reconfigured services.	**Prevention** Evidence of effective governance: • Speciality level plans in place • Meeting structure, attendance, escalation and resolution from speciality steering groups into CG and then Service Ready Group (SRG) • Service Reviews to assess readiness for moves with actions followed up by Care Groups • Robust critical path timeline that clearly articulates deliverables and interdependencies between specific deliverables • Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration) • Focus on Critical Path actions **Detection:** Internal Audit, NHP Scrutiny/Governance, external Gateway process, result of Service Review findings and progress on critical path actions. Go/No Go checklist and criteria	Moderate gaps: Development of Service reviews and associated scorecard. Focus on critical path actions during 2024. Changes to the build programme and interdependency with the reconfiguration programme Assurance that actions identified at speciality, CG and during Speciality reviews are completed Effective Working Groups in place to manage the hygiene factors (e.g Travel Working Group and Improving Staff Experience Group)

There will also be potential challenges associated with the hygiene factors such as staff rest areas and transport and we will need to have effective governance and communications in place to manage this.		
PROGRESS – 27 March 2024		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
• Scored reduced to 16 (Likelihood reduced from 5 to 4) as transition to new governance complete and working well • Inaugural meeting of Transforming Care Together Group held on 26 Feb 2024 and TOR's agreed as assurance group reporting into Board. • Care Group reporting strengthened and new focus on critical path actions from January 2024. • Service review process well underway with 36 initial services now reviewed and clear action plans in place. 8 services rated red to date and will be reviewed again in 3 months to review progress. Haematology Service Review moved from red to amber with good progress on move planning for April 2024 move. Theatres and H&N moved from red to red/amber in March 2024. • Service Review schedule amended to prioritise services moving in April 2025 • Agreed for go/no go checklist and QIA to be used for all Move Early service to ensure consistency • Maternity Big Room Event on 19 Feb 2024 to start moving planning process/approach – all corporate services involved and launch of Go/No Checklist • Transitional funds reviewed and monies to support operational delivery brought forward – current recruitment of operational change delivery resources to support capacity in Care Groups to deliver integration plans and service review actions • FBC A approved at Joint Investment Committee on 22.03.24. FBC B drafted for submission in April 2014 • Recent changes to parking permits and update to Staff Partnership Forum on travel actions. Recruitment for Transport and Travel Manager now commenced.	Risk score reduced to 16 in August 2023 as revised governance and service review process now in place. However, issue remains the same with biggest risk being capacity and capability to implement integration plans, actions identified by service reviews and actions identified by SRG and CG TSG's. Progress variable access different specialties with operational pressures taking precedence Move planning for Maternity needs to start April 2024. 2 workshops in February and March to prepare for this. Workforce planning remain key risk for Service ready - some workforce plans still outstanding. Review process being developed with ED and Maternity but need to understand those services that cannot manage within workforce envelop in new build and the appetite to restrict beds. Also need to understand number of staff moving with their services. We have total number expected to move. The actual number will not be confirmed until consultations completed and we can then assess the gap. Workshop scheduled for this on 25 March 2024. From a build ready perspective, Building Safety Act is now key risk. Both Bournemouth and Poole main buildings (plus Parkstone House) fall within the parameters of the Building Safety Act and must comply. This will increase the programme time and cost for all projects which fall under Category A works. Possible delays to Junior Dr Mess could impact on critical path. Space also remains a challenge but space requests to be submitted by 1 April 2024 and space principles document going to BRG/SRG in April 2024. Scenario testing being completed in March to understand impact and mitigations for build delays and operational readiness on overarching programme.	Monthly meetings (BRG, SRG, Care Grp TSG's) that reviews and escalated any barriers and delays. Linking of operational and integration plans via COO. External support and Internal Audit review of Reconfiguration Programme

TITLE	BAF Risk 10 - Risk that the trusts Electronic Patient Record (EPR) not fit for purpose for UHD and this contributes to the 3 risks referenced below													
Ref	1950 1872 (20) 1378 (15)	**The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose** Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding Lack of Electronic results acknowledgement system												
Strategic Priority	Population and System Working	Risk Score 2023/24												
Review Date	01/03/24	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Finance Officer	20	20	20	20	20	20	20	20	20	20	20	20	6
Lead Committee	FPC													
Risk Rating	20	Likelihood	5	Consequence		4	Gaps in Controls		High					

Context	Controls	Gaps in Controls or Assurances
UHD has an EPR (Graphnet) using 1990s computer code, to which few coders can now use. UHD is the sole remaining customer and the supplier will only support the system until April 2027. The Medical Staff Committee (MSC) at UHD have written as a body highlighting there are considerable clinical risks with Graphnet, and these are reflected in the Trust risk register. These risks are: i. Inhibited Patient Flow and increased length of stay, due to poor functionality (risk rating 20) ii. Lack of closed loop reporting of results, leading to delayed or missed diagnosis (risk rating 15) Clinicians are also highlighting the impact of reduced productivity as less patients are seen per clinic, theatre list and ward round due to the time taken navigating multiple disjointed, separate systems. Doctors in training rotating between Trusts see the difference and are less likely to want a career at UHD due to "unsafe, and labour-intensive IT systems."	The Electronic Health Record Programme (EHR) is moving forward where UHD will partner with Somerset and Dorset to procure a new system that will replace all the current key IT systems, an update was provided to the Board in January 2024. The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place: • Underpinning legal contracts with software suppliers • Immutable backups (i.e. cannot be affected by malware) • Staff training programmes • Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit • UHD wide Business Continuity Plan • Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state • Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state	• Substantial gaps in the functionality of our EPR ecosystem relating to the management of the workflow of diagnostic results and reports and assured clinical transactions generally (e.g. therapy input and interprofessional referrals). • No effective single user interface for clinicians to manage their core care processes. • Local departmental Business Continuity Plans are not yet in place – these are in development with a plan to develop by April 2024.

PROGRESS – 4th April 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
• Dorset and Somerset Partnership Board and Programme Board are now running regularly. • Outline business case progressing but due to outstanding affordability issues the date has moved to the end of April 2024. • Pre-Market Engagement costs have been re-sought from the market with the confirmed scope for Dorset. • Current scope – Somerset Acute / Community / Mental Health and Dorset Acute / Mental Health	The current timeline for the EHR Programme is being challenged to see if the contract award can be done by end of March 2025. This should then ensure delivery into live use before end of March 2027, removing the EPR risk. Affordability for other organisations in Dorset remains a challenge. We	• Single Dorset and Somerset Partnership Board with Chief Execs, SROs and the Programme Director has had their first meeting, regular dates now in the diary. • Single Dorset and Somerset EHR board is now in place and running monthly to keep decisions moving forward. • Somerset Programme director is leading the Business case and procurement process jointly. And Ethical remains supporting the Dorset Programme for readiness. • Weekly EHR Leadership meting to ensure workstreams are progressing as required.

• Communication plan needs to be stepped up to increase the Trust wide communications, but this will be progressed once the business case is in the approval process. • Specification for the EHR has now been completed with an aligned spec for the scope.	are looking at scope changes / phasing as a mitigation. Risk of a further delay to business case submission being proposed to resolve the affordability issues.	• Dorset contract for support by Ethical was extended for 3 months from 1st April/

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

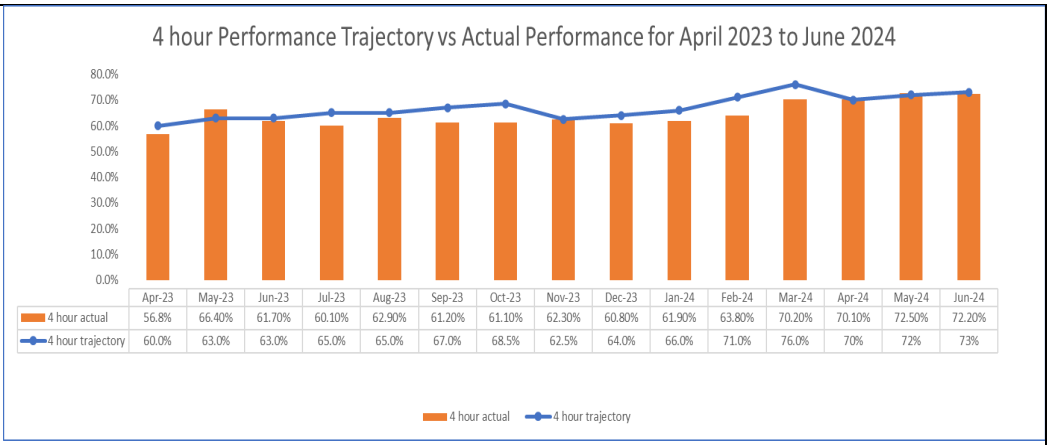
Meeting Date: 29 July 2024

Agenda item: 5.2

Subject:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
Prepared by:	Executive Directors, Leanna Rathbone, Judith May, David Mills, Dr. Matthew Hodson, Irene Mardon, Jo Sims, Andrew Goodwin and Tracy Moran
Presented by:	UHD Chief Officers

Strategic themes that this item supports/ impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☒ ☒ ☒ ☒ ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risks 1-7 Trust Integrated Performance report for June 2024 - Appendix A	
Purpose of paper:	Information	
Executive Summary:	At the end of June 2024 the Trust has reported a deficit of £6.288 million against a planned deficit of £5.133million, resulting in an adverse variance of £1.155 million. Of this variance, £1.029 million relates to the financial impact of the Junior Doctor industrial action in June. Emergency Department (ED) attendances continued to see a daily rate increase in June compared to May and April 2024, as well as the same period last year; though ambulance conveyance levels remained relatively static. Meantime and time to decision continue to remain within normal variation but there was a reduction in both patients waiting longer than 12 hours in the department as well as 12 hours from a decision to admit. Nevertheless, the Trust marginally missed the June trajectory of 73% delivering 72.2% against the 4-hour standard. No Criteria to Reside (NCtR) has seen a small decrease to an average of 186 per day in June but remains above plan, impacting hospital flow. A Dorset-wide UEC strategic partner (Newton) will be commencing a 10 week diagnostic period at the end of July 2024 related to NCtR. Elective activity increased to 110.3% against the 2019/20 baseline in June 2024 (108.1% year to date). A reduction in length of waits for elective care also continues to be delivered and no patients remained with a wait >78 weeks at the end of June. Waits over 65 weeks have increased in June to 472 which was above the trajectory of 295, but the Trust continues to plan to eliminate 65 week waits by September 2024. The overall Referral to Treatment (RTT)	

	waiting list and waits over a year have both continued to be below trajectory in June. The cancer 28 Day Faster Diagnosis Standard performance recovered in May 2024 achieving 75.3%, although the 62 Day Standard fell marginally below (0.4%) the Trust trajectory.
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums the ability if needed to deep dive into a particular area of interest for additional information and scrutiny. As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by: • Extending best practice use of Statistical Process Control (SPC) Charts. • Greater focus on key indicators as part of our Patient First roll-out programme linked to the Trust Strategic priorities and the Trust refreshed SDR process. • Providing SPC training to operational leads who compile the narrative against the data included within the report. ***We recognise as a Trust Board that behind every single metric discussed in this paper there is a patient.***
Urgent & Emergency Care (1 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Advise (1): Performance against the 4-hour standard for June 2024 is 72.2% against an internal trajectory of 73% and a year-end target to achieve 78% by March 2025.** • The Trust did not meet its internal trajectory in June 2024 by 0.8%, delivering 72.2% against a target of 73% (Type 1 and Type 3 attendances). • Emergency department Type 1 non-admitted performance dropped slightly in June contributing overall performance. • However, admitted performance saw the largest variation dropping as low as 20% at points during the month. This was largely driven by reduced hospital flow due to high numbers of patients with NCTR as well as managing a number of infection control cases across both sites. • The total number of handovers that were over 60 minutes increased to 322 in June versus 279 in May and 245 in April, however, show normal variation. The IPR provides detailed performance against the national Urgent & Emergency Care standards.



The Trust's trajectory for 24/25 has been submitted with the national requirement to see a performance increase to 78% from 76%.

Improvement Actions:

- Review of work plan following improvement across quarter 4 in 2023/24 to ensure the department has clear steps to meet the national push and stretch target in 2024/25 of 78%.
- Further improvement in Urgent Treatment Centre (UTC) service provision cross-site is ongoing with slot utilisation and direct streaming from ED.
- The revised fortnightly Urgent and Emergency Care (UEC) Programme Board is using the Patient First methodology and reports to Trust Management Group. Engagement and plans are being monitored. A suite of metrics is in place.

Key areas of focus remain:

1. **Clinical Workforce capacity:** Improving capacity in our Ambulatory Care Area (ACA)
2. **Senior clinical assessment** – Continued focus on supporting and increasing senior decision-making capacity (Triage & RAT)
3. **Reduce time in ED, with senior leaders escalating** so the flow blocks are removed – professional standards / culture.
4. **Signposting to alternatives**: Slot utilisation and direct streaming from ED to UTC & SDEC.
5. **Work with system partners** to improve attendance/admission avoidance and timely discharge and capture of all the programmes of work.

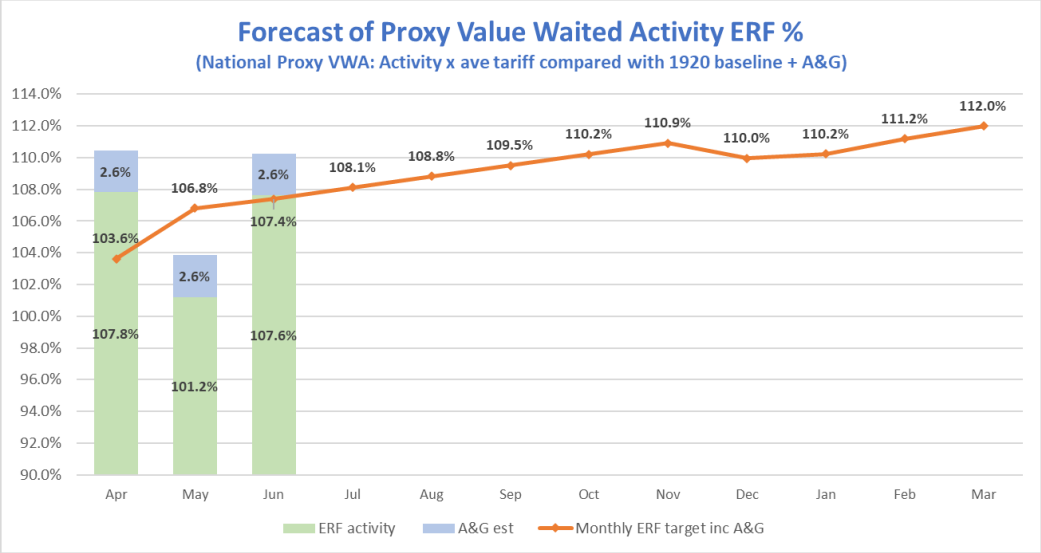
Occupancy, Flow & Discharge (1 Advise)

Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.

Advise (1) Ongoing challenges with occupancy and flow are resulting in escalation beds/spaces open and a number of beds occupied by patients with No Criteria to Reside.

The largest factor driving occupancy remains patients with No Criteria to Reside (NCtR) who occupy acute hospital beds at UHD. No Criteria to Reside (NCtR) has seen a small improvement with the June average of 186 (compared to 189 in May) but remains higher than plan. Internally patients with lengths of stay in excess of 100 days are reviewed as part of a weekly meeting with system partners to ensure all actions are progressed.

	Improvement Actions: Focus continues on 5 key actions aimed at improving pathways for patients ready to leave hospital. This is being progressed at a Place level within the Dorset system, with UHD working closely with BCP Local Authority. This work has continued in June. There are key workstreams at UHD to support improved processes. • Effectiveness of Transfer of Care Hub at each site with partners to facilitate improved discharge planning and transfers. • Use of the EDD (Estimated Date of Discharge) as a proactive planning tool. • Continuing work with Poole Trauma wards in embedding a process that removes a significant number of steps in progressing a patient to a community rehabilitation bed; this is now being rolled out to older persons wards. • Focus on patients waiting over 21 days with a criteria to reside to make sure that we have optimised the patient pathway for these group of patients. Further internal actions are in place to continue to optimise discharges operationally daily, measured through the UEC Programme Board.
Referral to Treatment (RTT) (4 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Assure (1): Forecasted elective activity delivered in June 2024 is 110.3% of the 2019/20 baseline (108.1% year to date), meeting the Trust's operational plan trajectory.** National data on elective activity levels in 2024/25 is not yet available. A Trust forecast of proxy value waited activity has been made based on actual activity values multiplied by an average tariff. Advice and Guidance using average value of 2.6% has then been applied, as outlined in the graph below. This approach as also now been adopted system-wide in Dorset. Current data signals in June 2024, an increase in activity compared to May 2024 (110.3% versus 103.8% in May) and year to date delivery has been 108.1% against the 2019/20 baseline period. Internal activity plans are in place to increase this further as we move through the year.



Assure (2) The Trust has delivered a reduction in the Referral to Treatment waiting list in June 2024.
Assure (3) RTT waits greater than 78 weeks have been eliminated. While there was an increase in month end >65 week waits in June 2024, the Trust is maintaining progress to eliminate 65 week waits by September 2024.

- The RTT waiting list has reduced in June to 67,997 (-366), delivering the June target.
- 65 week waits are above trajectory, but there are plans in place to eliminate these by September 2024 (with the exception of where patients decline proposed dates). June's month end position was impacted by industrial action in month; both in terms on cancelled activity and reduced booked activity.

Planning requirement	May 24	June 24	
Referral to treatment 18-week performance	62.4%	61.1% ▼	National Target 92%
Eliminate >78 week waits	11	0 ▼	Plan Trajectory 0 (Excl. IA)
Eliminate >65 week waits	393	472 ▲	Plan trajectory 295 June 2024 (Excl. IA)
Reduce >52+ weeks	2,960	2,999 ▲	Plan Trajectory 3,005 by June 2024 (Excl. IA)
Stabilise Waiting List size	68,343	67,977 ▼	Plan Trajectory 68,140 June 2024 (Excl. IA)

The Planned Care Improvement Group is using the Patient First methodology to deliver improvement and reports to Trust Management Group.

Key areas of focus

- Prioritising patients at risk of breaching >65 weeks before September 2024 to eliminate these waits, with actions in place to ensure all patients in this group are booked into outpatient appointments where required.
- Increasing elective activity in line with the delivery plan in place.

- Delivering on productivity improvement plans for outpatients, theatres, endoscopy, length of stay and radiology.

Theatre productivity:

- Capped utilisation rates have decreased in June for both main theatres (74%) and day case theatres (75%). The overall utilisation being 75%
- The Trust's trajectory for 2024/25 is to deliver 80% by March 2025 and is in line with the national guidance to achieve an increase of at least 4% from the current baseline.

Improvement actions:

- **Increase booking of lists:** Early results of booking lists to 105% across a range of specialities has reduced late starts and decreased turnaround times between cases.
- **Focused action in Orthopaedics:** Improvement actions are in place within orthopaedics and showing evidence of improvement, to:
    - **Reduce late starts** by improving the timeliness of sending for patients and reducing turnaround times between cases.
    - Increase the **number of patients per list** and **reduce early finishes** by booking to 105% of list capacity.
- **Commence 'Golden patient' process:** Commenced in June, identifying a 'Golden patient' to start lists is evidenced to reduce delays to operating lists and reduced last minutes changes to list planning, this in turn reduces patient safety events.
- Start **'New' Theatre planning** weekly, inclusive of focus on >65 week long waiters.

Outpatient productivity

- A 30% reduction in missed appointments rates (Did not attends) has been delivered since April 2023. The current rate remains at 5.1% in June (improved position in month) against a target of 5% and a baseline position of 7.6% in April 2023.
- 83.8% of all clinics have text reminders switched on or have been excluded for clinical reasons. This, alongside a DNA predictor trial is expected to support a further reduction DNAs and patient experience.

Advise (4): Performance for time to theatre for fractured neck of femur (# NoF) patients has reduced in June 2024.

- June performance for time to theatre for fractured neck of femur (#NoF) patients decreased marginally, whereby 77% of patients achieved surgery within 36 hours of being fit for surgery and 50% of patients were operated on within 36 hours from admission. Fluctuations in performance however represent normal variation and remains within the process control limits.
- Overall trauma admissions decreased in June 2024 with 388 admissions, including 75 with a fractured neck of femur (#NoF) (compared to 97 in May 2024).
- The Hand Hub which commenced in March 2024 continues to be successful, operating 2 sessions per week with up to 15 patients through the service, releasing 10 main theatre sessions.

Cancer Standards (1 Assure)	**Strategic goal:** **To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Assure (1) Performance against the Cancer 28 Day Faster Diagnosis Standard (FDS) in May 2024 was finalised at 75.3%, meeting both the national threshold and Trust trajectory. Performance against the 62 Day Standard decreased in May 2024 to 66.8% which is below the Trust trajectory of 67.2%. This is expected to recover in June 2024.**

- 28-Day Faster Diagnosis Standard - Performance in May increased to 75.3%, achieving the national standard and Trust trajectory. This is an improvement of 9.0% compared to April 2024. 9 out of 14 tumour sites achieved the standard.
- 31-Day Standard - Performance in May achieved the 96.0% threshold at 96.5% which is an increase of 1.9% compared to April 2024.
- 62-Day Standard - Performance in May decreased by 1.6% to 66.8% compared to April 2024 which is below the Trust trajectory of 67.2%. The main breach reasons in May were caused by capacity at the front end of the pathway and delays to surgical and oncological treatments. Performance in June 2024 is currently 67.5% which is the meeting the Trust trajectory of 67.5%
- PTL Over 62 Days - The total number on the PTL over 62 days remained below the 220 target with 203 patients over 62 days at the end of May.

KPI	Target	Mar 24 FINAL	Apr 24 FINAL	May 24 FINAL	Jun 24 - Prov
28 Day Faster Diagnosis Standard	75%	75.2%	66.3%	75.3%	73.0%
31 Day Standard	96%	96.1%	94.6%	96.5%	96.0%
62 Day Standard	85%	68.9%	68.4%	66.8%	67.5%
Over 62 Days PTL	220	177	207	203	215

Improvement actions are detailed within the IPR and include:

Gynaecology:
Escalation meeting with Chief Operating Officer held in July to review rapid recovery plan. Actions include:

- Additional weekday and insourcing Post Menopausal Bleeding sessions planned in July.
- Amendments to clinic template to address backlog and increase core capacity for 1st appointment.
- Maintaining the additional GA hysteroscopy activity which commenced in Q1 2024/25.
- Pathway navigator starting early July - this role will focus on planning capacity to meet fluctuations in demand.

The National Clinical Lead for Maternity and Gynecology for GIRFT (Getting it Right First Time) was also invited to visit the Trust in July to support the review of progress in Gynecology against the GIRFT improvement actions.

<table>
<tr><td></td><td>Skin:
Additional insourcing activity continues, to accommodate the year-on-year increase in referrals.
Impact of Tele-Dermatology to be reviewed in order to inform future capacity requirements.</td></tr>
<tr><td>DM01 (Diagnostics report) (1 Advise)</td><td>Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.

Advise (1) The DM01 standard has achieved 88.4% of all patients being seen within 6 weeks of referral; 11.6% of diagnostic patients seen >6weeks in June 2024.

No more than 1% of patients should wait more than 6 weeks for a diagnostic test

<table>
<tr><th>JUNE 2024</th><th>Total Waiting List</th><th>< 6weeks</th><th>> 6 weeks</th><th>Performance</th></tr>
<tr><td>UHD</td><td>13,279</td><td>11,739</td><td>1,540</td><td>11.6%</td></tr>
</table>
UHD remains one of the top performing trusts for diagnostics in the Southwest region. Overall, the number of patients waiting over 6 weeks reduced from 12.9% to 11.6% of patients waiting a diagnostic test in June 2024. Nevertheless, there are challenges related to workforce capacity in Echocardiology, Neurophysiology and Radiology (imaging) which continue to be worked through.

Improvement actions are being delivered as detailed within the IPR, including the delivery of the Community Diagnostic Centre programme.</td></tr>
<tr><td>Health Inequalities (1 Advise)</td><td>Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.

Advise (1)
Waiting list by Index of Multiple Deprivation (IMD) The median weeks waiting at the point of treatment for people in IMD 1-2 shows no variation compared to people from IMD 3-10. Analysing the same data by age band identifies no variation between children (<18 yrs) and adults.
Waiting list by ethnicity: An analysis of the median weeks waiting by ethnicity grouping also now shows no variation between patients within community minority groups and White British populations in Quarter 1. This is an improvement. The level of variation for <18-year-olds from community minority groups also reduced from 7 weeks to 6 weeks.
Emergency dept. attendances by Index of Multiple Deprivation (IMD) Attendances are lowest in deprivation deciles 1-3, continuing the trend seen in previous months.</td></tr>
<tr><td>Maternity (1 Advise)</td><td>Advise (1) There are 3 areas currently flagging as red RAG rated:

3rd /4th degree tears although within normal variance range</td></tr>
</table>

	• Apgar <7 at 5 minutes-increased over last two months • Prompt Training -below 90% compliance. Improvement actions are detailed within the IPR.
Infection Prevention and Control: (2 Alert, 3 Advise, 2 Assure)	**Quality, Safety, & Patient Experience Key Points** **Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)** **To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture** • **Alert (1)** Three cases of invasive fungal infection identified in haematology patients, ward 11. One case was a rare fungal infection. Sadly, two patients passed away. Full case investigation completed, including post infection review, ward audits and environmental swabbing and settle plates. No links identified with full case report to be submitted to IPCG • **Alert (2):** Two cases of measles identified at UHD. Contact tracing exercise commenced by IPC alongside outbreak management meeting with UKHSA, Local Authority and partners. No link between cases. Highlights pathway concerns regarding management of prophylaxis outside of standard business hours • **Advise (1) *Clostridioides difficile* cases**: Reduction in cases identified in the month of June compared to May 2024 • **Advise (2) MRSA bacteraemia:** No cases of Trust attributable MRSA bacteraemia in the month of June • **Advise (3) Hospital Associated cases trend** **HCAI Trends by month** • **Assure (1)** Procurement exercise completed for replacement hand hygiene products supplier for UHD due to withdrawal of GoJo from UK market. Supplier to be confirmed in due course. Mitigations in place through procurement stock management and temporary dispensers in interim period • **Assure (2)** Wards 4, 5 and 8 affected by outbreaks of norovirus in June. Ward 22 affected by co-infection outbreak of norovirus and Covid-19. Patients and staff affected with ward and bay closures as appropriate.
Clinical Practice Team ***(4 Advise)***	**Clinical Practice Team:** **Advise (1) Moving and Handling - Essential Core Skills** The challenges to meet the face-to-face level two training requirements for clinical staff continues but have seen marginal improvement. The risk register entry remains at 10 (moderate). The development of an eLearning Level 2 package is progressed with a draft version due in September 2024.

Organism	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
C Diff	11	4	8	8	4	8	6	9	13	4	10	8
E Coli	14	9	11	11	11	17	17	8	8	14	14	9
MRSA						1	1		1	1	2	
MSSA	4	4	5	5	4	3	3	6	6	4	1	4

	Falls prevention & management: **Advise (2)** The number of serious falls incidents in month has decreased with 2 moderate incidents reported in month. These incidents will be following the appropriate scoping and investigation process through the patient safety investigation framework. **Tissue Viability:** **Advise (3)** The ability of the service to meet the increased demand remains on the risk register entry 1821 and rated as 9 (moderate), the action plan has been updated. There remains a significant number of complex patients being referred to the service. The TVN team additional substantive Band 6 TVN has now started, and the risk will be reviewed one established. **Advise (4) Pressure Ulcers:** Agreed with the CNO that Pressure Ulcer Data will now be reported 8-weeks in arrears- June 2024 Data will be reported in August, thus allowing time for appropriate investigation to be completed. This change in reporting means that no confirmed data will be presented in July 2024, rather June Pressure ulcer data will be reported August 2024. This will facilitate: • More accurate, validated data • Time for investigations to be completed/ aetiology confirmed • Time for confirmation of outcome (deterioration or evolution/resolution of suspected DTI for example) • The sharing of more meaningful learning from the incidents reported
Patient Experience ***(4 Advise)***	**Strategic goal: Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.** **Patient Experience and Engagement Team Overview:** **PALS and Complaints numbers for June 2024** **Advise (1) The number of open complaints over 55 days** continue to be prioritised within the complaints team and care groups and has continued to decrease with further measures to reduce the number of outstanding complaints continued. **Advise (2) Average complaint response timescale** continues to improve, June 2024 it was 44.5 working day average for a final response. Team are working on reducing this further **Advise (3) Friends and Family Test (FFT)** The volume of FFT being received has maintained prior to the Patient Experience Team and BI managing the SMS FFT Service. UHD has seen a sustained high satisfaction score. The Trust's overall positive score remains above the upper control limit. **Advise (4) Mixed Sex Accommodation Breaches** There were 16 occurrences of MSA in June 2024 in critical care – continued monitoring of areas is in place with care group matrons.

Nurse Staffing: (2 Advise, 2 Assure)	**Care Hours per Patient Day (CHPPD):** **Advise (1) June** 2024 CHPPD remained stable at 4.8 for Registered Nurses/Midwives combined. **Red Flag Reporting:** **Assure (1)** Nine red flags were raised in month for UHD. Of note, no red flags were raised within maternity services. All red flags were mitigated/resolved with no critical staffing incidents reported. **Workforce Controls:** **Advise (2)** Allocate Safe Care continues to be embedded for safe staffing oversight. Training continues around the importance of 'live' roster updates when staff are moved. This ensures accurate capturing of CHPPD at the twice daily audit points. **Assure (2)** Ongoing review shows no impact on care delivery or safety as a result of the current workforce controls.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement and retention**
CPO Headlines:	
HR Operations **(1 Advise)**	**Advise – Industrial Action** **Industrial Action covering: Thurs 27th June 07:00 to Tues 2nd July 06:59** **Data as at: 03/07/2024 16:09:06**

Staff Type		27/06/2024	28/06/2024	29/06/2024	30/06/2024	01/07/2024
Doctor in training	Dataset Completed %	100.0%	100.0%	100.0%	100.0%	100.0%
	Confirmed Rota'd to work	410	377	99	99	409
	Confirmed absent due to IA	249	243	70	71	258
	IA Absence % (of those rota'd)	60.7%	64.5%	70.7%	71.7%	63.1%
	IA Absence % (of all Doctor in training staff	37.8%	36.9%	10.6%	10.8%	39.3%

Occupational Health ***(2 Advise)***	**Advise – Recognition Awards -** The Occupational Health clinical service and the staff physiotherapy service have both been shortlisted in the NHS at work network recognition awards. These awards are to celebrate and showcase the impactful projects and initiatives being delivered in the occupational health and wellbeing sector. **Advise -** Occupational **health** - Referrals into staff physiotherapy remain high, 70 referrals were received in June 2024. Currently urgent referrals have an 11 day wait to first appointment and routine have a 24 day wait to first appointment. This has reduced due to the staffing increase.
Workforce Systems (1 Assure, 1 Advise)	**Assure - Job Planning** – As at 1st July 2024, 582 (90.6%) job plans are on Healthrota with only 60 (9.4%) job plans remaining with no details added. A further review of the job planning process will take place during July and August. **Advise - Medical and Dental Rostering Project** – All areas with Doctors in Training except NICU, Trauma & Orthopedics and Anesthetics are progressing with their implementation onto Healthrota. Support is in place to assist those areas who are not yet compliant.

Resourcing (1 Alert)	**Advise – Recruitment Events -** Two focused recruitment events recently held were successful in attendees and offers. One was focused on recruiting Catering Assistants, which took place at the Job Centre with their support and the second was an event at the Bournemouth International Centre, specifically for those leaving the Armed Forces, and looking for a role outside of the services. This was supported by our Armed Forces Community Advocate, and other members of UHD staff previously in the Armed Forces.
Temporary Staffing (1 Advise)	**Advise – Medical Locums** – Locums Nest ad hoc timesheets have now been switched off from 1st July 2024, this will provide the Trust with greater transparency and tighter controls when requesting additional duties.
Blended Education and Training (1 Advise)	**Advise - Purple Flag** - is going national following a successful bid from NHS England to support the development of a Purple Flag App which is currently being created.
Organisational Development (4 Advise)	**Advise (1) – Freedom to Speak Up -** 137 staff have raised concern with the FTSU team for Qtr 1, 2024/5. This is an increase of 140% from the same period the year before. **Advise (2) – Equality, Diversity & Inclusion -** Pride events were celebrated during week commencing 8th July and planning is underway for UHD's Cultural Day supported by all the staff networks to reduce communication barriers and improve civility and inclusion. **Advise (3) - Staff Experience –** the Quarterly Pulse Survey for July is now open. **Advise (4) – Leadership & Talent Management -** 79 managers have attended the 'Appraiser Essentials' course and 6 UHD applicants have been accepted onto the September 2024 cohort of Bournemouth University's Senior Leaders Programme
Trust Finance Position ***(1 Alert, 3 Advise, 1 Assure)***	**Strategic goal: To return to recurrent financial surplus from 2026/27** **Alert (1): Efficiency Improvement Programme** Efficiency savings of £8.161 million have been achieved against a target £8.345 million. As of 30 June 2024, EIP (Efficiency Improvement Plans) are reporting a forecast risk adjusted saving of £31.3 million against a target of £42 million leaving a potential shortfall of £10.7 million. **Advise (1): Revenue Position** At the end of June 2024 the Trust has reported a deficit of £6.288 million against a planned deficit of £5.133million, resulting in an adverse variance of £1.155 million. Of this variance, £1.029 million relates to the financial impact of the Junior Doctor industrial action in June. Income is £0.713 million adverse to plan year to date. Included within this position is a £0.264 million favourable variance against Dorset ICB and a £0.200 million adverse variance against Hampshire and Isle of Wight ICB. Other patient care income £0.192 million adverse due to a shortfall in private patient income

	of £0.098 million and RTA income of £0.123 million. The impact of industrial action on income in month amounts to £0.469 million. Operating expenditure is £1.425 million adverse to plan year to date. Pay is £1.417 million adverse to plan year to date, primarily due to premium nursing agency expenditure, non-delivery of recurring pay EIP and industrial action costs of £0.586 million. Clinical supplies expenditure is £1.115m favourable to plan year to date due to CDC costs. Drugs expenditure is £1.698 million adverse to plan year to date mainly due to Dorset ICS block contract drugs. Purchase of healthcare is £0.772 million adverse to plan year to date due to CDC costs. Premises and fixed plant expenditure is £0.852 million favourable to plan year to date due to energy costs. Agency spend in month is £1.401 million against a planned level of £1.123 million being the cap value equating to 3.2% of total pay expenditure. Whilst this is a reduction when set against the expenditure in March, it represents an adverse variance to budget of £0.278m. **Advise (2): Public Sector Payment Policy** In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 92.3% against the national standard of 95%. **Advise (3): Capital Programme** The Trust has reported capital expenditure of £22.3 million against a plan of £25.2 million. The underspend is due to slippage on committed schemes due to phasing delays. **Assure (1): Cash** As of 30 June 2024 the Trust is holding a consolidated cash balance of £87.8 million which is fully committed against the future Capital Programme.
Key Recommendations:	Members are asked to note the content of the report
Implications associated with this item:	Council of Governors ☐ Equality, Equity Diversity & Inclusion ☒ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒

CQC Reference:		
	Safe	☒
	Effective	☒
	Caring	☒
	Responsive	☒
	Well Led	☒
	Use of Resources	☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Group	July 2024	Pending
Quality Committee (Quality)	July 2024	Pending
Finance & Performance Committee (Operational / Finance Performance)	July 2024	Pending

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)		
	Commercial confidentiality	☐
	Patient confidentiality	☐
	Staff confidentiality	☐
	Other exceptional reason	☐

University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: June 2024
Meeting Month: August 2024

Contents

Achievements

In 2024/25 the achievements to date have been

- Friends and Family Test (FFT) : We are seeing a sustained increase in the number of Family and Friends Tests (FFT) responses being received. The Trust overall positive score remains above the average.
- Waits for elective treatment greater than 78 weeks have been eliminated in line with the national ambition to reduce long waiters and a reduction in the referral to treatment waiting list has been delivered.
- UHD continues to deliver strong performance for diagnostic (DM01) waits within the SW region.
- The faster diagnosis 28 day standard for cancer pathways has been delivered.
- All monthly bowel screening targets have been successfully met or exceeded.

Performance at a Glance Indicators (1)

			standard	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
SAFE																
Quality	Presure Ulcers (Hospital Acquired Cat 3 & 4)			9	5	11	8	7	16	17	15	10	11	12	9	6
Quality	Inpatient Falls (Moderate +)			5	1	3	4	6	3	4	2	13	7	4	8	3
Quality	Medication Incidents (Moderate +)			1	1	1	2	1	2	2	8	4	3	2	7	2
Quality	Patient Safety Incidents (All)			1355	1458	1446	1468	1381	1367	1278	1260	1187	1230	1176	1278	1174
Quality	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	1	1	0	1	1	2	0
Quality		MSSA		8	4	4	5	5	4	1	3	6	6	4	1	4
Quality		C Diff		19	11	4	8	8	4	8	6	9	13	4	10	8
Quality		E. coli		17	14	8	11	11	11	8	17	8	8	14	14	9
EFFECTIVE																
Mortality	HSMR In Month (UHD) Latest Feb 24 (source HED)			108.2	108.8	114.5	102.7	112.2	103.9	117.8	104.2	119.5	95.8			
Mortality	Patient Deaths in Hospital			215	196	227	200	252	232	281	245	233	215	230	214	238
Mortality	Deaths within 36hrs of Admission			34	33	43	25	35	40	45	23	38	32	30	24	39
Mortality	Deaths within 5 day readmission spell			17	22	23	18	17	16	20	14	19	21	18	19	20
CARING																
	Complaints Received			91	37	41	47	65	89	81	62	60	66	78	90	68
	Complaint Response Rate (55 Days)			52.9%	23.6%	31.9%	14.3%	20.8%	42.3%	58.2%	56.2%	38.8%	38.8%	40.5%	58.6%	54.9%
	Friends & Family Test			91.0%	93.8%	94.2%	94.4%	93.3%	94.8%	94.4%	94.1%	94.2%	94.0%	94.7%	94.6%	95.0%
WELL LED																
Safety	Risks 12 and above on Register			37	33	38	39	40	47	47	48	43	40	36	38	45
Safety	Risks 15 and above on Register			19	16	19	19	19	24	22	20	18	19	18	18	21
Safety	Red Flags Raised*			25	19	13	20	15	13	15	28	13	14	13	11	9
People	Turnover			13.4%	12.9%	12.3%	12.1%	11.7%	11.2%	11.0%	11.1%	11.1%	11.1%	10.9%	10.7%	10.6%
People	Vacancy Rate	Reported 1 month in arrears		8.1%	9.1%	8.2%	7.7%	6.9%	6.3%	6.3%	7.1%	9.4%	7.7%	9.6%	8.9%	
People	Sickness Rate			3.9%	4.1%	4.1%	4.3%	4.8%	4.6%	4.4%	4.5%	4.4%	4.4%	4.4%	4.4%	4.4%
People	Statutory and Mandatory Training			89.41%	89.70%	89.75%	89.25%	88.88%	88.92%	88.93%	88.91%	89.43%	89.0%	89.5%	90.1%	90.2%
People	Appraisal Compliance - Values Based			43.27%	44.74%	45.89%	54.87%	59.18%	61.18%	61.48%	62.18%	62.00%	62.3%	61.8%	59.4%	55.1%
People	Appraisal Compliance - Medical & Dental			74.25%	74.24%	72.98%	70.6%	74.25%	72.59%	72.08%	75.96%	76.10%	75.7%	79.0%	78.6%	78.1%
People	Temporary Hours Filled by Bank			53.1%	53.6%	54.2%	51.0%	51.8%	53.1%	52.4%	53.5%	55.6%	57.6%	57.8%	57.7%	61.3%
People	Temporary Hours Filled by Agency			24.4%	26.3%	25.2%	26.8%	26.2%	27.8%	27.0%	24.6%	22.9%	23.2%	22.8%	22.0%	19.2%
People	Agency Pay as Proportion of Total Pay			4.6%	4.7%	4.5%	5.0%	5.1%	4.5%	4.9%	5.3%	5.2%	4.4%	3.7%	3.5%	3.0%

Performance at a Glance Indicators (2)

Performance at a Glance - Key Performance Indicator Matrix

		standard	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	
RESPONSIVE																
RTT	18 week performance %	92%	55.1%	55.4%	57.0%	57.6%	59.7%	60.8%	59.8%	60.3%	61.3%	62.0%	63.0%	62.4%	61.1%	
RTT	Waiting list size	68,140 (June 24)	74,483	75,884	73,727	73,726	70,914	69,158	68,967	67,983	66,909	68,398	70,012	68,343	67,977	RAG rated based on trajectory
RTT	No. patients waiting 52+ weeks	3,005 (June 24)	4,574	4,613	4,501	4,426	4,199	4,196	3,879	3,722	2,967	2,767	2,813	2,960	2,999	RAG rated based on trajectory
RTT	No. patients waiting 65+ weeks		1,053	1,122	1,293	1,234	1,331	1,271	1,313	1,220	840	328	335	393	471	
RTT	No. patients waiting 78+ weeks	0	32	34	43	43	47	59	57	86	45	29	22	11	0	RAG rated based on trajectory
Theatre	Theatre utilisation (capped) - main	85%	73%	73%	74%	75%	75%	74%	71%	73%	74%	73%	74%	74%	74%	
Theatre	Theatre utilisation (capped) - DC	85%	73%	72%	72%	74%	74%	75%	75%	76%	73%	72%	74%	75%	75%	
Theatre	NOFs (Within 36hrs of admission - NHFD)	85%	37%	37%	31%	47%	43%	56%	60%	73%	62%	64%	63%	51%	50%	
Outpatients	**Outpatient metrics**															
Outpatients	Overdue Follow up Appts		30,594	29,622	27,619	27,946	27,493	26,506	26,733	26,506	25,844	26,075	26,161	26,046	25,642	
Outpatients	% DNA Rate	5%	6.1%	6.2%	6.3%	6.2%	6.3%	5.9%	6.2%	5.9%	5.6%	5.3%	5.3%	5.3%	5.1%	
Outpatients	Patient cancellation rate		11.6%	11.0%	11.3%	11.6%	11.8%	11.2%	12.3%	11.3%	11.1%	10.6%	11.0%	11.4%	11.6%	
Outpatients	% non face to face (telemedicine) attendances	25%	17.5%	17.4%	17.5%	17.1%	17.0%	17.3%	17.4%	17.5%	17.1%	17.2%	17.0%	17.3%	17.1%	
DM 01	**Diagnostic Performance (DM01)**															
DM 01	% of >6 week performance	1%	7.7%	9.4%	13.2%	12.1%	10.4%	9.3%	10.8%	11.8%	8.7%	10.7%	11.8%	12.9%	11.6%	
Cancer	28 day faster diagnosis standard	75%	71.9%	60.1%	54.7%	64.7%	67.0%	64.3%	66.6%	72.5%	77.8%	75.2%	66.3%	75.3%	*73.0%*	*June cancer position provisional*
Cancer	62 day standard	85%	60.2%	63.0%	57.1%	60.2%	68.9%	65.8%	64.4%	62.7%	65.0%	68.9%	68.4%	66.8%	*67.5%*	
Emergency Dept	4 hour care standard		61.7%	60.1%	62.9%	61.2%	61.0%	62.3%	60.8%	61.9%	63.8%	70.2%	70.1%	72.5%	72.2%	
Emergency Dept	Arrival time to initial assessment	15	22.0	24.0	16.0	16.0	21.0	19.0	19.0	20.0	20.0	20.0	19.0	19.0	20.0	
Emergency Dept	Clinician seen <60 mins %		35.6%	20.3%	27.2%	26.1%	27.7%	32.2%	31.9%	31.3%	33.0%	32.0%	29.0%	30.0%	29.0%	
Emergency Dept	Patients >12hrs from DTA to admission	0	13	59	2	-	-	70	294	483	202	207	145	214	171	
Emergency Dept	Patients >12hrs in dept		504	871	723	857	882	851	1271	1681	927	979	745	801	785	
SWAST SCAST	Ambulance handovers		4015	4268	4447	4238	4433	4295	4456	4394	3974	4365	4130	4414	4100	
SWAST SCAST	Ambulance handover >15mins breaches		2336	2686	2816	2818	3455	3495	3707	3679	3035	3379	3046	3373	3105	
SWAST SCAST	Ambulance handover 30-60mins breaches		684	750	824	874	1046	1139	1248	1238	876	1016	868	1040	921	
SWAST SCAST	Ambulance handover >60mins breaches		383	615	588	677	805	551	711	733	270	327	246	277	322	
Patient Flow	Bed Occupancy (capcity incl escalation)	85%	94.4%	94.6%	93.5%	95.3%	95.8%	96.7%	95.3%	96.4%	92.4%	93.0%	94.0%	93.7%	92.7%	
Patient Flow	Stranded patients:															
Patient Flow	Length of stay 7 days		480	474	476	500	502	526	534	566	551	528	527	512	510	
Patient Flow	Length of stay 14 days		294	295	308	310	318	331	339	370	363	336	339	324	327	
Patient Flow	Length of stay 21 days	108	199	202	220	211	220	220	231	266	255	235	241	230	229	
Patient Flow	Non-elective admissions		6347	6223	6233	6141	6551	6519	6214	6538	6135	6718	6494	7030	6365	
Patient Flow	> 1 day non-elective admissions		3783	3863	3821	3779	4065	3934	3909	3981	3673	4175	3973	4193	3957	
Patient Flow	Same Day Emergency Care (SDEC)		2560	2358	2410	2310	2393	2458	2157	2391	2295	2395	2365	2629	2384	
Patient Flow	Conversion rate (admitted from ED)	30%	31.60%	28.70%	28.60%	30.70%	32.50%	32.90%	30.50%	28.47%	29.30%	30.70%	31.10%	30.30%	29.90%	

Statistical Process Control (SPC) – Explanation of Rankings

Variation/Performance \ Assurance	P	?	F	
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
○	**Good** — **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
○				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

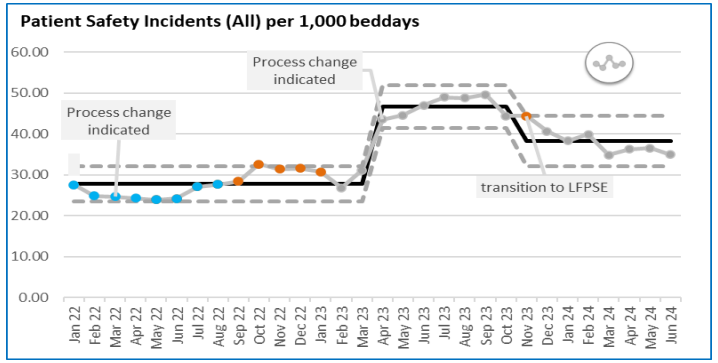
Quality Outcomes & Safety Patient Experience

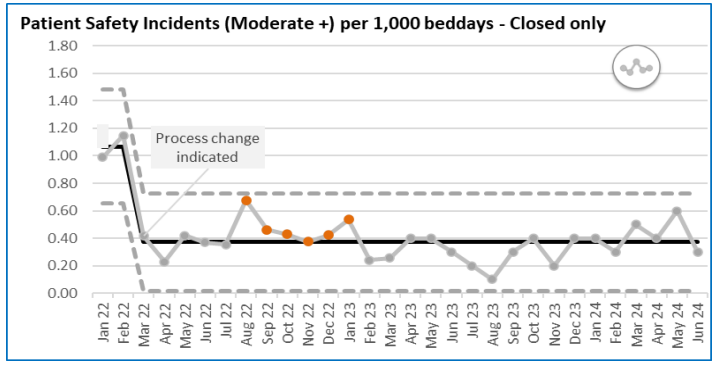

Sarah Herbert
Chief Nursing Officer
Dr Peter Wilson
Chief Medical Officer

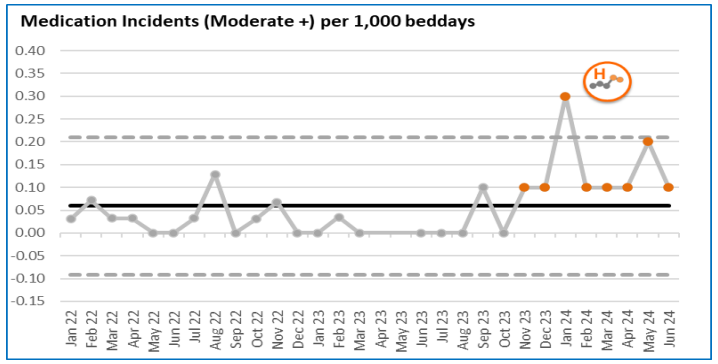
Operational Leads:
Matthew Hodson – Deputy Chief Nursing Officer (IPC, Clinical Practice and Patient Experience)
Fiona Hoskins – Deputy Chief Nursing Officer (Workforce and Safeguarding)
Sean Weaver – Medical Director for Quality & Safety
Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
Mr Alex Taylor – Clinical Director
Sarah Macklin - Care Group Director of Operations, Women's, Children, Cancer and Support Services

Committees:
Quality Committee

Quality (1) – Safe







Background/target description

To improve patient safety.
Number of patient safety incidents per 1,000 bed days
Number of patient safety incidents (moderate or above) per 1,000 bed days – closed only
Number of medication incidents (moderate or above) per 1,000 bed days

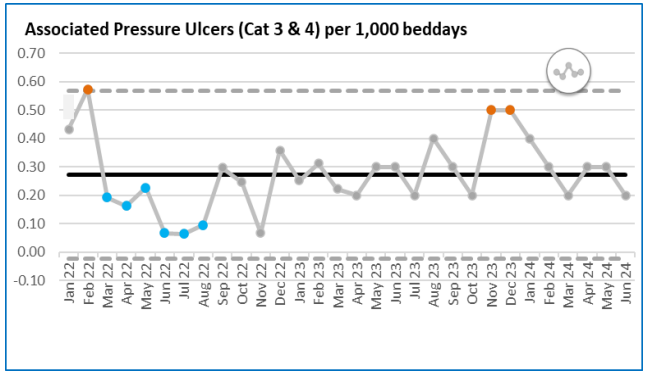
Performance

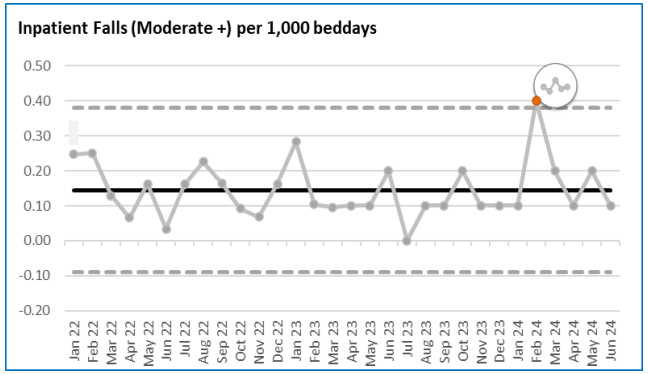
- The Trust transitioned to LFPSE in November 23 meaning the adoption of a completely different taxonomy for reporting a patient safety event was introduced. The definition change significantly reduced the number of incidents reportable to LFPSE as a Patient Safety Incident.
- No significant trends or changes in IPR reported metrics in month (Nov 23 – June 24 position).
- Redesign of IPR and Quality Dashboard metrics to report on PSIRF themes and trends is in progress.
- From 1 April 24 the Trust has adopted the PSIRF framework which means the language of "Serious Incident" will no longer be used. Patient Safety Incident Investigations (PSIIs) will be undertaken in accordance with the Trust PSIR Plan
- PSIRF investigation response tools are available on the Quality and Risk pages of the intranet

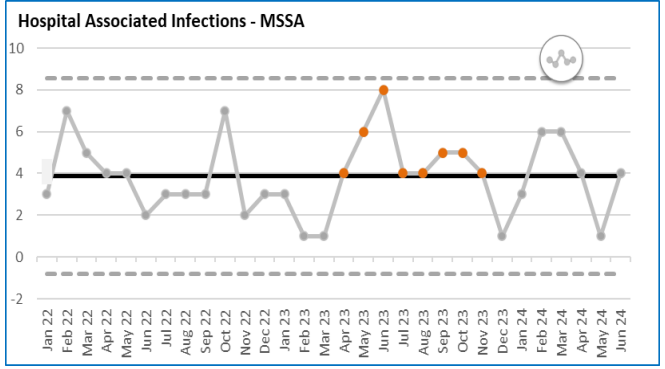
Key Areas of Focus

Full report on learning from completed investigations to be included in CMO report to Quality Committee and Board. Learning is also shared via Safety Alerts, SBAR reports, LERN synopsis and the CGG Top 10.

Quality (2) – Safe







Background/target description

To improve patient safety and care; supporting reduced length of stay.

Performance

Clinical practice:

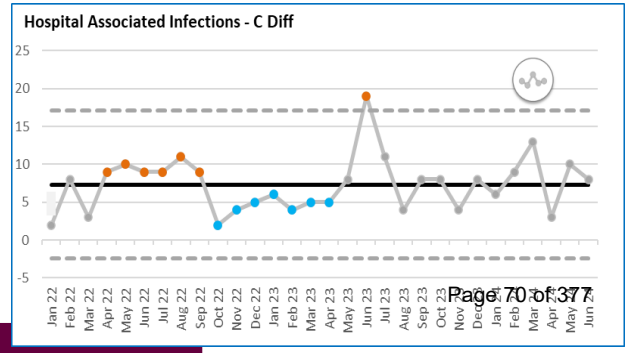
- Pressure Ulcer Data will now be reported 8 weeks in arrears- June 2024 data will be reported in August, thus allowing time for investigation to be completed.
- There has been a decrease in the number of serious* falls incidents in month with two moderate falls reported. These falls will follow the appropriate follow-up as per the patient safety framework investigation. Falls are within common cause variation.

Infection Prevention and Control

- No cases of *Methicillin-resistant staphylococcus aureus (MRSA)* attributable to UHD in the month of June .
- There was a reduction in the total number of *Escherichia coli* bacteraemia in June compared to May, greatest burden of cases remains in the medical care group. IPC continue trend and case analysis to formulate improvement actions required
- June saw a reduction in the total number of cases of *Clostridioides difficile* compared to May 2024.
- Cases of COVID-19 increased during June 2024, although remaining at an overall low level
- Outbreak of norovirus confirmed affected wards 4,5 and 8 on RBH. Ward 22 saw an outbreak of norovirus and Covid-19 co -infection during June 2024
- Incidence of invasive fungal infections identified on Ward 11. Case investigation commenced.
- Two measles cases identified - contact tracing completed by IPC and Occupational Health - action of prophylaxis and warn and inform as appropriate completed

Key Areas of Focus

- Work continues with ward teams on Falls and Tissue viability improvement plans
- Infection Prevention and Control Team focused on outbreak management and case investigations during June

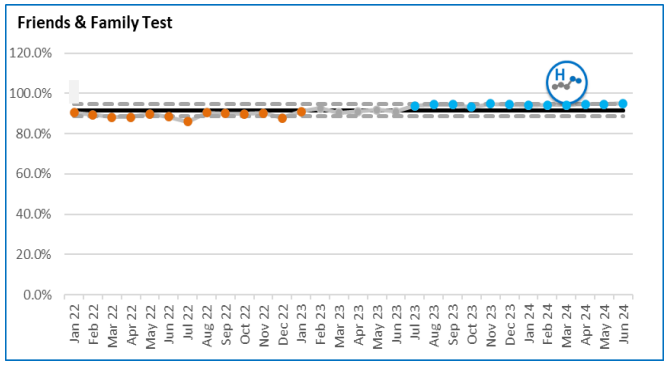


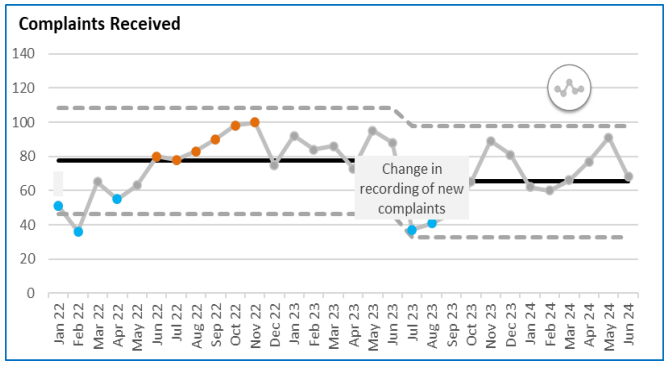
HCAI Trends by month

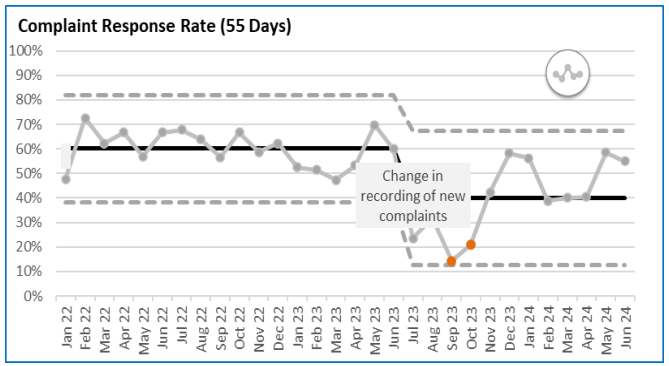
Organism	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
C Diff	11	4	8	8	4	8	6	9	13	4	10	8
E Coli	14	9	11	11	11	17	17	8	8	14	14	9
MRSA						1	1		1	1	2	
MSSA	4	4	5	5	4	3	3	6	6	4	1	4

*Categorised as Moderate or Severe

Quality (3) – Caring







Performance and Areas of Focus

PALS and Complaints Data for June 2024:

Overview:

- 485 PALS concerns raised
- 35 new formal complaints
- 33 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed was 82

Complaints and PALS themes include communication and not meeting fundamentals of care. The top 5 issues are being discussed through the PEG with Trust wide actions to address through the Nursing Midwifery and Professions Forum and Ward Leaders meetings.

The number of open complaints over 55 days continue to be prioritised within the complaints team and care groups and has continued to decrease, as identified in the SPC chart as a special cause high improving variation. The average complaint turnaround time was 44.5 days in June 2024.

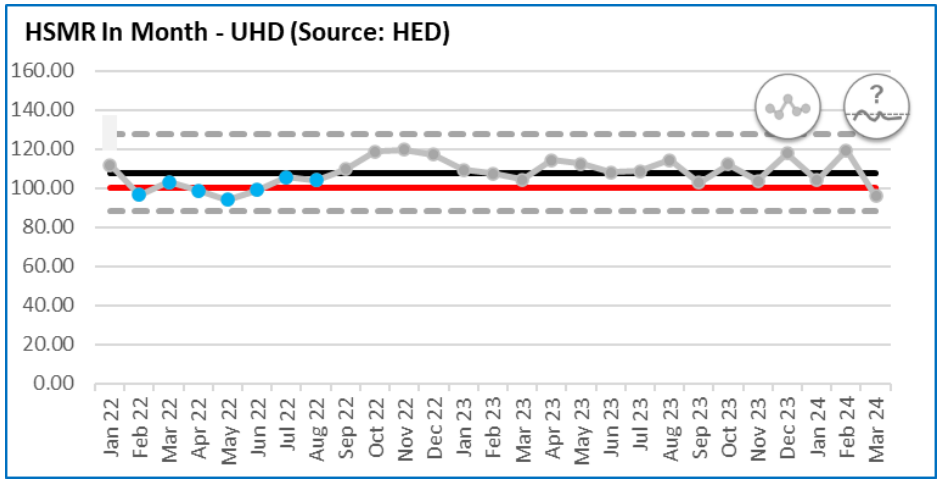
Friends and Family Test (FFT)

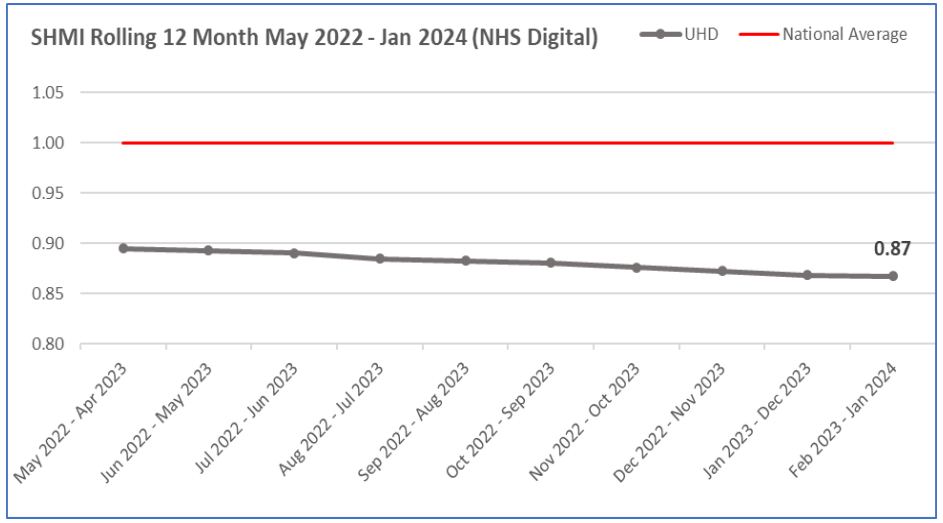
FFT results: FFT responses being received remain steady. More clinical areas are now receiving FFT results. The Trust overall positive score has been above the upper control for eight consecutive months and remains above the average score. Seen in the SPC chart as special cause improved variation. To note, the interface between ED Aygle and BI has still not been realised, meaning that ED responses to FFT remain low, BI are working on this.

Mixed Sex Accommodation Breaches

There were 16 occurrences of MSA in June 2024 in critical care – continued monitoring of areas continues with care group matrons.

Quality (4) – Effective & Mortality





Background, Performance and Areas of Focus

The headline figure for mortality reporting is UHD trust-wide Hospital Standardised Mortality Ratio (HSMR). This is the key metric for the Patient First Quality Outcomes and Safety strategic theme.

The other main mortality metric is the Summary Hospital-level Mortality Indicator (SHMI)*. This does not alter by change in data supplier (now HED) and is set by NHS Digital over the previous year.

Our in month HSMR for March is below 100 for the first time this year. There is a downward trend

We have had a relentless downward trend in our SHMI and it is the lowest of any acute trust in the South West.

We have a very low rate of palliative care coding which is unusual given that we have two hospices

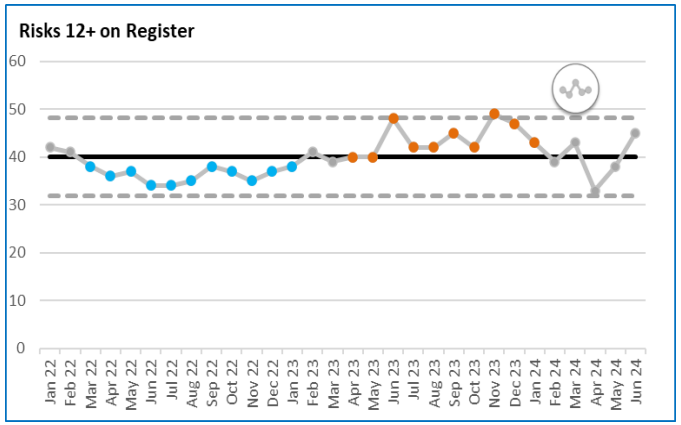
*The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust (within 30 days) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

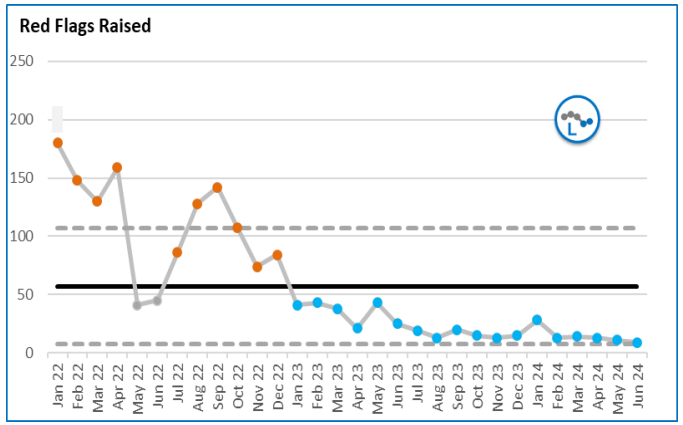
Areas of Focus

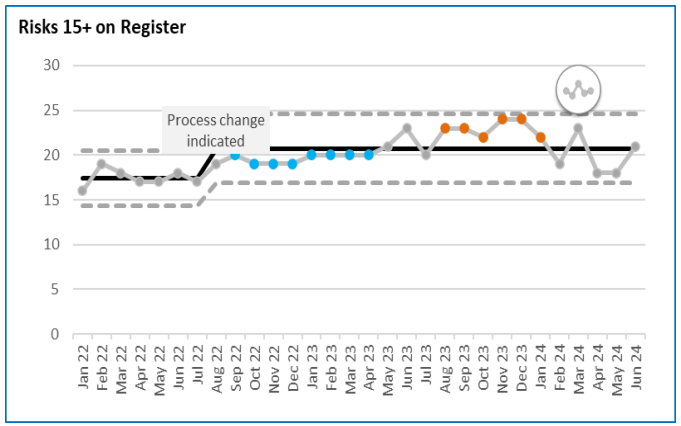
A change in how we code palliative care is being proposed in line with clinical practice locally and regionally. This is in the form of an SBAR to Trust Management Group and Quality Committee

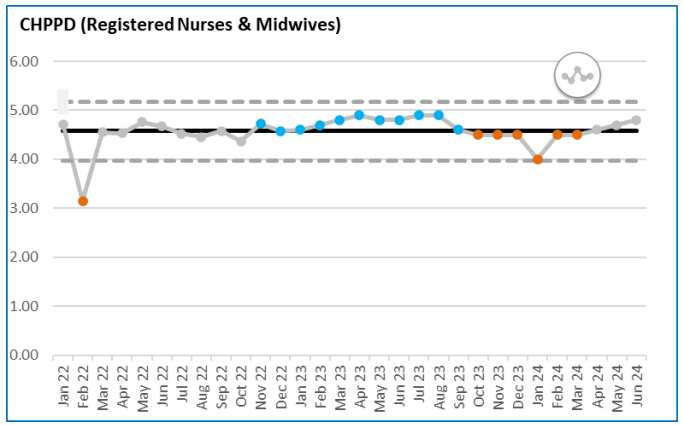
It is essential that care groups enable care group mortality processes. It is also vital that they are appropriately represented at trust wide Mortality Steering Group (MSG) and submit reports in an alert, advise assure framework.

Quality (5) – Well Led









Performance

- June 2024 CHPPD for registered nurses and midwives combined is 4.8. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for June was 9 raised in month (zero for maternity.) No critical staffing incidents were reported during this period indicating that the flags were mitigated, and safe staffing was maintained.
- Overall percentage rota fill rate against planned staffing (day & night) was 93.9% for June 2024.

Key Areas of Focus

- Separate risk report provide to Trust Management Group (TMG) Quality Committee and Trust Board
- UHD Trust Risk management strategy being updated to include more detail on risk appetite, risk tolerance and risk escalation. Draft to TMG, Quality Committee and Audit Committee in July 24.
- The use of Safecare continues to be embedded across the Trust; the focus on timely recording of staff movement continues.

Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) June 2024/25

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	15154	83473.6	77300.3	92.6%	5.1
Bournemouth & Christchurch	16578	78134.0	74412.6	95.2%	4.5
UHD Total	31732	161607.6	151712.9	93.9%	4.8

Maternity (1)

Executive Owner: Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: : Sarah Macklin (GDO) / Lorraine Tonge
Director of Midwifery / Mr Alex Taylor Clinical Director

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	0	0	0	0
	3rd/4th degree tear overall rate	>3.5%	1.7%	2.2%	2.3%	1.7%	3.70%	4.2%	1.7%
	Obstetric haemorrhage >1.5L	>3%	5.4%	3.9%	4.8%	3.6%	4.50%	2.80%	4.7%
	Term admissions to NNU	National <6%, Regional <5%	4.90%	6.10%	4.70%	6.00%	6.50%	6.50%	3.50%
	Apgar < 7 at 5 minutes	<1.2 %	1.4%	1.9%	0.9%	0.9%	0.70%	0.6%	1.2%
	Stillbirth number	Actual	0	0	0	0	0	1	3
	Stillbirth number/rate (per 1,000) per quarter	<2.6 /1000	3			0			4
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:22	01:22	01:21	01:21	01:21	01:21	01:21
Feedback	Number of compliments (Smiles via Badgernet)		no data	40	36	38	no data	96	no data
	Number of concerns (PALS) negative		1	0	5	0	5	2	0
	Complaints	3	2	1	1	4	4	4	7
	FFT Repsonse from November 23		276	297	307	no data	140		no data
Training	UHD Mandatory training - women's health midwives	90%	85%	87%	88%	90%	89%	89%	90%
	PROMPT/Emergency skills all staff groups	90%	82%	86%	88%	95%	96%	97%	93%
	K2/CTG training all staff groups	90%	86%	86%	86%	96%	99%	96%	95%
	CTG competency assessment all staff groups	90%	86%	86%	86%	96%	99%	98%	95%
	Core competency framework compliance - Midwife update	90%	91.00%	moved to ccf2	moved to ccf2	96%	no data	98%	96%
	Coroner Reg 28 made directly to the Trust		N	N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action		Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)

Data and Target

The national PQS Scorecard is RAG rated based on comparison with the national average position, rather than the target.

Performance

There are 2 areas currently flagging as red RAG rated:

- PPH >1.5 litres
- Still birth rate of 4 per 1000 for quarter 1 however quarter 4 represented 0 per 1000 so overall rate within expected limits.

Both areas remain within maternities top 3 priorities for PSIRF

Key Areas of Focus

3rd/4th degree tears: Consultant Midwife is leading on this piece of work to ensure a sustained reduction in serious tears. In June, the quality improvement programme included a lithotomy challenge for UHD staff to raise awareness and a relaunch to promote the importance of protecting the perineum. This has shown a significant improvement for this month and work will continue with the team to sustain improvements.

Term admissions to NICU : term admissions to NICU has fallen below national and regional standards for June but will be continued to be monitored as this could be a variation only.Areas of Focus

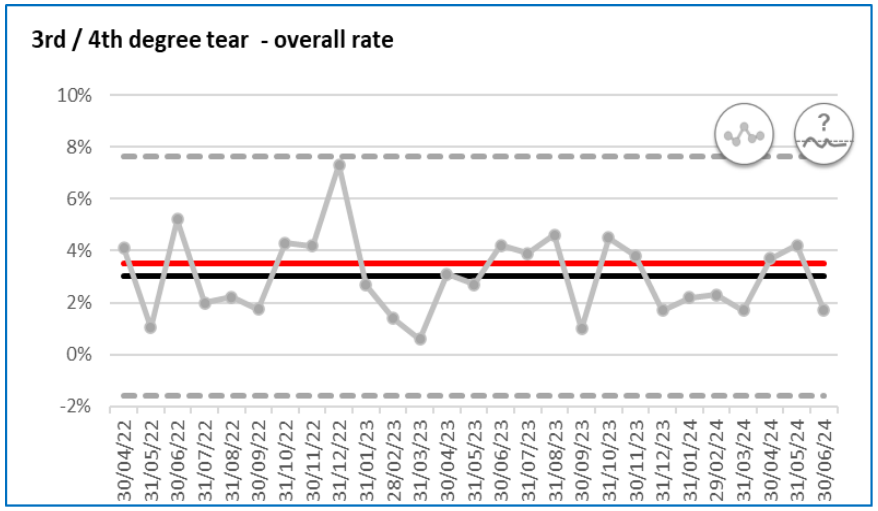
Training – CTG and Prompt training midwives update day continue to be above >90% and the team continue to sustain this standard.

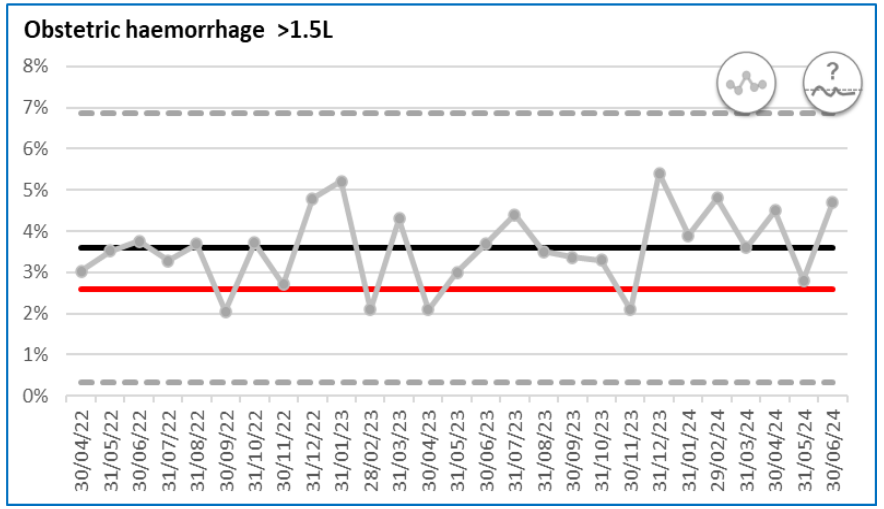
Maternity (SPC)

Executive Owner: Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: : Sarah Macklin (GDO) / Lorraine Tonge
Director of Midwifery / Mr Alex Taylor Clinical Director

Maternity - Areas of Focus

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
3rd / 4th degree tear - overall rate	Jun 24	1.7%	3.5%			3.0%	-1.6%	7.7%
Obstetric haemorrhage >1.5L	Jun 24	4.7%	2.6%			3.6%	0.3%	6.9%
Term admissions to NNU %	Jun 24	3.5%	6.0%			5.5%	2.5%	8.6%





Maternity (2)

Executive Owner: Sarah Herbert (Chief Nursing Officer)
Management/Clinical Owner: : Sarah Macklin (GDO) / Lorraine Tonge Director of Midwifery / Mr Alex Taylor Clinical Director / Kerry Taylor Head of Midwifery

CQC Maternity Ratings UHD Assessment 2019 and Oct 2022.	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
	Inadequate	Inadequate	GOOD	OUTSTANDING	OUTSTANDING	Inadequate

National position & overview

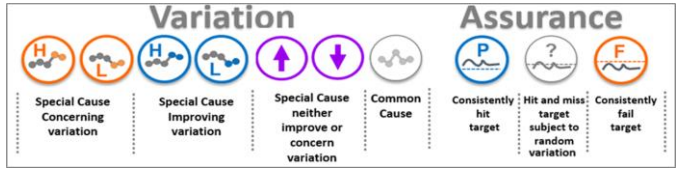
- The Perinatal Quality Surveillance Dashboard describes a standard data set for Trust Board overview
- The dashboard implementation using the Perinatal Quality Surveillance Tool forms part of our Maternity Safety Self Assessment and Ockendon 1 requirements
- There are a number of items which require narrative rather than graphic benchmarking and these are described below

Findings of review of all perinatal deaths using the national monitoring tool	Matters for Board information and awareness	Progress in achievement of Year 5 Maternity incentive scheme
MBRRACE reportable cases: There have been 3 reportable cases for MBRRACE in June. 3 IUD's one of which was a late fetal loss. Initial learning identified in one case and will be reviewed as a PSII. **PMRT** There were 1 new PMRT case reviewed in June – no care issues identified L129706 Joint PMRT monthly meeting held by UHD and Dorset County Hospital Quarter 1 - PMRT 2024 April to June reported to safety champions. **MNSI** There were no new cases in June to MNSI	**Patient Safety Incident Response Framework** (PSIRF) PSIRF is being implemented in maternity and our top 3 areas identified for thematic reviews are 1. Stillbirth 2. Term admissions to NICU - 6 months deep dive presented to ICB and safety champions in November ongoing action plan. 3. PPH greater than 1.5 liters initial quality improvement commenced. **There has been NHSR learning submitted in June through safety champions/quality committee.**	**MIS year 6 - new standards published 2nd April 2024.** Work continues on all safety standards with monthly assurance meetings to monitor compliance. There will be a mid-way review in July with the auditors to ensure progress towards standards continues. **For the standards partially met, further progress has been made in June** **CQC maternity action plan** All actions now complete continue to monitor standards and ensure sustainability **CQC patient survey** Action plans developed with the MNVP and in progress. **Insight and 3- year delivery plan** On target to achieve insight actions and year 2 plan **MSSP exit criteria** Good progress being made.

Performance at a glance
Quality - Key Performance Indicator Matrix

Quality IPR

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	Jun 24	0.20	-			0.27	-0.02	0.57
Inpatient Falls (Moderate +) per 1,000 beddays	Jun 24	0.10	-			0.14	-0.09	0.38
Medication Incidents (Moderate +) per 1,000 beddays	Jun 24	0.10	-			0.06	-0.09	0.21
Medication Incidents (All) per 1,000 beddays	Jun 24	5.30	-			5.09	3.24	6.95
Patient Safety Incidents (All) per 1,000 beddays	Jun 24	34.90	-			38.20	32.08	44.32
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed	Jun 24	0.30	-			0.37	0.02	0.72
Serious Incidents	Jun 24	0	-			3	-3	8
Never Events	Jun 24	0	-			0	-1	1
Hospital Associated Infections - MRSA	Jun 24	0	-			0	-1	1
Hospital Associated Infections - MSSA	Jun 24	4	-			4	-1	9
Hospital Associated Infections - C Diff	Jun 24	8	-			7	-2	17
Hospital Associated Infections - E Coli	Jun 24	9	-			8	-2	19
HSMR In Month - UHD (Source: HED)	Mar 24	95.80	100.00			107.93	88.10	127.77
Mixed Sex Accommodation Breaches	Jun 24	16	-			8	-15	30
Complaints Received	Jun 24	68	-			65	33	97
Complaint Response Rate (55 Days)	Jun 24	55%	-			40%	13%	67%
Friends & Family Test	Jun 24	95.0%	-			91.6%	88.6%	94.6%
Patient Deaths in Hospital	Jun 24	238	-			236	170	302
Deaths Within 36hrs of Admission	Jun 24	39	-			35	14	57
Deaths Within Readmission Spell (5 day readmission)	Jun 24	20	-			22	8	36
Risks 12+ on Register	Jun 24	45	-			40	32	48
Risks 15+ on Register	Jun 24	21	-			21	17	25
Red Flags Raised	Jun 24	9	-			57	7	107
CHPPD (Registered Nurses & Midwives)	Jun 24	4.80	-			4.57	3.97	5.18
			-					



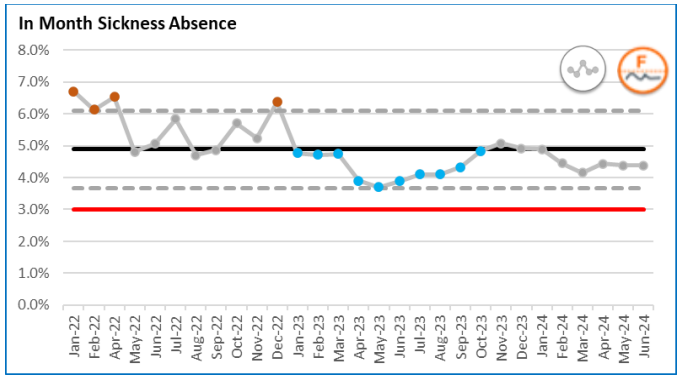
Our People

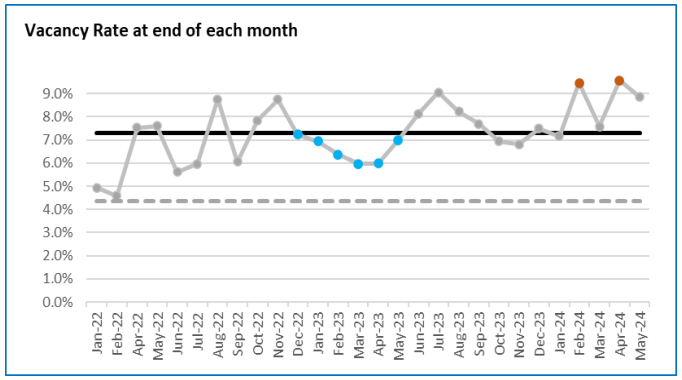
Tina Ricketts
Chief People Officer

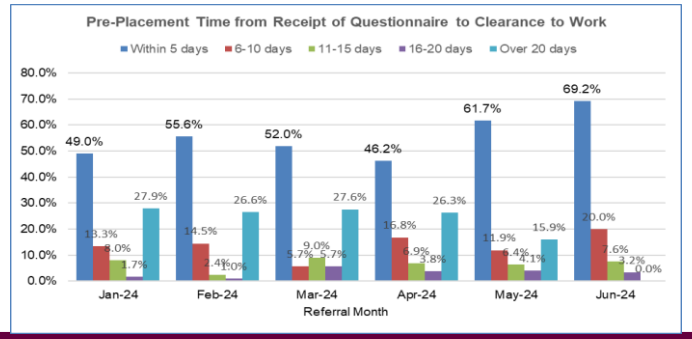
Operational Leads:
Irene Mardon - Deputy Chief People Officer

Committees:
People and Culture Committee

Well Led - Workforce (1)







Performance

Sickness Absence and Wellbeing

- In month sickness absence for June 2024 was at 4.4% which is the same as the previous 2 months. The latest rolling 12 month rate (as at end of June 2024) is 4.5% which is same as the previous month and demonstrates normal variation.
- Anxiety/stress/depression was the top reason for absence in June (risk 1493).

Vacancy Rate

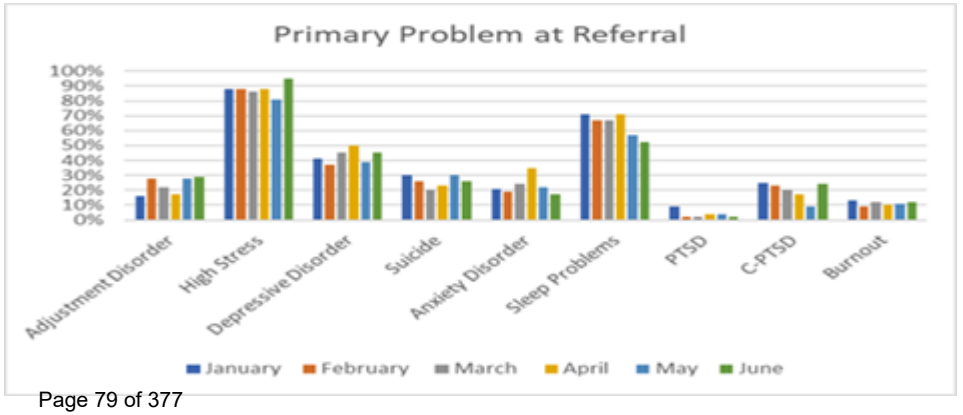
- Vacancy rate is reported a month in arrears to allow for reconciliation with the ledger. The latest vacancy position is 8.9% (as at end of May) which is a decrease from April at 9.6%.
- The number of Starters for the month was 151 in total, 141 of which were for non- medical roles. This is the second lowest number of monthly starters over the past 12 months, although consistent with the same month last year.
- Newly Qualified Nurse - We still have 35 successful Newly Qualified nurses to place following a highly popular open day event

Healthcare Support Worker Recruitment and International recruitment

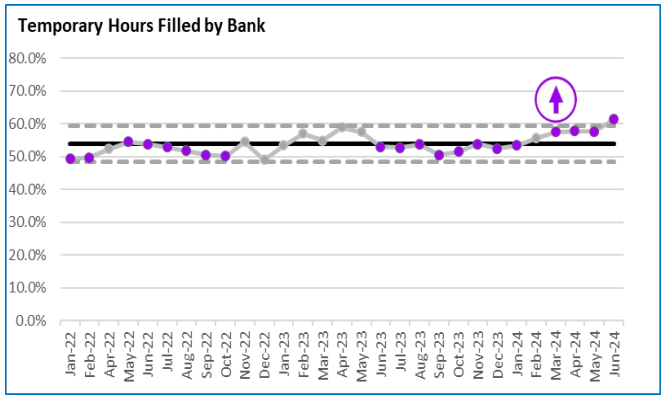
- The last 7 Nurses being recruited via our International Nurse Programme are due to arrive on 26th July.
- 20 Healthcare support workers have started during June further reducing our vacancy rate.

Occupational Health

- 69.2% of pre-employment referrals were cleared to work in 5 days, an improvement from 61.7% in May 2024.
- Stress remains the highest reason for referrals into the Psychological support and counselling service. It is currently a 14 day wait for an initial appointment and 5 week wait for a counselling appointment.



Well Led - Workforce (2)

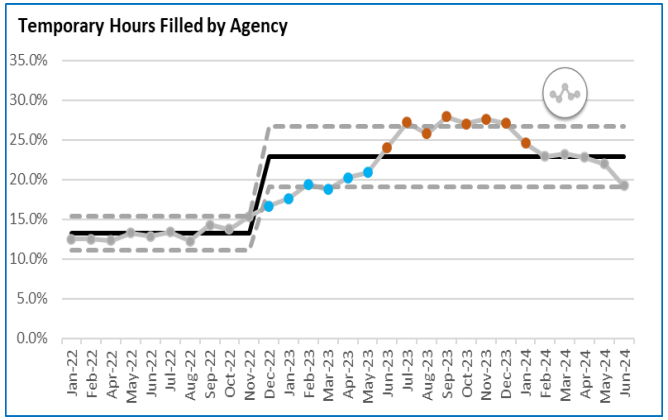


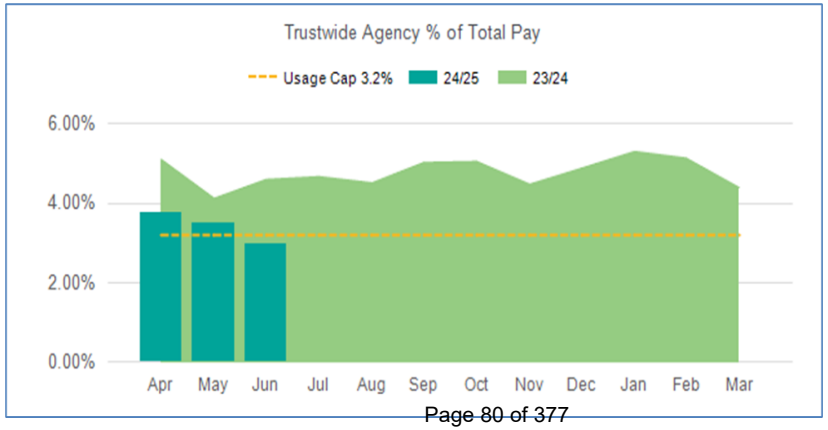
Performance

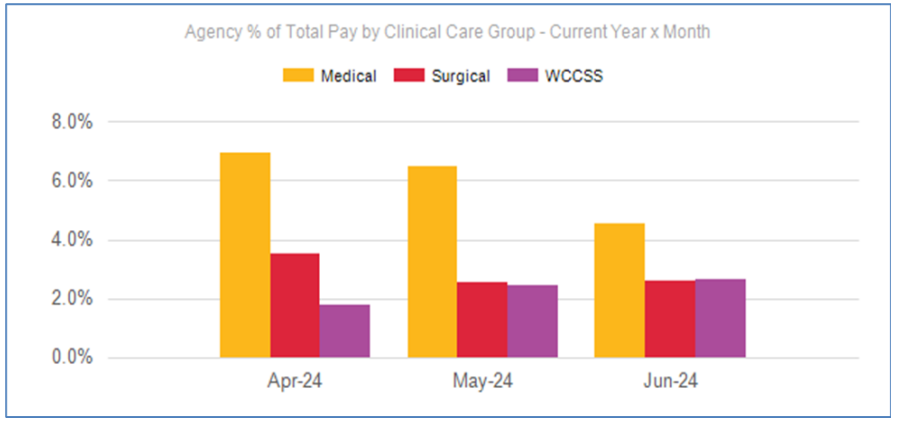
- We have seen an overall decrease in agency spend from 3.51% in Month 2 to 2.99% in Month 3.
- Agency spend has decreased in the Medical Care Group from 6.5% (May 2024) to 4.5% (June 2024), the Surgical Care Group has seen a small increase from 2.5% to 2.6%. Women's, Children, Cancer and Support Services Care Group has increased from 2.4% to 2.6%.
- Total off-framework usage was less than 1% in Month 3 compared to 1.6% in Month 2 1 x off framework locum remains within Child Health who will be exiting on 22nd July 2024
- There was a 4.75% decrease in requests for additional shifts to be filled via Temporary Staffing in Month 3
- The was a 17.15% decrease in shifts filled by agency in M3.
- Agency Price Cap the 3rd phase on the agency rate reduction plan has been implemented from 1st July 2024 which brings the majority of clinical supply (Nursing, Midwifery and Support workers) at or under cap. Specialist areas such as ED, Child Health and Theatres on a reduced specialist rate with a flight path to meet cap compliance by October 2024

Key Areas of Focus

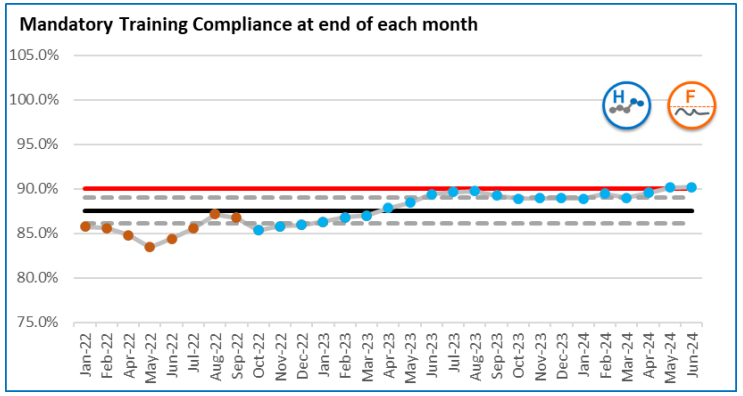
An agency reduction plan is in place which is monitored through the Trust Management Group

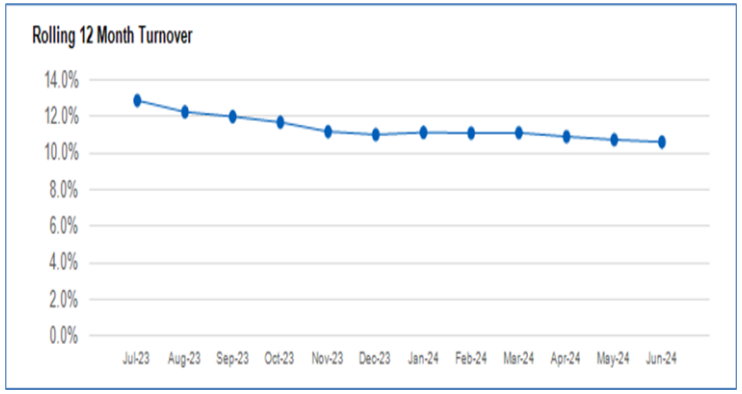






Well Led - Workforce (3)





Performance

Mandatory Training

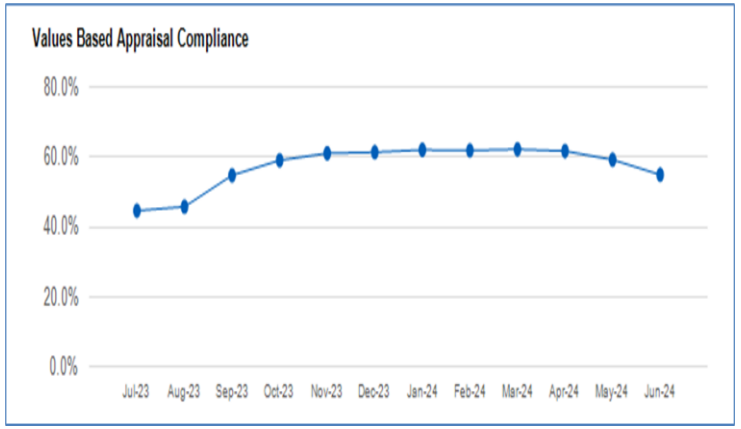
- Mandatory Training compliance has increased to 90.2% as at end of June 2024, just over the target of 90%.

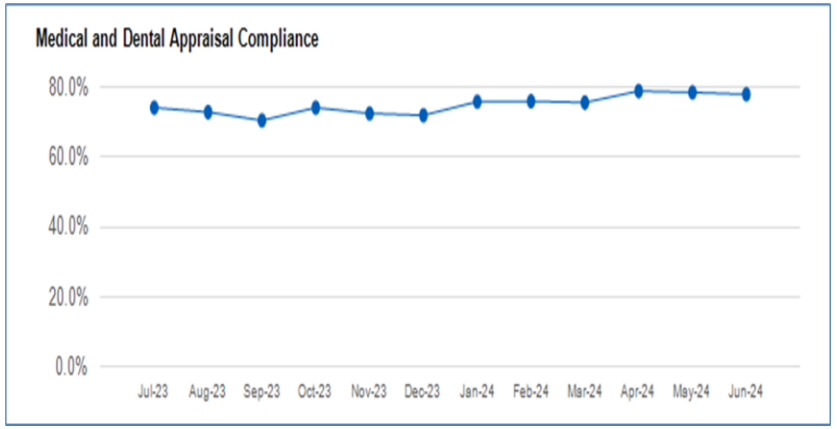
Turnover

- The rolling 12 month staff turnover rate (excluding fixed term temp) is at 10.6% as at end of June 2024, a slight reduction on last month at 10.7%. The trend remains downward year to date.

Appraisal

- Updated appraisal procedure was ratified in May 2024
- Appraisal compliance for values based as at end of June 2024 is at 55.1%, this is now using a rolling 12 month rolling period. Medical and Dental compliance is at 78.1% (significant increase due to improvements method of identifying junior doctors to exclude).

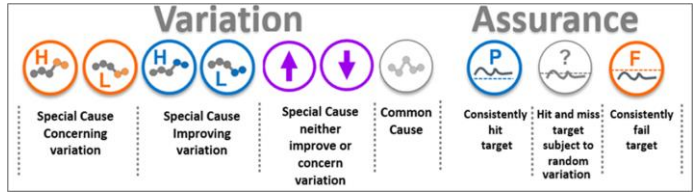




Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	May 24	8.9%	-			7.3%	4.4%	10.2%
In Month Sickness Absence	Jun 24	4.4%	3.0%		F	4.9%	3.7%	6.1%
Mandatory Training Compliance at end of each month	Jun 24	90.2%	90.0%	H	F	87.5%	86.1%	89.0%
Temporary Hours Filled by Bank	Jun 24	61.3%	-			53.9%	48.4%	59.3%
Temporary Hours Filled by Agency	Jun 24	19.2%	-			22.9%	19.0%	26.7%
Agency Pay as Proportion of Total Pay	Jun 24	3.0%		L	?	4.5%	3.0%	6.1%



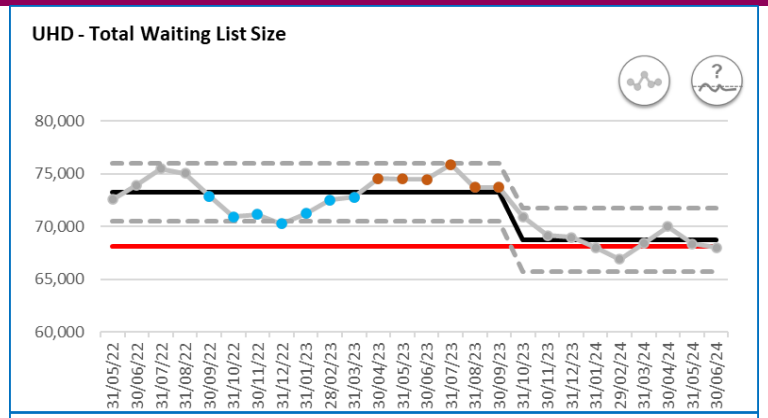
Population Health and System Working

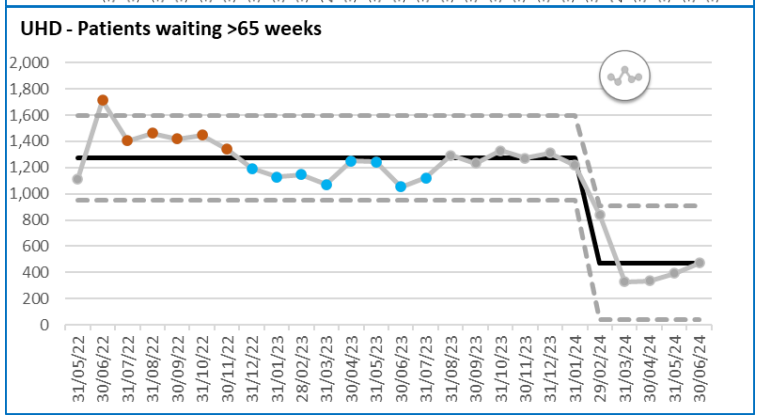
Mark Mould
Chief Operating Officer

Operational Leads:
Judith May – Director of Operational Performance and Oversight
Mark Major – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Sarah Macklin – Group Director of Operations – Women's, Children, Cancer and Support Services
Leanna Rathbone – Group Director of Operations – Medical

Committees:
Finance and Performance Committee

Responsive – (Elective)
Referral to Treatment (RTT)





	Standard	UHD	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	61.1%	
Waiting list size (and trajectory)	68,140	67,977	20%
Waiting List size % variance compared to trajectory		-0.2%	
No. patients waiting 26+ weeks		15,933	35%
No. patients waiting 40+ weeks		7,235	40%
No. patients waiting 52+ weeks (and % of waiting list)	4.4%	2,999	46%
No. patients waiting 65+ weeks (and % of waiting list)	0.7%	472	57%
No. patients waiting 78+ weeks (and % of waiting list)	0.0%	0	0%
% of Admitted pathways with a P code		98.10%	

Data Description and Target

Total number of patients waiting on an RTT elective waiting list.
Number of patients on an elective RTT waiting list whose wait exceeds 78 weeks. National target 0.
Number of patients on an elective RTT waiting list whose wait exceeds 65 weeks. National target 0 by Sept 2024.

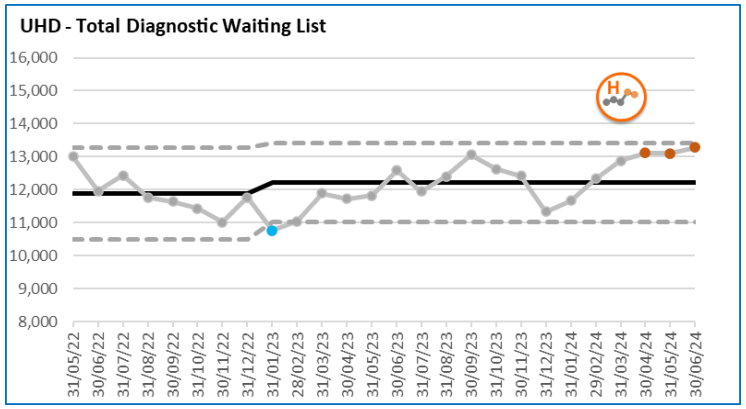
Performance

- The Referral to Treatment (RTT) waiting list size shows a reduction below the process mean in June 2024 (-366) to 67,977 and is now achieving the operational planning trajectory (68,140). RTT performance decreased from 62.4% in May to 61.1% in June.
- System modelling of activity data indicates UHD delivered 110.3% compared to the 2019/20 baseline period.
- In June, 90% of patients waiting 12 weeks or more on the waiting list have has their pathway validated, in line with the national standard and plan. Performance is expected to be maintained with a combination of administrative, technical, digital and clinical validation.
- The Trust successfully eliminated RTT waits greater than 78 weeks in June.
- Over 65-week waits increased to 472 and was above the operational plan trajectory for June (295). Industrial action by junior doctors at the end of June had an impact on the Trust's ability to treat long waiters in month. Despite being off plan, the rate of reduction continues to indicate that elimination of 65 week waits by September 2024 is achievable.
- Gynaecology, ENT, Colorectal and Orthopaedics (Shoulders) remain the most challenged specialities.
- Waits greater than 52 weeks are lower than the operational plan trajectory (3,005).

Key Areas of Focus

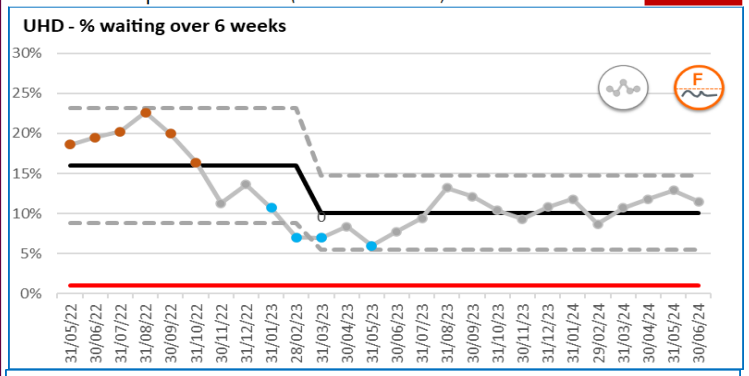
- Delivery of capacity plans to maintain zero 78 week waits and eliminate 65 week waits by September 2024 (except where patients choose to wait longer).
- Maintain elective activity rates above 109% against 2019/20 baseline.
- Prioritise booking all patients in the September 65 week cohort into capacity in July and August.
- Increase productivity within core capacity, including reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates.
- Conclude the interventions designed through the Intelligent Workflows (process mining) project in Outpatients.
- Expand insourcing and waiting list initiatives to increase available capacity and reduce the waiting list.

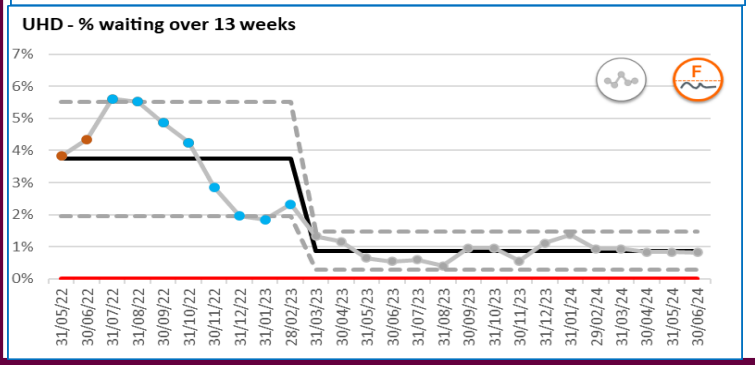
Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)

% of >6 week performance	*(6+ Weeks / Total)*	1%	1540/13279	11.6%





Data Description and Target

Total number of patients waiting a diagnostics test
Number of patients whose wait for a diagnostic test exceeds 6 weeks. Target 1%

Performance

June 2024 performance improved to 11.6% compared with 12.9% at the end of May 2024. Performance remains within the upper and lower process control limits; however further improvement is required to meet the 1% target. An increase in the overall diagnostic waiting list (showing special cause variation) is reflective of increased urgent suspected cancer referrals and elective activity.
There are currently 76 patients waiting more than 13 weeks for a diagnostic test (cardiac MRI, echo and colonoscopy).

Endoscopy performance improved to 12.5% at the end of June (16.5% at the end of May), despite impact of further industrial action.

- there is ongoing use of 18 Weeks Support insourcing and waiting list initiatives (WLIs) to support delivery of the Community Diagnostic centre (CDC) activity plan.

Echocardiography performance has fallen to 16.8% in June, (from 12.3% in May), due to limited insourcing capacity.

- Heart failure remains the challenge in achieving DM01. Additional Heart Failure clinic capacity from a visiting GP is now in place. However, there are ongoing vacancy gaps and sickness reducing capacity and a significant increase in referral numbers.

Neurophysiology performance remained broadly unchanged at 33.3% in June (from 33.7% in May).

- Consultant vacancy has led to reduced capacity and longer waits within the department. There is ongoing use of locum cover and redistribution of other clinical work in the department to manage performance.

Radiology performance has improved to 7.0% in June (from 9.1% in May).

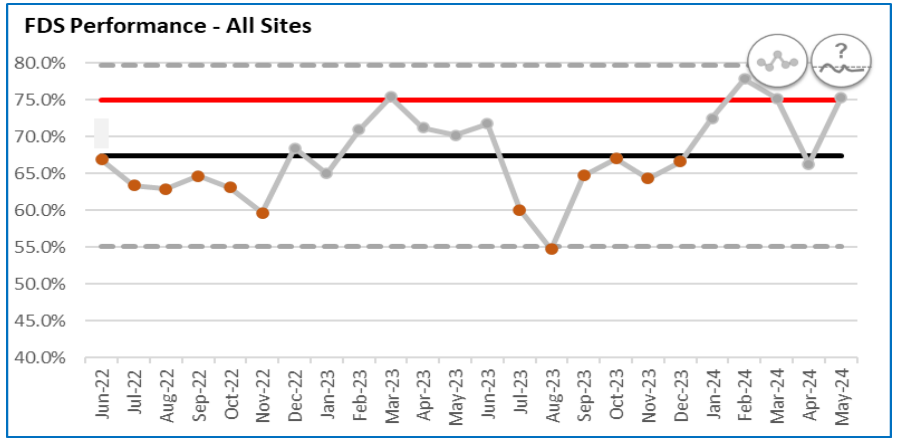
- Target is not being achieved predominately due to the ongoing reduction in cardiologist CT / MRI sessions.

Key Areas of Focus

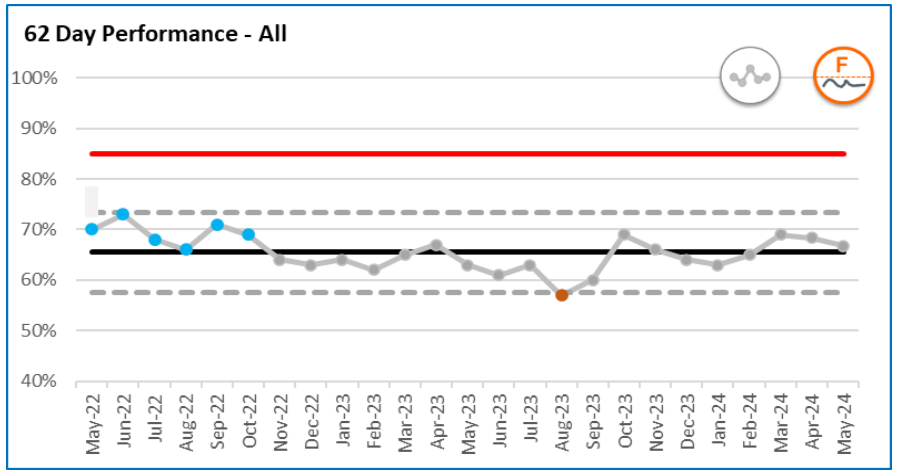
- **Endoscopy:** Additional capacity added from July for rest of the financial year.
- **Echocardiography:** Progress TomCat / Dr Doctor integration enabling greater focus on patient 'Did not attends' (DNAs) reduction through appointment reminders.
- **Neurophysiology**: Exploring outsourcing to support recovery.
- **Radiology**: Mobile CT and mobile MRI contracts have now ended; capacity replaced through use of additional weekend and evening sessions, meeting with Bournemouth University to enquire about access to their MRI capacity. Paediatric MRI (General Anaesthetic) list now at almost 10 week wait, due to insufficient anaesthetic capacity.
- **Cardiology** have provided some additional sessions with a locum helping to recover the cardiac position (currently 477 patients breaching 6 weeks). Agreement with Nuffield to send cardiac CTs (10 per week) and weekend WLIs (Waiting List Initiatives) for cardiac MRIs (14 per week).

Responsive (Elective)
Cancer FDS & 62 Day Standard

28 Day Faster Diagnosis Standard (National Target & Trust Trajectory 75%)
Finalised UHD May Performance (75.3%)



62-Day Standard
(National Target 85%, Trust Trajectory 67.2%)
Finalised UHD May Performance (66.8%)



Data Description and Target

- Percentage of patients informed of diagnosis within 28 days from referral. Faster Diagnosis Standard = 75% (77% by March 2025)
- Percentage of patients who receive their 1st treatment for cancer within 62 days. 62 Day Standard = 85% (70% by March 25).
- The number of 62-day patients waiting 63 days or more on their pathway – remain below 220.
- The proportion of patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, who then start that treatment within 31 days. 31 Day Standard = 96%

Finalised May Performance

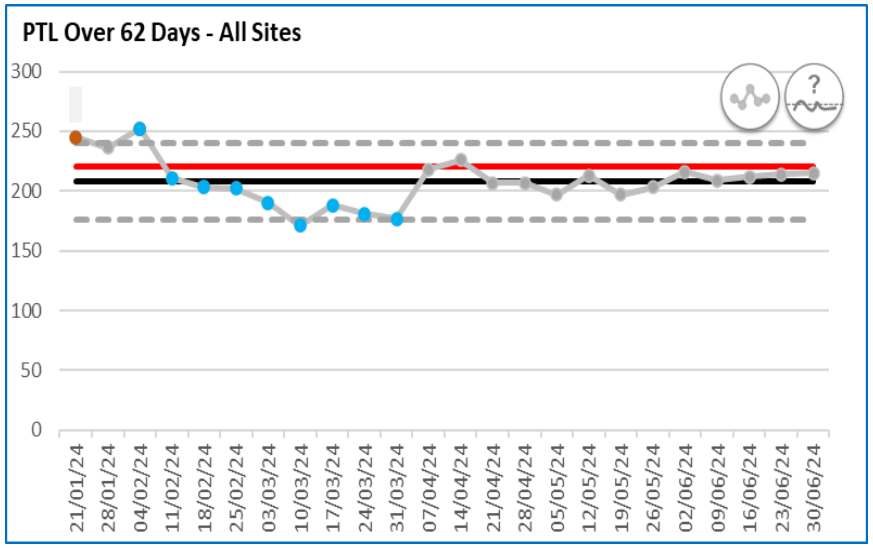
- **28 Day Faster Diagnosis Standard** - Performance in May 2024 increased to 75.3%, achieving both the national standard and the Trust trajectory. This is an improvement of 9.0% in month compared to April 2024 and remains within the process control limits. 9 out of 14 tumour sites achieved the standard.
- **62 Day Standard** - Performance in May 2024 decreased by 1.6% to 66.8% compared to April 2024 which is below the Trust trajectory of 67.2%. Performance continues to demonstrate normal variation within the process control limits, with the upper process control limit positioned below the standard. A change in process therefore is needed to meet the standard. The main breach reasons in May 2024 were due to capacity challenges at the front end of the pathway and delays to surgical and oncological treatments.
- **31 Day Standard** - Performance in May 2024 was achieved at 96.5%.
- **Patient Treatment List (PTL) Over 62 Days** - The total number on the PTL over 62 days remained below the 220 target with 203 patients over 62 days. This was a decrease of 4 patients compared to April 2024.

Provisional June Performance (un-finalised)

- **28 Day Faster Diagnosis Standard -** Performance in June is currently 73.0%. The main reason for the decrease in performance is due to a high number of gynaecology and skin breaches due to delays in the 1st appointment.
- **62 Day Standard** - Performance in June is currently 67.5% which is meeting the Trust trajectory of 67.5%.
- **31 Day Standard** - Performance in June is currently achieving the 96.0% threshold at 96.0%.
- **Patient Treatment List (PTL) Over 62 Days** - The month end position continues to be below the 220 threshold with 215 patients over 62 days.

Responsive (Elective)
Cancer Over 62 Day Breaches

Over 62 Day PTL (Target May: 220)
Finalised UHD May Performance: 203



High Level Performance Indicators

Cancer Standards	Standard	Final	Provisional
		May-24	Jun-24
28 Day Faster Diagnosis Standard	75%	75.3%	73.0%
31 Day Standard	96%	96.5%	96.0%
62 Day Standard	85%	66.8%	67.5%
PTL Over 62 Days	220	203	215

Key Areas of Focus

In 2024/25 the focus for Cancer Performance has returned to the 3 main National Standards (28 Day, 31 Day and 62 Day). UHD remain committed to maintaining the over 62-day PTL under 220. The national standard for 62 Day performance is 85%. However, in 24/25, the operational planning target is to meet 70% by March 25.

Key areas of focus for Quarter 2 are the 4 most challenged tumour sites:

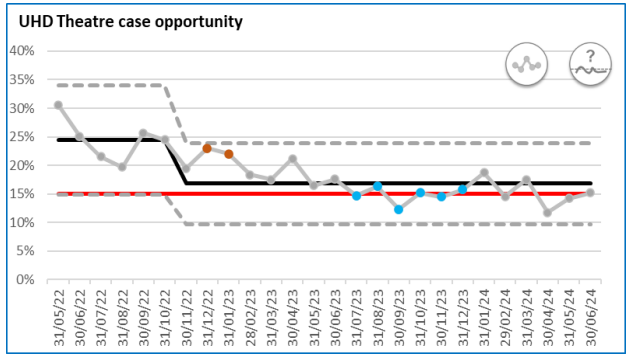
Gynaecology:
- Additional weekday and insourcing Post Menopausal Bleeding sessions planned in July.
- Amendments to clinic template to address backlog and increase core capacity for 1st appointment.
- Maintaining the additional GA hysteroscopy activity which commenced in Q1 2024/25.
- Pathway navigator starting early July - this role will focus on planning capacity to meet fluctuations in demand.

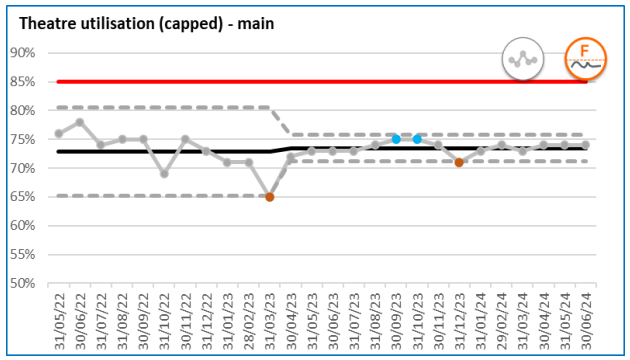
Skin:
- Impact of Tele-Dermatology to be reviewed in order to inform future capacity requirements.
- Additional insourcing activity continues to accommodate the year-on-year increase in referrals.

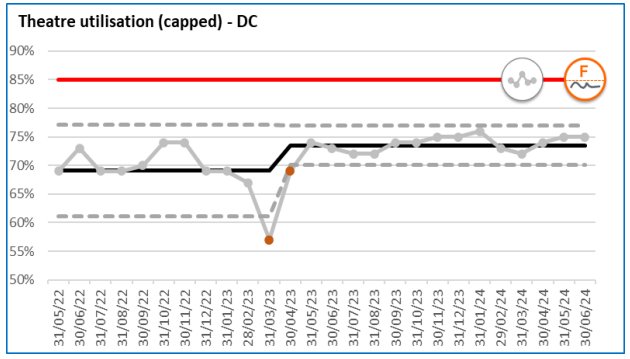
Iron Deficiency Anaemia (IDA):
- Provision of intelligence relating to the capacity for urgent suspected cancer referrals which will support the service to develop a case for required workforce changes.

Colorectal:
- Outcome of Wessex Pathway Analyser to be utilised to support ongoing improvements in performance against all standards including over 62 days.
- Ongoing insourcing to manage demand alongside elective long waiters.

Responsive (Elective)
Theatre Utilisation







Data Description and Target

Trust is pursuing a **capped utilisation** of 85% which takes into consideration downtime between patients.
Intended utilisation is the utilisation booked into lists and excludes any on the day / 1-day prior cancellations. Theatre utilisation as reflected below includes trauma capacity which will be lower than capped utilisation (left) due to the unpredictable nature of emergency and trauma versus planned lists.
Case opportunity is a measure of the time lost to inefficiency and expressed as the number of additional patients that could have been treated.
Day case rate (Target 85%)

Performance

- Capped utilisation within main theatres remains lower than the 85% target but sitting above current mean. In June capped utilisation is 75% overall, 74% for main and 75% for day cases. There has been a sustained reduction in variation, but further action is required to deliver a process capable of meeting the 85% target.
- Ongoing focussed work around orthopaedic lists has triggered special cause variation (improvement) for both capped utilisation and early finishes, however further improvements are still required. Key drivers of performance in Orthopaedics are - early finishes, late starts, booking processes and theatre E-camis data validation
- Overall there is continued improvement on late starts and inter case activity, reducing down time further between patients
- An increase of 55 patients seen in month across theatres was achieved in June.
- Gynaecology and general surgery lists booked well and supporting management of long-waiters.
- The day case activity rate is 84% (target 85%), with performance being maintained.

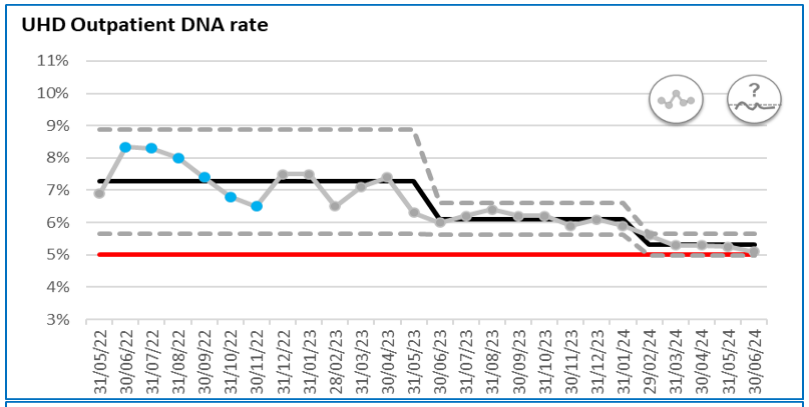
Key Areas of Focus

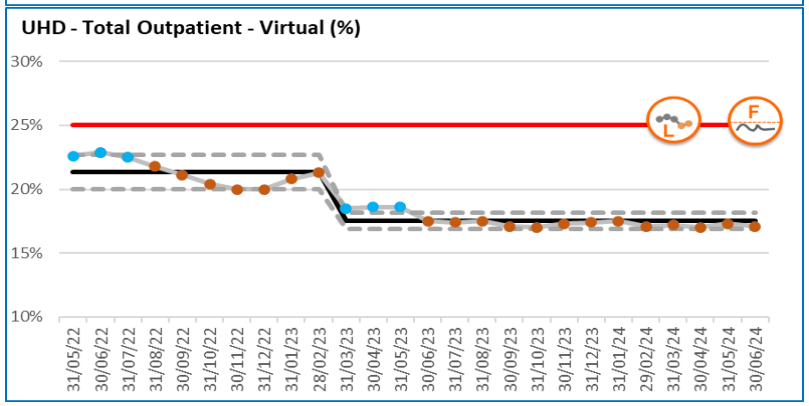
Further work is underway to unlock case opportunity and increase utilisation across all specialities.

- Continue with the initiative of automatically sending for patients at 08.05 which avoids delay at the start of theatre sessions
- Golden patient process commenced in June 2024
- Focus on utilisation, list planning, and speciality specific improvement
- Increase cluster support to ensure fully utilised lists, with appropriate support and equipment
- Improving data quality and delay reasons to inform improvement work.
- On the day cancellations focus required for specialities to improve.
- Ensure data validation of scheduled activity correctly captured through E Camis

Responsive (Elective) Outpatients

Referral Rates (MRR Return)		Standard	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	30150	-3.6%
Total Referrals Rate year on year		-0.5%	46334	-1.8%
Outpatient metrics				
Overdue Follow Up Appointments (Cons-Led Only)				25642
New Attendances				21426
Follow-Up Attendances				30747
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%	2831 / 52173	5.1%
Hospital cancellation rate	*(Hospital Canx / Total Booked Appts)*		11426 / 75154	15.2%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*		8724 / 75154	11.6%
Reduction in face to face attendances (acute only)				
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%	8919 / 52173	17.1%





Data Description and Target

- Reduction in Did Not Attend (DNA) rate (first and follow up) to 5%
- 25% of all attendances delivered virtually
- Reduction in overdue follow up appointments

Performance

DNA rate in June is at 5.1% which is an improved in month position and within normal variation. The process control limits indicate the target can be met within existing processes. The planned switch on of text reminders across all clinics is being staggered. Currently 83.8% of all clinics which are suitable (not excluded), have text reminders switched on. Once the remaining clinics are switched on, this is expected to have a further positive impact on reducing DNAs.

17.1% of attendances were delivered via telemedicine/video in June which has remained static over the past year. Current process control intervals demonstrate the target will not be met unless process improvements are made. Work is ongoing to ensure all activity is being captured on our patient administration systems, including video consultations.

The number of patients overdue their target date for a follow up appointment reduced by 2396 in June 2024. A proportion of the reduction in numbers are due to the “Focus on Follow Up” validation work and performance does not appear to have been negatively impacted by the industrial action at the end of June/beginning of July.

Key Areas of Focus

- Ongoing monitoring of clinic utilisation and template reviews at specialty level.
- Delivery of outpatient productivity improvements, which support a reduction in DNA rates, increased use of Patient Initiated Follow Ups (PIFU) and increased clinic utilisation, including Process Mining Interventions
- E outcomes form ready for testing with rheumatology/dermatology (OAC) teams and evaluation
- Progress single repository (Bookwise) implementation for room booking/management and cancellations within the Trust.
- Continue to monitor clinic cancellations with less than 6 weeks-notice. Single UHD cancellation process now in place. Standard Operating Procedure completed and being reviewed - to be approved by Outpatients Improvement Board. Standardised reasons for cancellation agreed.
- Identify Outpatients team member to lead on focussed PIFU workstream.
- Follow up on Dr Doctor drop-in sessions held on 9th July, to engage with specialties interested in adopting some of the products available to support with elective recovery and different ways of working

Responsive - (Elective) Screening Programmes

Breast Screening

High Level Board Performance Indicators **June** position :

BREAST SCREENING	STANDARD	ACHIEVED
Round Length within 36 months	90.00%	73%
Screening to first offered assessment appointment within 3 weeks	98.00%	100%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36
UPTAKE – QTR 2 (Jan – Mch 24)	70%	66.6%

Background/target description
To ensure the breast screening access standards are met.

Performance:
- All monthly targets have been successfully, except the round length which has dropped in June.

Underlying issues:
- Round length factors include high failsafe numbers and low screening throughput due to staffing issues both in Radiography and Radiology.
- Radiology staff pressures are increasing due to retirement, leavers, sickness and maternity leave as well as a vacancy. This is on the risk register as a 15. This is adding increasing pressure which will impact services significantly in the coming months especially through the peak holiday period without additional staff support.
- Low Radiography staffing levels and long-term sickness continue to impact the rate of screening. It is essential to increase and maintain a higher volume to keep on track and effectively manage the expected pressures following the covid recovery. A regular throughput of between 2500 – 3000 per month is essential to meet the round length target going forward. At the current low rate of screening, breaches will be experienced in the round length towards the end of summer 2024.

Actions:
- An open appointment system is in place to enable us to effectively manage the throughput of screening and minimise any future breaches whilst reducing wasted unused screening appointments. However, this places a great deal of strain on the admin process in the unit due to the high volume of calls to book appointments when there are also admin staff vacancies. The position is being monitored.
- The National Breast Screening incident - Clinical reviews will take place this month and those women affected will be advised of the outcome by the end of July which is in line with the expected NHSE target.

Bowel Screening

Bowel Screening Standard	Target	Trust June Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	98.5%

Background/target description
To ensure the bowel screening access standards are met.

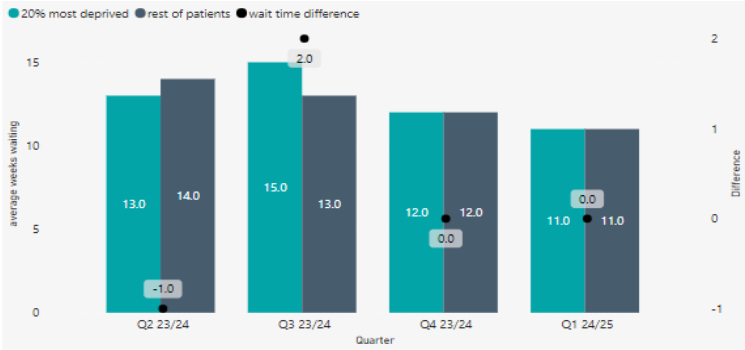
Performance:
- SSP Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 98.5% in June 2024.

Underlying issues:
- One screener at DCH has left. This reduction in capacity will be partly mitigated but there will be a reduction in overall capacity. Succession plan being worked through but will take time for aspirant screeners to gain accreditation.
- Next phase of age extension due April 2024 but NHS England has delayed, moving to Q2.

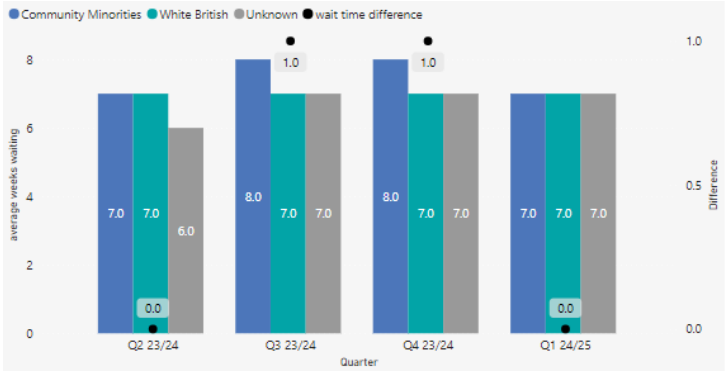
Actions:
- Future planning needed for the future fit@80 roll out. This may increase demand by up to 50% across the system.
- Deliver plans with Dorset County to use additional insourcing capacity in 24/25
- Support accreditation process for 2 potential new screeners and identify other endoscopists where possible

Health Inequalities

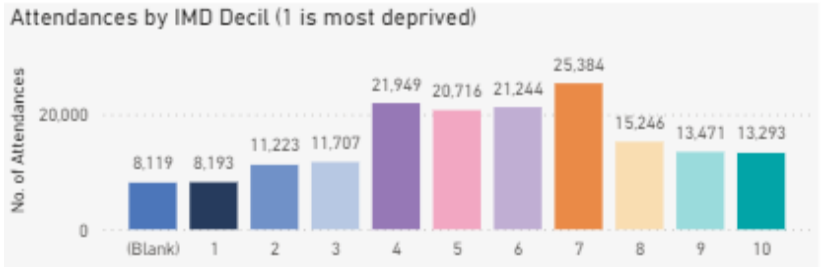
Median Weeks (elective) waiting by Deprivation Group



Median Weeks (elective) waiting by Ethnicity Group



Emergency Department attendances by Deprivation Group



Data Description and Target

Analysis of variation in weeks waiting on an elective waiting list according to the patient's Index of Multiple Deprivation, age and ethnicity grouping to understand areas of variation.
Emergency department admissions by Index of Multiple Deprivation (IMD) decile

Performance

Waiting list by Index of Multiple Deprivation (IMD) Analysing elective waits in Quarter 1 2024/25, 8.3% of patients on the waiting list live in the 20% most deprived areas of Dorset (IMD 1-2). The median weeks waiting at the point of treatment for people in IMD 1-2 continues to show no variation compared to people from IMD 3-10. Analysing the same data by age band also identifies no variation for children (<18 yrs).

Waiting list by ethnicity: 11.1% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the median weeks waiting by ethnicity grouping identifies no variation between patients within community minority groups and White British populations in Quarter 1. This is an improved position compared to the previous 2 Quarters.
However, the level of variation increases to 6 weeks for <18 year olds from community minority groups. This is an improved position compared to last month. A deep dive into ENT services to understand the variations in 'did not attend' rates by IMD group and ethnicity has commenced to understand the reasons for missed appointments which are a contributing factor to increased waits. Three improvement interventions are planned to commence on Quarter 3.

Emergency dept. attendances by Index of Multiple Deprivation (IMD) Attendances are lowest in deprivation deciles 1-3.

Key Areas of Focus

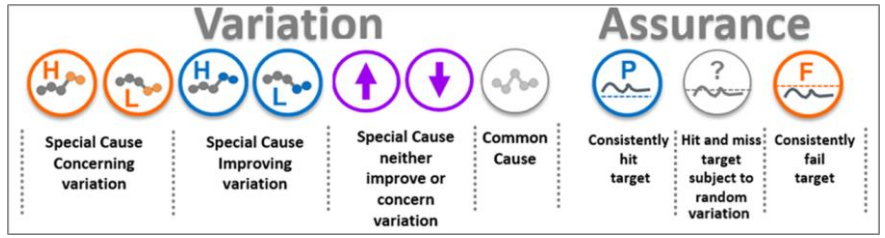
The Trust Health Inequalities group are working to:

- Deliver against the duties outlined within the NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) to collect, analyse and publish information on health inequalities.
- Deliver the Trust's strategic objectives for population health and system working; with a focus on (i) reducing outpatient DNAs and variation according to IMD and ethnicity and (ii) managing High Intensity Users of emergency care.
- Commence analysis of the Dorset DiiS Population Health System Core20Plus5 PHM dashboard for adults and children.
- Promote awareness raising on health inequalities and population health through education and training opportunities.

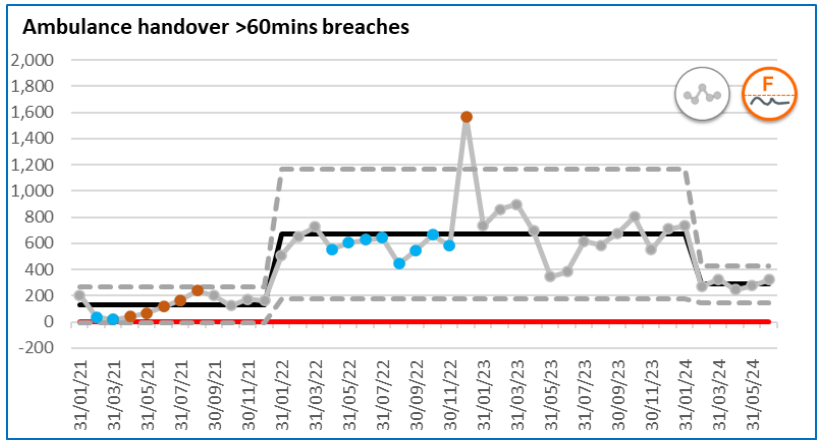
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Matrix

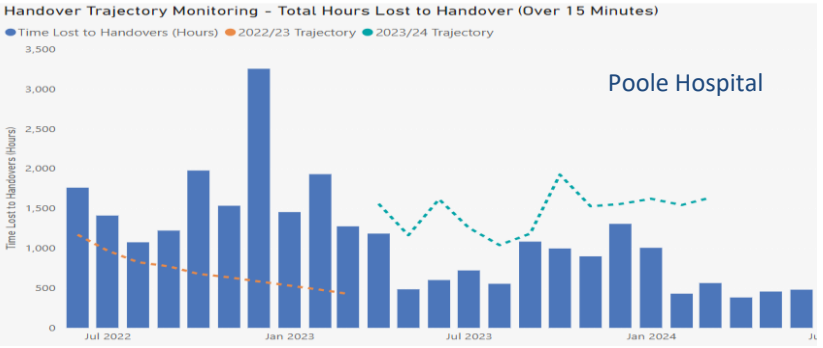
UHD Elective Care

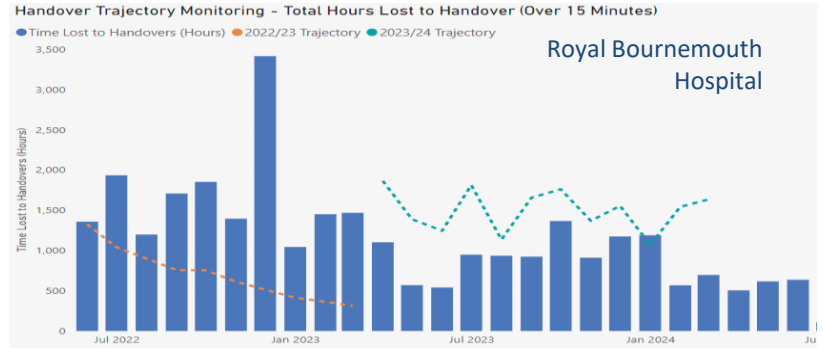
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Jun 24	67977	68140			68740	65700	71780
UHD - Patients waiting >78 weeks	Jun 24	0	-	L	P	51	8	93
UHD - Patients waiting >65 weeks	Jun 24	472	295			474	37	910
UHD - Patients waiting >52 weeks	Jun 24	2999	3005			3038	2407	3669
UHD - Patients waiting >52 weeks non admitted	Jun 24	1370	0		F	1512	970	2054
UHD - RTT Performance against 18 week standard	Jun 24	61.1%	92.0%		F	61.3%	58.7%	63.8%
UHD - Total Diagnostic Waiting List	Jun 24	13279	-	H		12223	11033	13412
UHD - % waiting over 6 weeks	Jun 24	11.5%	1.0%		F	10.1%	5.5%	14.8%
UHD - % waiting over 13 weeks	Jun 24	0.8%			F	0.9%	0.3%	1.5%
UHD - Faster Diagnosis Standard (FDS) 28 days	May 24	75.3%	75.0%			70.0%	57.0%	82.9%
UHD 62 day standard	May 24	66.8%			F	64.4%	56.2%	72.7%
Trauma Admissions	Jun 24	388	-			369	318	421
% of NOF patients operated on within 36 hrs of admission	Jun 24	50.0%	85.0%		F	60.5%	46.1%	74.9%
% Outpatient appointments with procedures	Jun 24	18.7%		H		17.0%	15.2%	18.8%
UHD - Total Outpatient - Virtual (%)	Jun 24	17.1%	25.0%	L	F	17.5%	16.9%	18.1%
UHD Outpatient DNA rate	Jun 24	5.1%	5.0%			5.3%	5.0%	5.6%
Theatre utilisation (capped) - main	Jun 24	74.0%	85.0%		F	73.5%	71.2%	75.7%
Theatre utilisation (capped) - DC	Jun 24	75.0%	85.0%		F	73.5%	70.1%	77.0%
UHD Theatre case opportunity	Jun 24	15.2%	15.0%			16.8%	9.7%	24.0%



Responsive – (Emergency) Ambulance Handovers







Data Description and Target

- Number of ambulance handover delays greater than 60 minutes from arrival to a receiving Emergency Department. 15 minutes is the target for an Ambulance to handover to a receiving ED from arrival. There should be no ambulances waiting over 60 minutes.
- Number of ambulance hours lost due to handover delays. There is a site level recovery trajectory for lost ambulance hours per day.

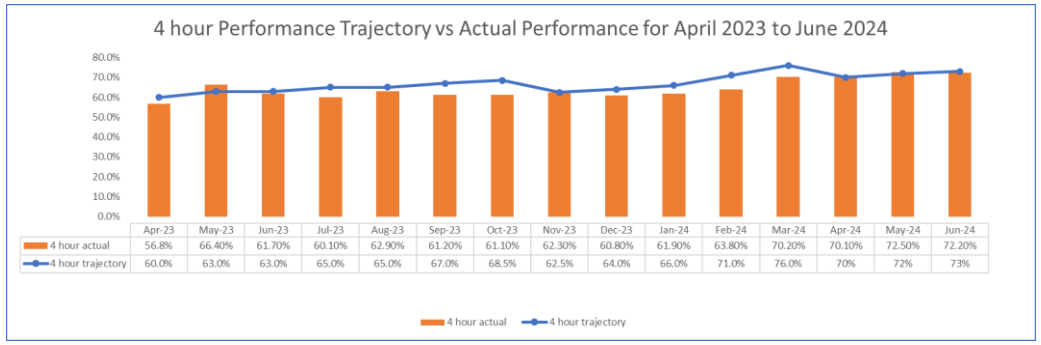
Performance

- The total number of Ambulance handovers reduced slightly in June to 4,100, vs 4,414 in May, resulting in 137 Ambulances per day against 142 in May and 137 in April. This was predominantly driven by a reduction at the Bournemouth site from 68 Ambulances a day in May down to 65 vs Poole remaining relatively static at 74 Ambulances a day vs 73 in May.
- Both sites still received more Ambulances than in June 2023, with approximately 12 additional conveyances a day cross-site.
- Ambulances waiting longer than 60 minutes increased marginally again to 322 in June vs 279 in May and 245 in April, however, this is within a normal level of variation. June 2024 performance amounts to 7.8% of total handovers vs 6.3% in May, 5.96% in April and 7.49% in March 24.
- Average handover duration also ranged from 26 to 35 minutes increasing marginally to an average of 27 minutes at PH in June vs 24.6 minutes in May and 35 minutes at RBCH vs 31.7 minutes. This increase correlates with the regional picture which increased significantly to 65 minutes in June vs 48.9 minutes and 45 minutes in previous months.
- Based on the 15-minute ambulance handover standard Poole reported a total of 479 hours lost in June and 639 in RBH. This is an increase of 74 hours from the previous month.

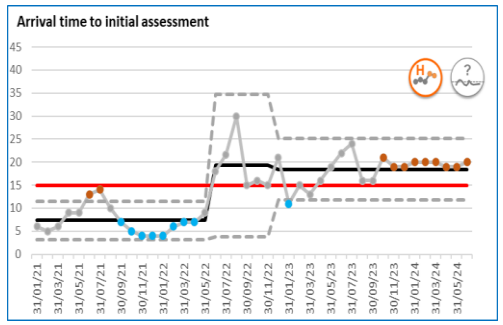
Key Areas of Focus

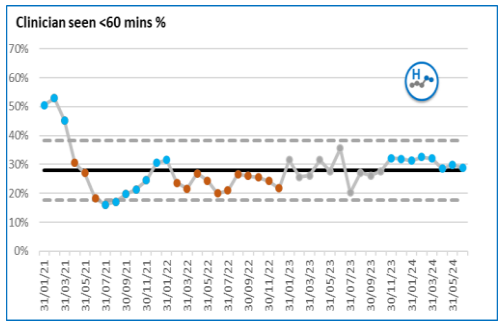
- The Trust risk score relating to Ambulance Handovers remains at 15 with the main reason for delayed handover relating to insufficient staff to complete handover as well as no physical capacity.
- The team have continued to combine cohorting and corridor care with SWAST, this has enabled the sites to maintain flow and improve handover performance- however safety and risk implications of this are under review with a risk to be added to the Trust risk register for assurance of appropriate mitigation purposes.

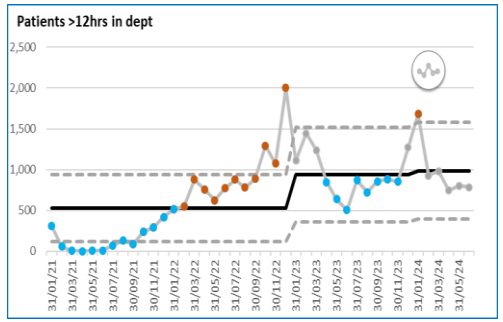
Responsive (Emergency) Care Standards

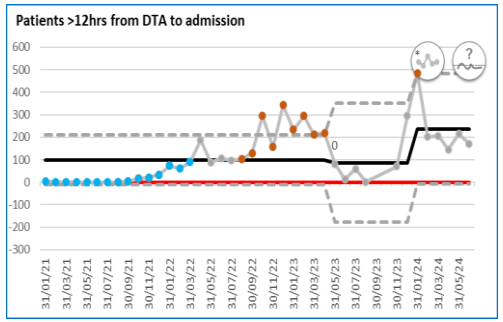


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
4 hour actual	56.8%	66.40%	61.70%	60.10%	62.90%	61.20%	61.10%	62.30%	60.80%	61.90%	63.80%	70.20%	70.10%	72.50%	72.20%
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	62.5%	64.0%	66.0%	71.0%	76.0%	70%	72%	73%









Data Description and Target

UHD has now returned to reporting against the national 4-hour standard. The national requirement is to achieve 78% of all patients leaving ED within 4 hours for 2024/25.

Performance

The Trust delivered 72.2% against an internal trajectory of 73% in June 2024 with the next target for July being 74%.

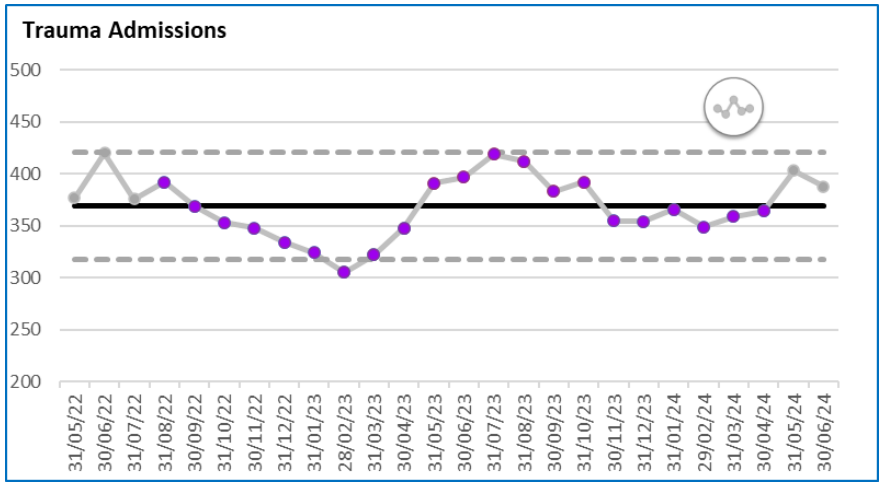
- Total attendances for June fell slightly to 14,916 vs 15,318 in May. However, with a shorter month the average daily attendance increased marginally from 494 in May to 497 in June. Average attendance also remain significantly higher than in June 2023 (419 attendances a day).
- Arrival time to initial assessment remains relatively static at 20.1 minutes in June vs 19.3 in May despite an on-going increase in attendances.
- This is also reflected in the meantime in the department which remains at 264 minutes in June vs 263 in May and 270 in April. This remains the seventh consecutive month of sustained or improved performance.
- Arrival time to decision to admit increased slightly but as a whole continues to see improvement at 252 minutes in June vs 234 in May and 246 in April.
- Total number of patients waiting more than 12 hours however dropped from 801 in May to 785 in June. This was mirrored in patients waiting longer than 12 hours following a decision to admit which was 171 in June vs 214 in May. Both remain within the range of normal variation.

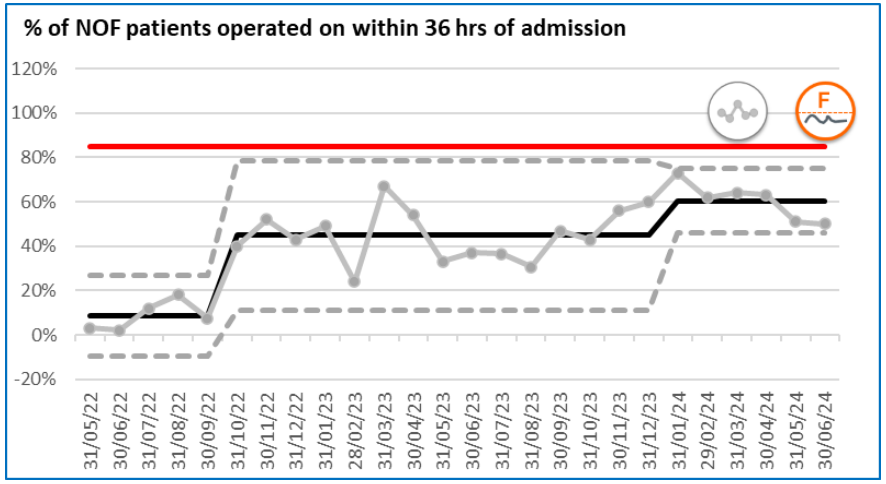
Key Areas of Focus

As a department Type 1 Non-Admitted performance dropped slightly in June contributing to the Trust not delivering against our internal trajectory. However, Admitted performance saw the largest variation dropping as low as 20% during the month. This being largely driven by limited hospital flow which saw an increase in patients with No Criteria to Reside as well as restrictions in moving patients due to infection control management limiting the ability to move quickly and manage hospital flow as effectively as possible.

A review of Urgent Treatment Centre (UTC) service provision cross-site is on-going with slot utilisation and direct streaming from ED and walk ins being implemented, whilst maintaining directly bookable and 111 capacity. In June there was a slight drop off in slot availability compared to May when additional capacity was put in place to support the bank holiday. This will have also impacted the Trusts four hour performance.

Responsive (Emergency)
Trauma Orthopaedics





Data Description and Target

National Hip Fracture Database (NHFD) Best Practice Tariff Target: Fractured neck of femur (#NoF) patients to be operated on within 36 hours of admission. NHFD average 56%
Quality Target: 95% of fractured neck of femur (#NoF) patients to be operated on within 36 hours of admission and being clinically appropriate for surgery.

Performance

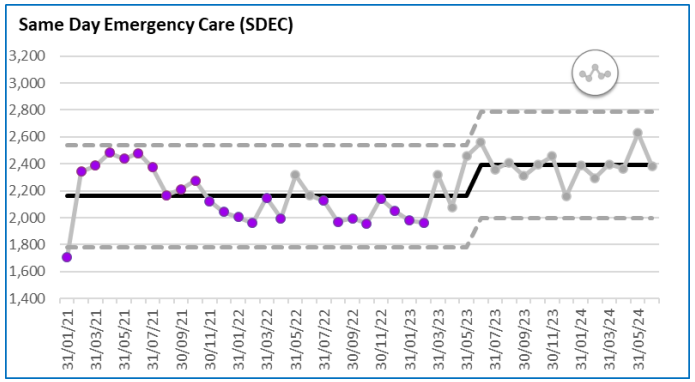
June performance for time to theatre for fractured neck of femur (#NoF) patients: 77% achieving surgery within 36 hours of being fit for surgery and 50% operated on within 36 hours from admission. This is a reduction in performance compared to April and below the national average.

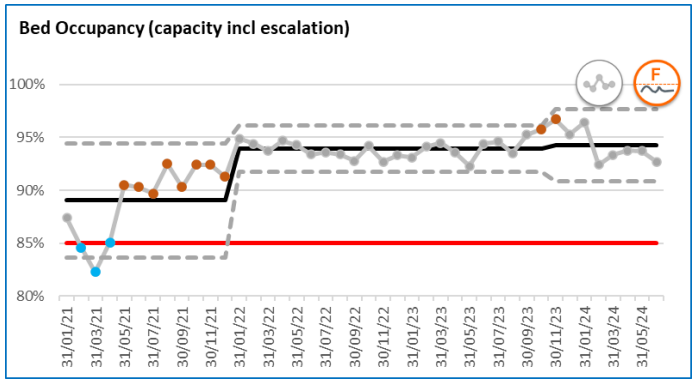
- Overall trauma admissions decreased with 388 in June including 75 with a fractured neck of femur (#NoF).
- 22 of the 75 #NoF's were unfit for surgery on admission.
- 15 Shaft of femur (SoF) fractures admitted in May with all requiring surgery, 5 patients with a #NOF required a Total Hip Replacement.
- 18 patients required 2 trips to theatre, equating to an additional 25 theatre cases .
- 15 patients treated through the Hand Hub procedure room.

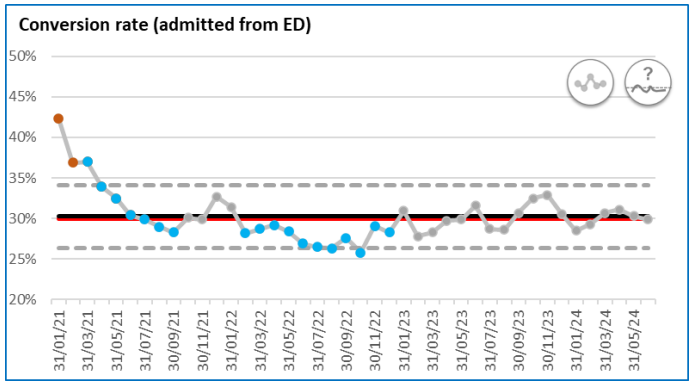
Key Areas of Focus

- e-Trauma , Digital ED link to Virtual Fracture Clinic (VFC) has ceased due to Agyle implementation, which has delayed e-trauma virtual fracture clinic implementation. Risk register updated, contextual link to be implemented, testing in progress.
- Hand Hub continues to be a success operating 2 sessions per week with 15 patients through the service, releasing 10 main theatre sessions
- Trauma outliers continue to remain low.
- Review of weekend trauma capacity underway.
- Reduced availability of orthogeriatric input due to reallocation of resources to OPS.

Responsive – (Emergency) Patient Flow







Data Description and Target

88% bed occupancy would support flow and delivery of rapid progression from the Emergency Department within an hour of being clinically ready to proceed. The ICB operational plan uses 92% occupancy as its ambition.

Performance

Bed occupancy in June averaged at 998 across UHD which is 92.7% of planned adult bed capacity (1085).

The average number of escalation beds open in June saw a further decrease compared to May to an average of 10, partially as a result of redesignated beds in line with the agreed 24/25 System Capacity Plan. In June there were significant delays with patients waiting for beds at times in ED, with an average of 10 per day waiting for beds every morning and exacerbated by restrictions in placing patients to support infection prevention and control measures.

The number of patients with no Criteria to Reside (NCtR) continues to impact occupancy and escalation.

Key Areas of Focus

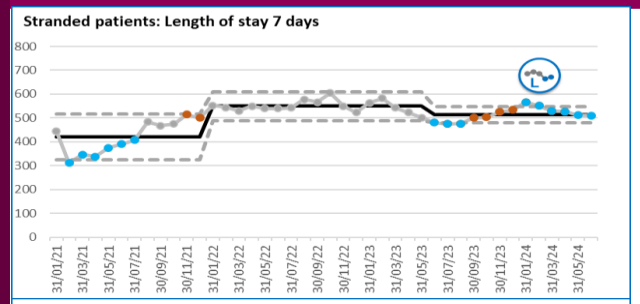
- UHD continues to support not reopening SDEC care spaces that have been released from bedded capacity. Some limited escalation capacity remained open on the Poole site in early May alongside escalation of the CIU (Cardiology Investigation Unit) in Bournemouth in order to maintain cardiology inpatients and access the lab; this has led to some cancellations of planned procedures as a result.

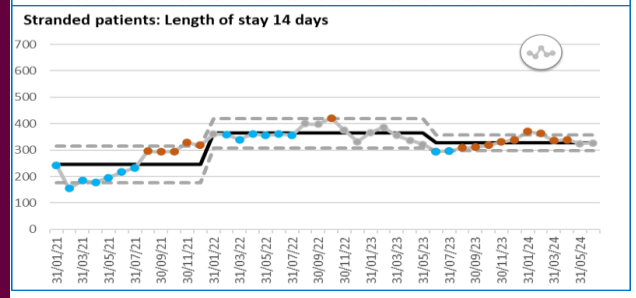
- We continue to progress the actions identified In March by the ICB Chief Operating Officer asking for immediate focus on 5 key actions aimed at improving pathways for patients ready to leave hospital. This has been progressed at a 'Place' level with UHD working closely with BCP. This continues with the Transfer of care Hub (ToC) established; however, benefits realisation has not been fully delivered.

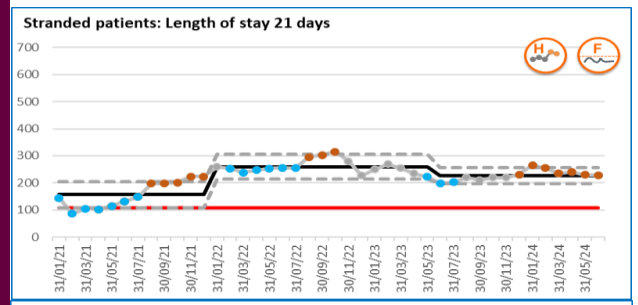
- The Virtual Wards / Hospital at home service continues to support a significant number of patients who would otherwise be in hospital, however there has been a small reduction in the number of bed days utilised in June at 1512 compared to 1673 in May.

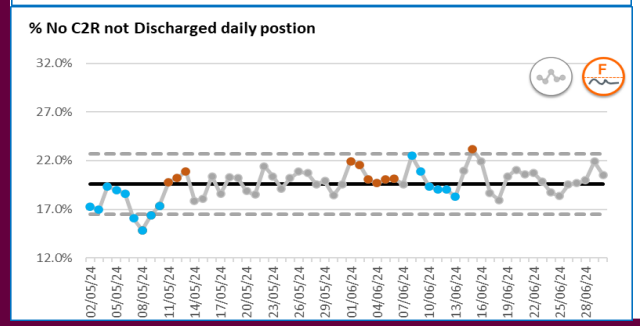
- Same Day Emergency Care (SDEC) continues to make progress with self-assessments being undertaken of each service to help shape the future operating model.

Responsive – (Emergency /Elective)
Length of Stay & Discharges









Data Description and Target

The number of patients with a length of stay greater than 7, 14 and 21 days.

The proportion of delays in discharge for whom the patient has no criteria to reside. 2023/24 ICB ambitions to reduce the number of patients with No Criteria to Reside (NCtR) were substantially missed, currently no ICS baseline or trajectory has been established for 24/25.

Performance

21+ day length of stay position shows we are significantly exceeding the target of a maximum of 108 patients. In June, the average number was 192, which is an increase in comparison to May 2024.

No Criteria to Reside (NCtR) has seen further improvement again during June with the average reducing to 186 (from 189 average in May).

Analysis of the discharge profile for the last 3 months shows that the improvements have not been achieved by higher numbers of discharges with support. This number remains challengingly low at an average of 4 a day with no improvement in June when compared to May, there has however been a marginal decrease to 6 discharges at weekends which is similar to April from an improved position in May. Further analysis of those discharged home with support (pathway 1) confirms that 40-50% of those discharged are supported by a service directly provided or commissioned by UHD, rather than community health or social care providers.

UHD continues to reduce unfunded beds in June in line with the agreed capacity plan. The number of escalation beds in use reduced from an average of 49 in May to 10 in June. The ICB has revised the ask of UHD as part of 24/25 operational planning and are being asked to establish 20 additional core beds. There have been further changes to the bed base in June in line with the capacity plan 24/25 which means reporting of beds is now in line with National standard definitions.

Key Areas of Focus

Every patient with a LoS of over 100 days is reviewed at a weekly meeting with system partners to ensure all actions are being progressed to achieve the discharge, community health care partners are joining this meeting moving forward.

As part of the UHD Capacity plan patients who have been in hospital longer than 21 days with a criteria to reside will be reviewed and tracked.

The Transfer of Care Hub (ToC) has started using the Estimated Date Ready (EDR) date for complex discharge planning and it is anticipated that this will bring forward discharge dates by reducing the time a patient has no criteria to reside in a hospital bed whilst discharge planning us undertaken. Alongside this there is a rollout of early discharge planning which has happened in Trauma and now is being rolled out across OPS.

Performance at a glance – (Emergency)
Key Performance Indicator Matrix

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Arrival time to initial assessment	Jun 24	20	15			18	12	25
Clinician seen <60 mins %	Jun 24	29%	-			28%	18%	38%
Patients >12hrs from DTA to admission	Jun 24	171	0			237	-8	482
Patients >12hrs in dept	Jun 24	785	-			986	395	1578
4 hour safety standard	Jun 24	72.2%	76.0%			64.5%	58.9%	70.2%
Ambulance handovers	Jun 24	4100	-			4243	3668	4817
Ambulance handover >15 mins breaches	Jun 24	3105	-			3364	2634	4094
Ambulance handover 30-60mins breaches	Jun 24	921	0			1044	660	1427
Ambulance handover >60mins breaches	Jun 24	322				288	146	431
Bed Occupancy (capacity incl escalation)	Jun 24	93%	85%			94%	91%	98%
Stranded patients: Length of stay 7 days	Jun 24	510	-			514	480	548
Stranded patients: Length of stay 14 days	Jun 24	327	-			327	298	356
Stranded patients: Length of stay 21 days	Jun 24	229	108			228	198	257
Non-elective admissions	Jun 24	6365	-			6049	5145	6953
> 1 day non-elective admissions	Jun 24	3957	-			3784	3189	4379
Same Day Emergency Care (SDEC)	Jun 24	2384	-			2393	2000	2785
Conversion rate (admitted from ED)	Jun 24	29.9%	30.0%			30.3%	26.4%	34.1%

Sustainable Servicers

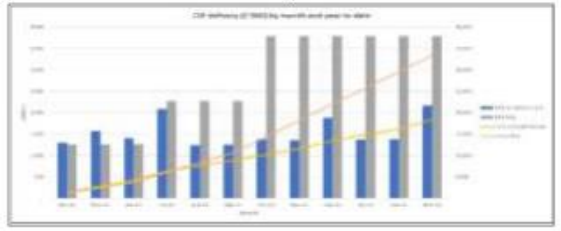
Pete Papworth
Chief Finance Officer

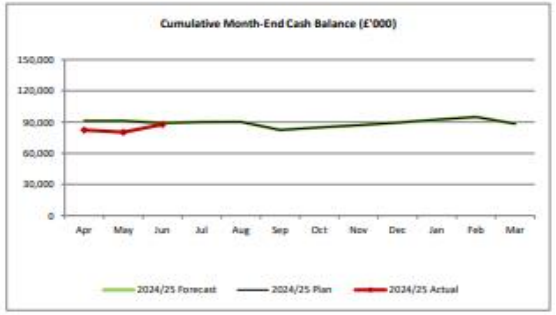
Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

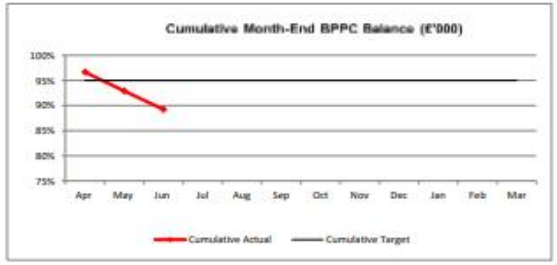
Committees:
Finance and Performance Committee

Finance

FINANCIAL INDICATORS	Year to date		
	Budget	Actual	Variance
	£'000	£'000	£'000
Control Total Surplus/ (Deficit)	(5,133)	(6,288)	(1,155)
Capital Programme	25,171	22,331	2,840
Closing Cash Balance	89,175	87,763	(1,412)
Public Sector Payment Policy	95.0%	92.1%	(2.9)%







Commentary

At the end of June 2024 the Trust has reported a deficit of £6.288 million against a planned deficit of £5.133million, resulting in an adverse variance of £1.155 million. Of this variance, £1.029 million relates to the financial impact of the Junior Doctor industrial action in June.

Income is £0.713 million adverse to plan year to date. Included within this position is a £0.264 million favourable variance against Dorset ICB and a £0.200 million adverse variance against Hampshire and Isle of Wight ICB. Other patient care income £0.192 million adverse due to a shortfall in private patient income of £0.098 million and RTA income of £0.123 million. The impact of industrial action on income in month amounts to £0.469 million.

Operating expenditure is £1.425 million adverse to plan year to date. Pay is £1.417 million adverse to plan year to date, primarily due to premium nursing agency expenditure, non-delivery of recurring pay EIP and industrial action costs of £0.586 million. Clinical supplies expenditure is £1.115m favourable to plan year to date due to CDC costs. Drugs expenditure is £1.698 million adverse to plan year to date mainly due to Dorset ICS block contract drugs. Purchase of healthcare is £0.772 million adverse to plan year to date due to CDC costs. Premises and fixed plant expenditure is £0.852 million favourable to plan year to date due to energy costs.

Agency spend in month is £1.401 million against a planned level of £1.123 million being the cap value equating to 3.2% of total pay expenditure. Whilst this is a reduction when set against the expenditure in March, it represents an adverse variance to budget of £0.278m.

Efficiency savings of £8.161 million have been achieved against a target £8.345 million. As of 30 June 2024, EIP (Efficiency Improvement Plans) are reporting a forecast risk adjusted saving of £31.3 million against a target of £42 million leaving a potential shortfall of £10.7 million.

The Trust has reported capital expenditure of £22.3 million against a plan of £25.2 million. The underspend is due to slippage on committed schemes due to phasing delays.

CAPITAL	Year to date		
	Budget	Actual	Variance
	£'000	£'000	£'000
Estates	1,363	1,363	0
IT	3,558	3,221	337
Medical Equipment	414	154	260
Donated Assets	87	55	32
Strategic Capital	19,749	17,538	2,211
Total	**25,171**	**22,331**	**2,840**

As at 30 June 2024 the Trust is holding a consolidated cash balance of £87.8 million which is fully committed against the future Capital Programme.

In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 92.3% against the national standard of 95%

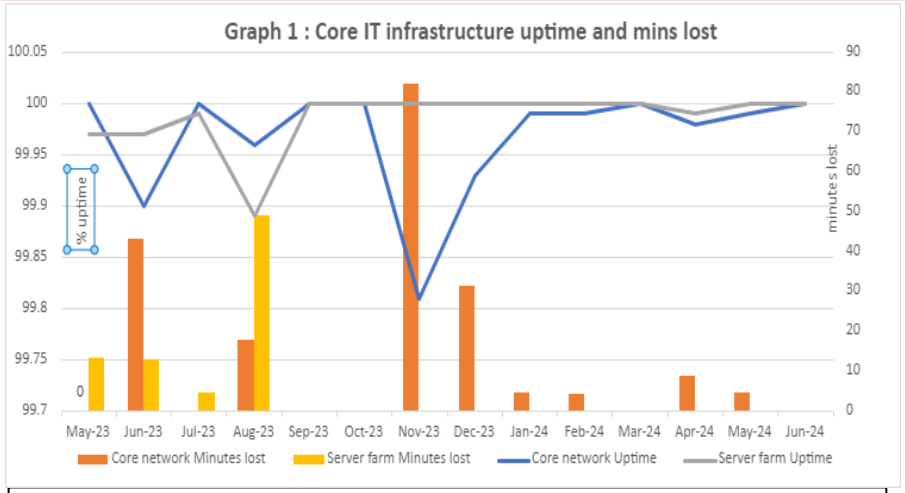
Digital

Pete Papworth
Chief Finance Officer

NHS
University Hospitals Dorset
NHS Foundation Trust

Information Technology

Service Manager Stats - June 2024



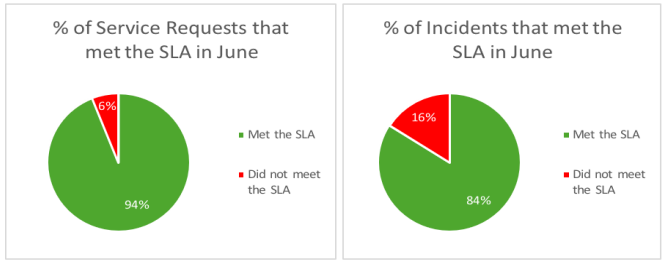
Graph 1: No downtime or outages on Core infrastructure for June 2024.

Table 3: Priority 1 System Downtime

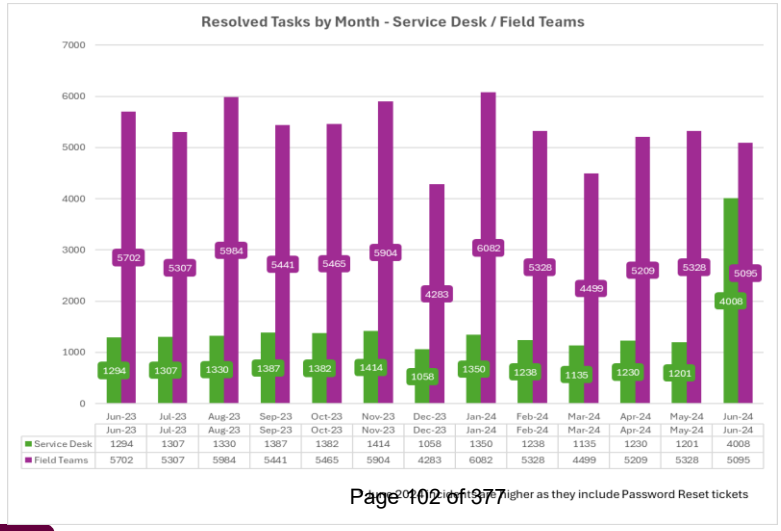
Priority 1 Incidents					
Incident Description	Date	Fixed within current SLA	Actual Fix Time (Hours)	Cause Resolution	3rd Party assistance
MOSAIQ failing to login for users	11/6/24	Yes	3	Space freed on full HDD	No
EPR - Not responding	12/6/24	Yes	3	Server issues fixed by Graphnet	Yes
eNA Clinical Compass down	18/6/24	Yes	1	Server restart resolved CPU issue	No
Synertec virtual Printing	27/6/24	Yes	0.5	Server restart resolved	No
HL7 Integration outage	19/6/24	Yes	3	Integration Engine Issue	No
EPR System outage	17/6/24	Yes	3	Server issues fixed by Graphnet	Yes
EPR – Documents unable to view	26/6/24	Yes	1	Server issu (Ctrl) Graphnet	Yes

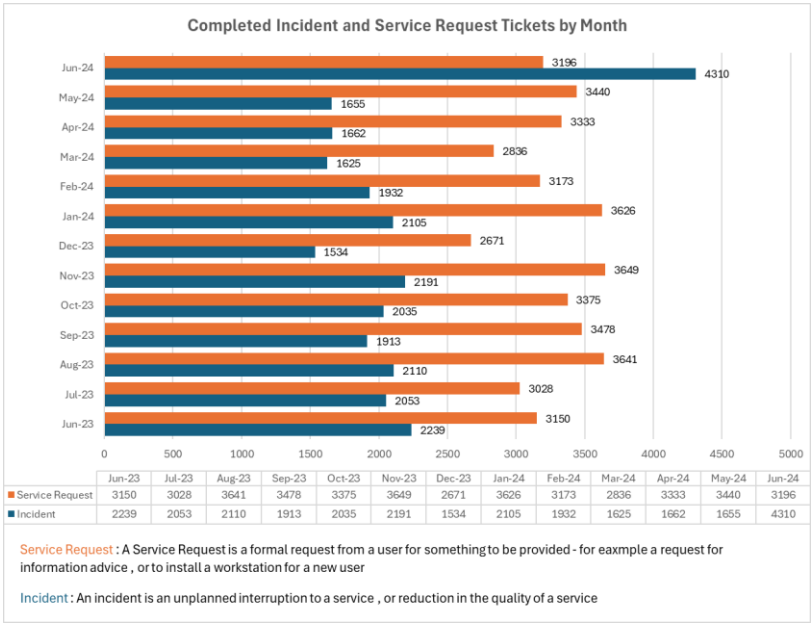
*Priority 1 SLA (Service Level Agreement) is 4 Hours

Top Tickets logged per Service		
Service		Total
Clinical Application		2005
Service Desk		1262
Non-Clinical Software		1164
Email		322
Hardware		460
Telecoms		112
Printing		324
Password		254
Network		96
Mobile Device		22
IT / Cyber Security		16



Graph 2: Service Requests SLA Position





Service Request : A Service Request is a formal request from a user for something to be provided - for eaxmple a request for information advice , or to install a workstation for a new user

Incident : An incident is an unplanned interruption to a service , or reduction in the quality of a service

Information Governance & Cyber

Table 4: Freedom of Information Act Compliance

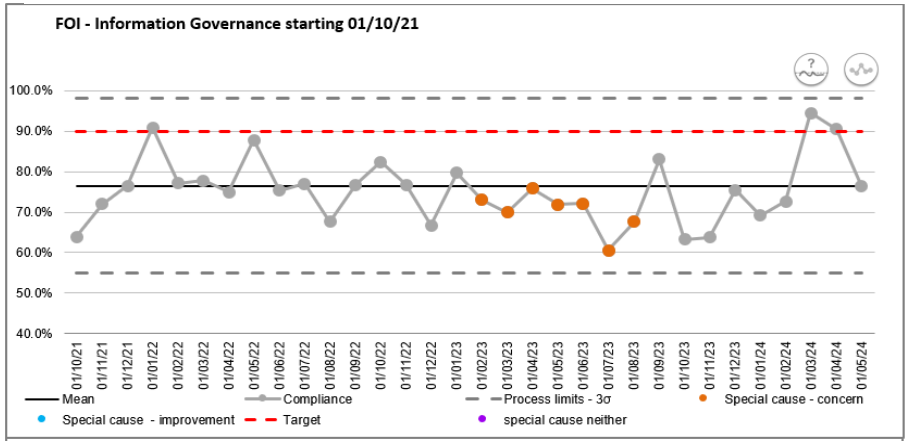
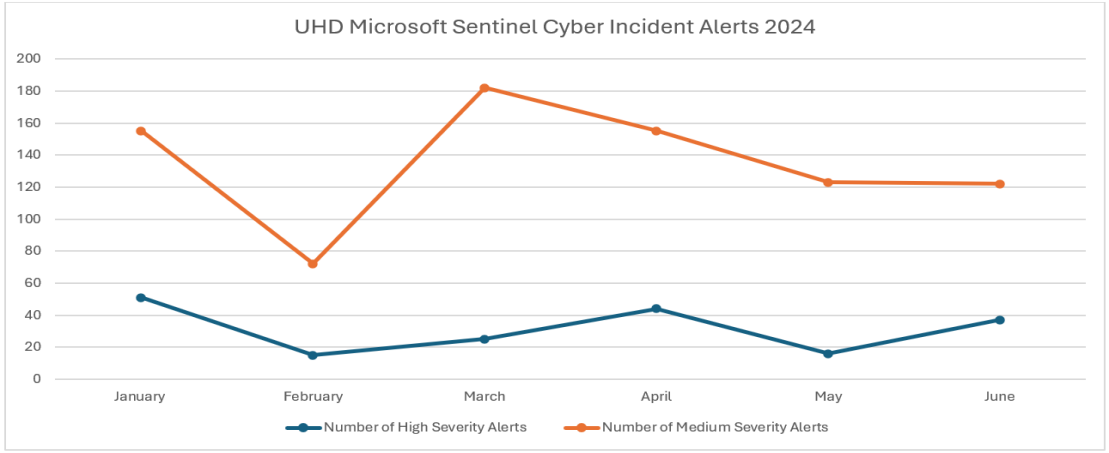


Table 5: SIEM Incident Alerts

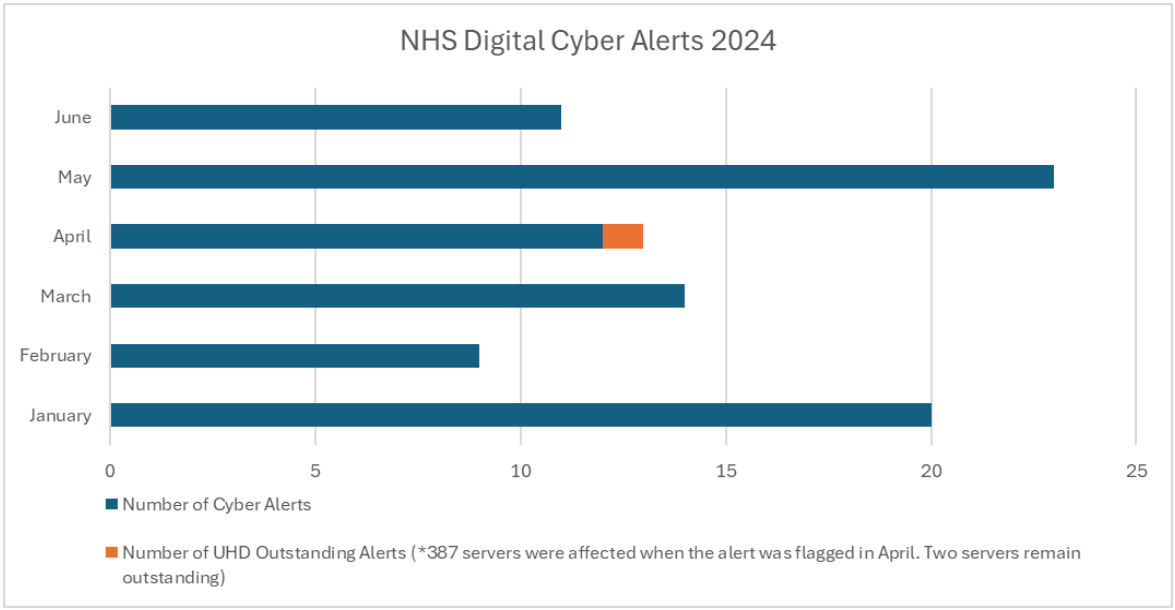


Microsoft Sentinel is a cloud-native security information and event management (SIEM) platform that uses built-in AI to help analyse large volumes of data across an enterprise. The alerts are based on potential suspicious activities.

Commentary

Table 4: shows a Statistical Process Control chart for the UHD Freedom of Information Act Compliance.
Chart 5: Show Microsoft Sentinel Cyber alerts trending for UHD
Table 6: Current position on NHS Digital Cyber Alerts

Table 6: NHS Digital Alerts

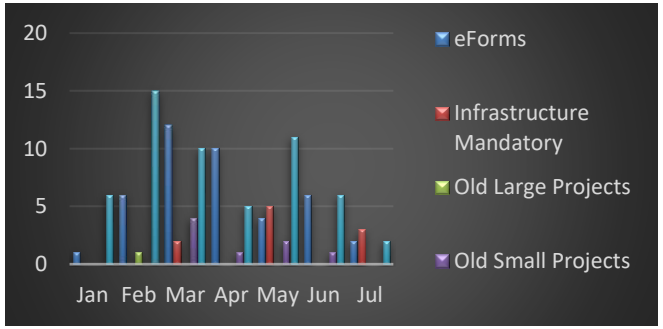


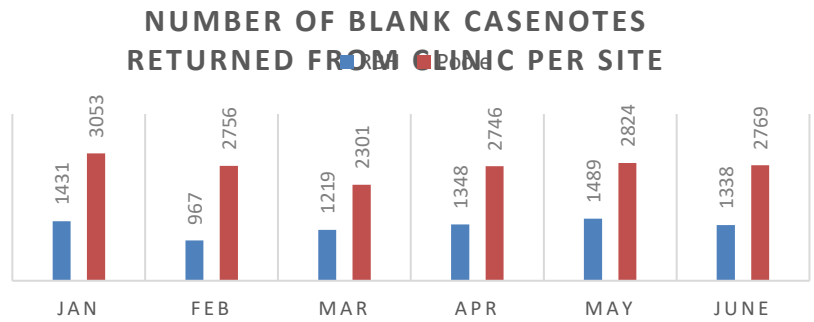
Development & Medical Records

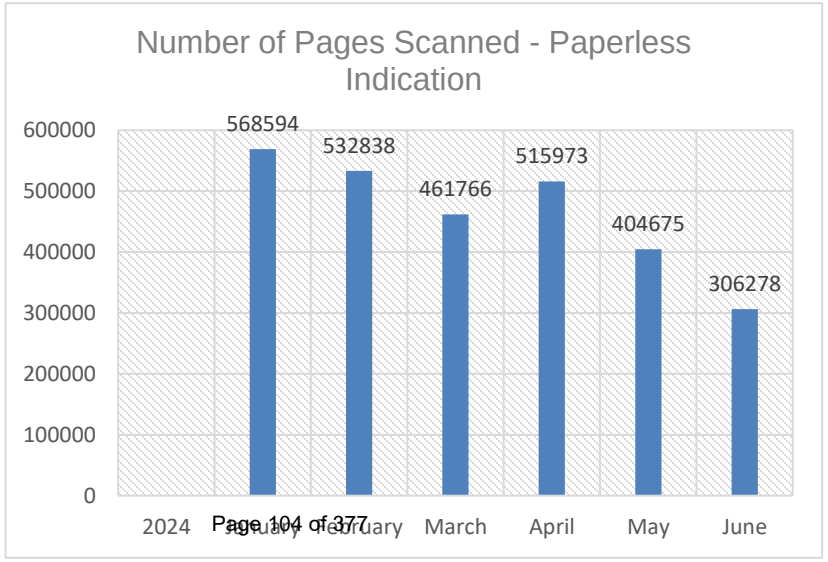
EHR Programme Timeline

Collaboration between Dorset and Somerset	Dec-23	Collaboration formed
OBC - Complete	May-24	Approved at Partnership Board
OBC - Trust Board / ICB Approval	Jun-24	Trust Board and ICB approval
OBC - Regional Approval	Jun-24	FCR complete in 4 weeks
OBC - National Approval	Sep-24	SME review in 8 weeks, EPRIB 11/09/24
OBC – Cabinet Office Approval	Oct-24	Cabinet Office review 4 weeks
FBC Stage of Business Case		
Commence Procurement Phase	Oct-24	Approvals on track
Conclude Procurement Phase	Apr-25	Procurement period 6 months
FBC	May-25	2 weeks to finalise following preferred supplier
FBC - Trust Board / ICS Approval	May-25	1 week following FBC finalised
FBC - Regional Approval	Jun-25	FCR complete in 4 weeks
FBC - National Approval	Aug-25	SME review in 8 weeks, EPRIB 27/08/25
FBC – Cabinet Office Approval	Oct-25	Cabinet Office review 4 weeks
Contract Award	Oct-25	Approvals on track
Deployment Stage		
Deployment	Apr-27	18-month implementation
Optimisation Stage		
Optimisation	Apr-28	12 months post go-live

IT Projects Completed by Month for 2024

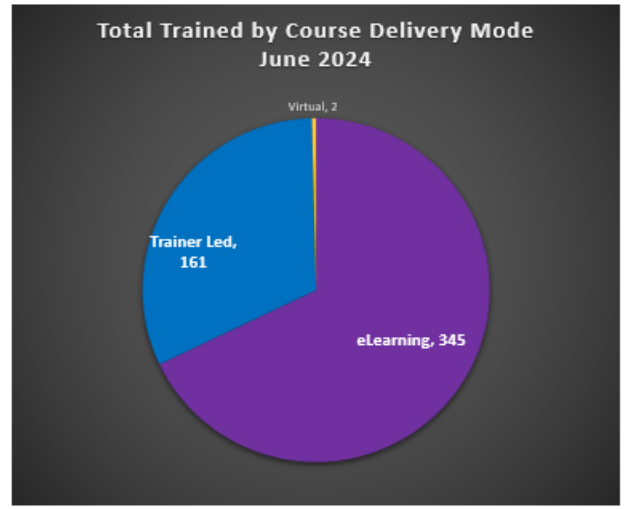






Training Statistics
Face to Face or eLearning Delivered

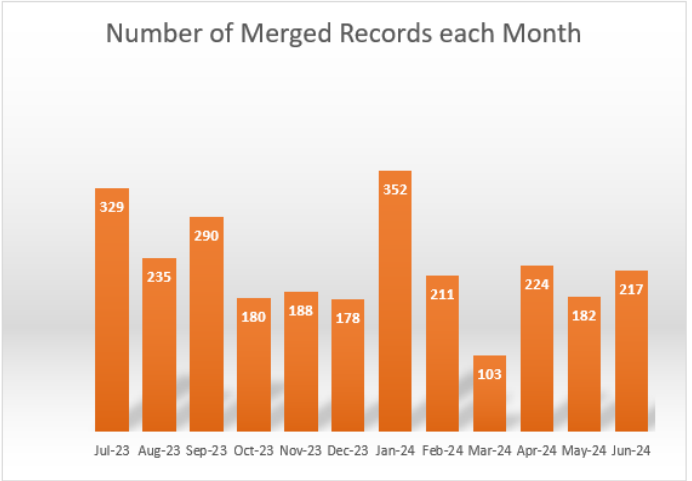
Total Trained in June: 478



Data Quality - Numbers of Merged Records per Month

An indication of Duplicate Records created and resolved

99.5% NHS number Compliant per month



University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 5.3

Subject:	Summary of Operational Plan
Prepared by:	Lizzie Sitali, Communications Support Officer, Strategy and Transformation
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☒ ☒ ☒ ☒ ☒
BAF/Corporate Risk Register: (if applicable)	All BAF risks	
Purpose of paper:	Information	
Executive Summary:	This film helps raise awareness about our Trust objectives and features colleagues from across the Trust as they explain each objective, our aspirations, how Patient First will help, and how it all aligns with our staff appraisals. The video is presented by Siobhan Harrington, our chief executive, who explains how our strategy will remain unchanged for the next five years.	
Background:	A video which explains how our strategic objectives will remain unchanged over the next five years. The video will be shared through the communications channels of the Trust (links in newsletters, social media etc.) and can also be used in induction and training sessions.	
Key Recommendations:	To review and to note the Summary of the Operational Plan.	
Implications associated with this item:	Council of Governors Equality, Equity, Diversity & Inclusion Financial Health Inequalities Operational Performance People (inc Staff, Patients) Public Consultation Quality	☒ ☒ ☐ ☐ ☒ ☒ ☐ ☒

	Regulatory Strategy/Transformation System Under the Code of Governance for NHS Foundation Trusts, The Council of Governors must be presented with the annual plan (operational plan).	☒ ☒ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☐ ☐ ☐ ☐ ☒ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Council of Governors	04/04/2024	The Council of Governors reviewed and noted the draft 2024/24 Operational Plan and was asked to obtain feedback from the members and wider public.
Council of Governors	31/05/2024	The Council of Governors received and noted the final version of the 2024/25 Operational Plan.
Board of Directors	05/07/2024	The Board of Directors approved the 2024/25 Operational Plan.

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality Patient confidentiality Staff confidentiality Other exceptional reason	☐ ☐ ☐ ☐

University Hospitals Dorset
NHS Foundation Trust

2024/25 Operational Plan: University Hospitals Dorset NHS Foundation Trust

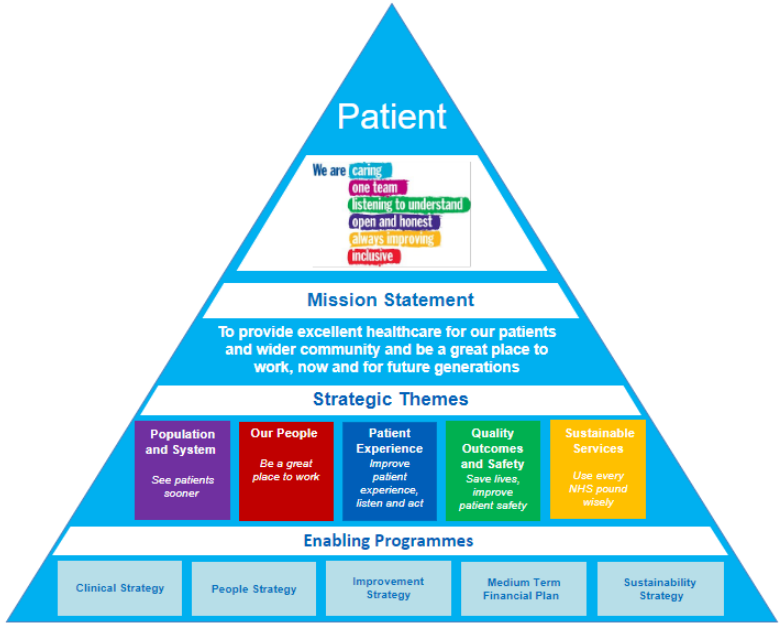
BOARD VERSION 03.07.2024

CONTENTS PAGE

1. Foreword – A Year of Transition Ahead

As we look forward to 2024/2025 as a team, dedicated to our patients and public, there are mixed emotions. There is hope, for the exciting future we are creating, trepidation at the scale and range of challenges, and pride at the awesome staff, partners and volunteers who deliver amazing things 24 hours a day, 7 days a week.

What this plan sets out to do is provide the framework guiding our efforts to achieve our vision. This is summarised in our triangle.

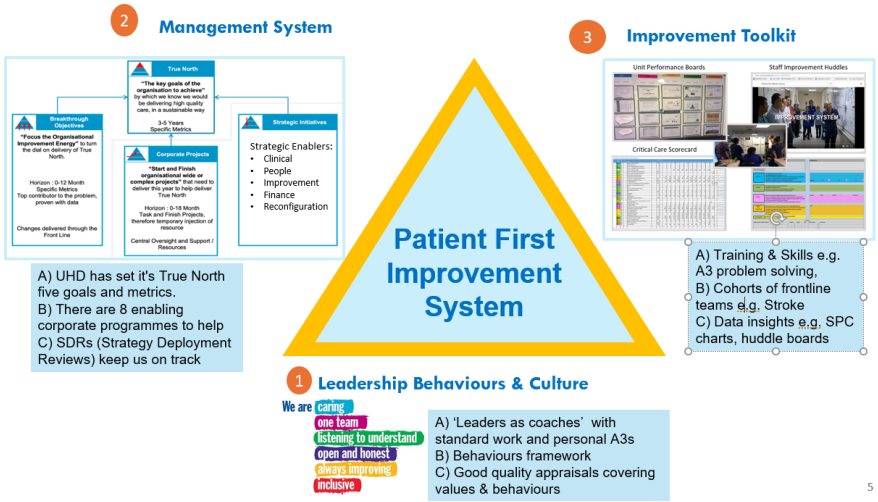


For 2024/2025 we have five objectives that every member of staff should be contributing to. These are:

It is my role as Chief Executive to ensure we create the conditions for all our staff to thrive. That way we can make real, tangible progress in all five areas. How we do that, and all the supporting plans required, are summarised in the Patient First Improvement System (PFIS) below, and in the pages that follow. As we start this year, we need a sense of curiosity. To enquire, to listen, to understand, go and see. The solutions lay with our staff and patients – where the magic happens, that makes great healthcare and a great place to work.

PFIS has three parts:

1. Living our values, and the behaviours that reinforce our Patient First approach, will be more and more about how we succeed in the future. This fits within our revamped management system.
2. Providing greater alignment and better ways of delivering major changes. Key to these are our 8 corporate projects and 10 breakthrough measures.
3. Having the tools and training for continuous improvement being deployed at scale in services.



This is a journey that will take many years, to embed our Patient First way of working. It is also accepting "better never stops". Learning from other NHS Trusts that started their similar journeys eight or nine years ago, shows we need to have perseverance and a willingness to change, along with the self-discipline and psychological safety for staff and services to thrive. With our values and twelve positive behaviours, we are set for the first full year of our exciting Patient First journey.

UHD's Values and 12 Positive Behaviors

With very best wishes
Siobhan Harrington

1.1 Background – enabling future success

University Hospitals Dorset NHS Foundation Trust (UHD) has an exciting future ahead, built upon many years of progress across a broad range of areas. These include:

- Creation of the largest planned care hospital in England by 2026.
- Creation of the major emergency care hospital, starting with the opening of the BEACH building in 2025.
- Integrated community neighbourhoods, as part of our NHS Dorset vision of Dorset becoming the healthiest place to live in the UK.
- A digital future, including an integrated electronic health record across Dorset and Somerset by 2026.
- A green and sustainable future, including 80% decarbonisation by 2030 and other targets set out in our Green UHD Strategy, including significant energy reduction investment in 2024.
- A workforce strategy, which has seen significant achievements already, including cutting our vacancies from 9% to 6%, and improvements across the board in our staff survey.
- A patient experience strategy agreed in 2024 which maps out improving our partnership with patients and listening to improve.
- Our clinical strategy, based upon the Clinical Services Review and creation of planned / emergency separation. This will be updated in 2024/2025 as part of our work to set our ambitions, by service, for the next ten years.

These form our enabling strategies to help us achieve our "True North" mission of excellent care, and a great place to work. They each have a background, based on many years of effort, and a forward looking, optimistic and ambitious approach.

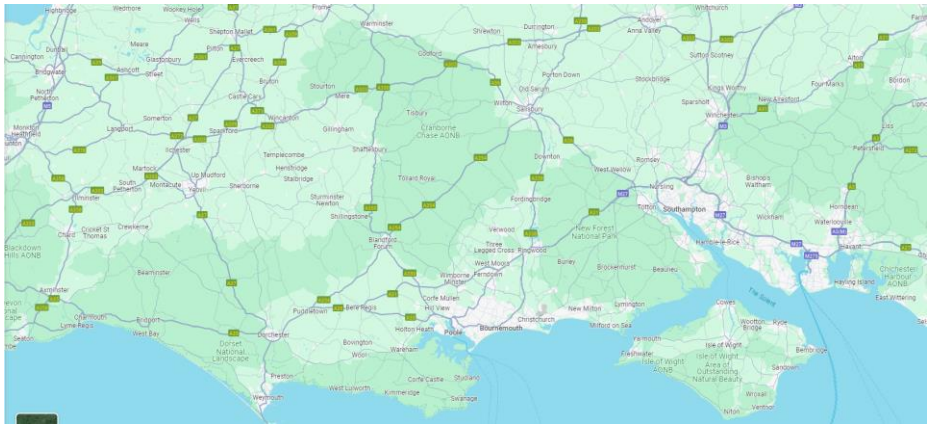
For an organisation formed by merger in October 2020, that has navigated Covid, industrial action and major construction programmes, this shows how we are both responsive to todays issues whilst also laying strong foundations for our future.

1.2 Our Trust and our communities

UHD serves Bournemouth, Poole and Christchurch, East Dorset and Purbeck, and parts of the New Forest for most hospital services. This is a population of around 750,000 with one of the most elderly populations in the UK. Significant health inequalities exist. For more information see the Director of Public Health report: (Annual report 2022-23)

Our specialist services also serve the whole of Dorset, South Wiltshire and parts of Hampshire, for a population of around 1 million. These services include Oncology, Neurology, Vascular, Cardiac and Interventional Radiology, along with specialist areas in services like Surgery.

Our three main sites are Poole, Royal Bournemouth and Christchurch hospitals. We also have services in many community setting including patient's homes. Our Outpatient Assessment Centre at the Dolphin Shopping Centre (Poole) is also popular. We then have many staff working offsite at Yeomans Way, Discovery Court and Alderney Sterile Services.



UHD employs around 10,000 staff including via our staff bank. We are blessed with hundreds of volunteers and strong partners, and have a thriving charity and allied independent charities.

All this stands us in good stead for what are significant challenges to meet the health needs of our population, which is ageing and growing, by about 1% per year. In addition the local area remains popular for 30,000+ students and over one million visitors a year.

More detail at service level is set out in the annexe.

1.3 Vision, Values and Strategic Themes

Our Vision

To positively transform our health and care services as part of the Dorset Integrated Care System

We are part of an integrated system of health and care, working towards making Dorset the healthiest place to live in England. That requires us to not just change, but transform in many ways. All our enabling strategies have this vision and a transformative ambition. Whilst this is an Annual Plan, it is a stepping stone to those positive transformations.

Our values have been developed as a result of engaging with and listening to our staff to understand 'what is important to them'? This appreciative inquiry was carried out over many months with the support of our culture champions - a representative group and cross section of staff across UHD.

Our values underpin our vision and mission. They are the standards shared by all UHD staff. They guide our day to day decisions and the way we behave. They describe what is important to us and 'the way we do things around here'.

What is striking about the values developed by staff is their duality. Each one consistently and equally speaks to the values for staff **and** for patients. This is a very distinct feature.

Patient First is the overarching strategy for University Hospitals Dorset. It's our guiding principle at the heart of everything that we do. It's also the long term approach we take to transforming health services. It sets out that our True North is the 'patient first and foremost'. This is supported by the values of compassion, teamwork, communication, respect, continuous improvement, and inclusion.

We will remain flexible in how we go about achieving these objectives, as we learn and listen, try different approaches and develop our improvement skills. What is key though, is the True North and Strategic Objectives remain consistent, so as a team we are all pulling in the same direction.

This is a journey that will take many years and includes delivery of our key strategic enabling programmes that will set us up for success. Taken together this is an ambitious plan, that will require our upmost ability and resilience to see through but is

the right thing for us to ensure we achieve putting our patients first.

Our strategic themes will support the delivery of our vision and shape our 'breakthrough' annual objectives and enabling programmes. The five strategic themes are:

Strategic Theme	Vision LONG TERM
POPULATION AND SYSTEM *Mark Mould*	Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients.
OUR PEOPLE *Tina Ricketts*	To be a great place to work, attracting and retaining the best talent.
PATIENT EXPERIENCE *Chief Nursing Officer*	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.
QUALITY OUTCOMES AND SAFETY *Peter Wilson*	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs).
SUSTAINABLE SERVICES *Pete Papworth*	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.

Within the next 12-18 months we aim to achieve the following which are known as our breakthrough objectives:

Strategic Theme	Breakthrough Objective SHORT TERM: 12 – 18 MONTHS
POPULATION AND SYSTEM *Mark Mould*	• **Planned Care** - to achieve 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance • **Emergency/Urgent Care:** >78% of patients treated within 4 hours through the emergency care pathway
OUR PEOPLE *Tina Ricketts*	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a place to work" > 65% • Staff Engagement Score > 7.1 / 10
PATIENT EXPERIENCE *Sarah Herbert*	• A 5% improvement in employees who see patient care as a top priority for UHD • To increase the Friends & Family Test (FFT) and Have Your Say (HYS) feedback rates by 30%
QUALITY OUTCOMES AND SAFETY *Peter Wilson*	• HSMR <100 • Improve Staff Survey safety culture questions by 5% • Implement UHD PSaF
SUSTAINABLE SERVICES *Pete Papworth*	• To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently

Progress has been made in 2023/2024 in these areas, but there is a long way to go. To help us get from here to there we have the following eight organisational wide and/or complex projects. They all need to deliver within 1 to 2 years to enable us to deliver our strategy. They are, each in their own right, a “blockbuster” programme with their own governance and projects. All are overseen by the Trust Management Group (TMG) the most senior operational group in the Trust.

These are covered in more detail in the specific sections within this document. Whilst the colour coding links to the primary strategic theme, all projects support multiple areas. They are therefore reinforcing each other and our transformation efforts.

Corporate Projects

1.4 Patient First and our Improvement Strategy

We are developing a culture of continuous improvement to support the delivery of our refreshed strategy and strategic priorities.

We believe that our staff working together in their teams are most engaged in their roles when they have a degree of authority and control over their work and environment, as well as the opportunity to stretch themselves and develop.

We also aspire to a new style of leadership, working alongside our frontline staff to better understand their practical challenges, supporting them to remove barriers and tackle daily frustrations.

Patient First will help us all by improving the way we work at UHD. It is not a 'quick fix', it will take time to embed and deliver this commitment across the whole organisation to ensure we rise to the challenges ahead and grow our UHD family.

Patient First is a process of continuous improvement that focuses on giving frontline staff the time and freedom to identify opportunities for positive, sustainable change and the skills to make it happen. It is a way of bringing us all together, following the merger and the pandemic, to truly engage with our hard-working and dedicated staff, and focus on the right things for patients.

Patient First is a systematic approach to improvement led delivery of quality that will help build upon UHD strong foundations and what works well within the organisation. It will refresh our culture of excellence and further developing *the way we do things around here*.

All of this will require a different way of working to unleash the passion and skills of our staff, create a sense of belonging, and promote a more inclusive service and workforce, so that all people will want to stay and positively contribute to the success of our organisation.

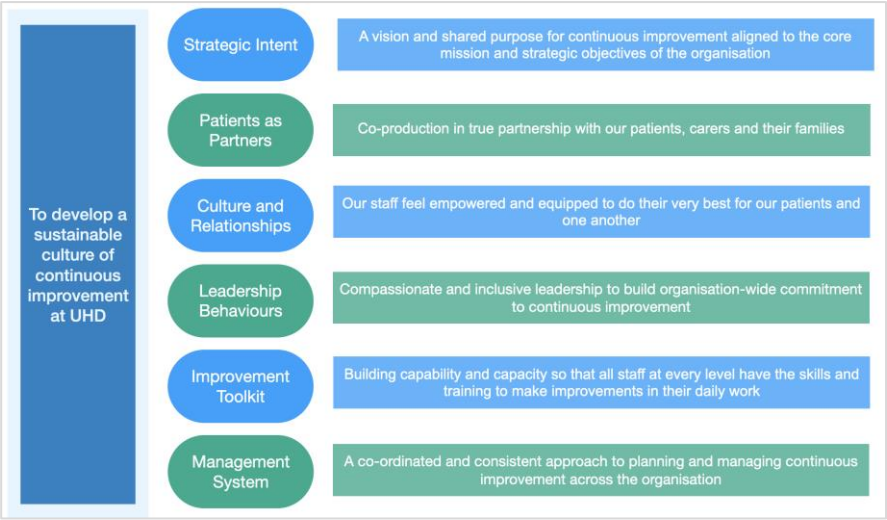
The first clinical services using this approach are Stroke, Critical Care and Christchurch Day Hospital. The next group starting in 2024 are Maternity, Paediatrics and Acute Medicine. Further cohorts of services will be selected over 2024/2025.

Patient First is the UHD Improvement Method

Patient First has a vision to develop a sustainable culture of continuous improvement at UHD. At its heart is an acknowledgement that when staff thrive our patients experience sustained improvements in the quality and experience of their care.

Our Patient First improvement strategy sets out our approach and proposed arrangements for a Patient First continuous improvement system, to be deployed organisation wide over the next three years.

To support delivery of our organisational strategy and priorities and ensure we create the right conditions for continuous improvement, we will adopt the following principles:



2. Patient Experience

True North Goal - Improve patient experience, listen and act	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.
Breakthrough Objectives	A 5% improvement in employees who see patient care as a top priority for UHD To increase the Friends & Family Test (FFT) and Have Your Say (HYS) feedback rates by 30%
Corporate Projects	***CQC Getting to Outstanding*** – One plan with one purpose to coordinate delivery of improvements in order that: • Staff feel they work in an outstanding organisation committed to delivery of great care. • There is structure, capacity and resilience to excel going forward • We are confident that we will be able to demonstrate we are well led.

The UHD Patient Experience and Engagement Strategy 2023-2025 sets out how the Trust will deliver the patient first objectives and guide how we will continue to meaningfully engage with patients during the continued transformation of our services.

As part of the Patient First journey, our patient experience **CARE** Priorities further expand on the trust priority of 'improving patient experience' by acting on feedback. The **CARE** priorities for the organisation are the following;

Continuous Feedback- increasing the opportunity for patients to give their views on their care and increase accessibility by using different methods to enable patients to tell us about their experiences.

Areas for Improvement- teams use this feedback to recognise and drive changes, ensuring any improvements that are made deliver the intended improvement.

Recognising People- ensuring all patients who use our services are heard, by actively seeking out their opinion through engagement with the community.

Excellent Partnerships- working with health, social and voluntary partners to understand the views of the public and work together to solve problems.

The **CARE** Priorities link to our trust values. The strategy describes what activities and measures will be taken to achieve these Priorities. During 2024-2025 it is expected that the **CARE**

priorities, set out in the strategy will be realised in full, with the outcome being outstanding care for our patients.

Clear and transparent communication with the public about the transformation of our services has been vital and will continue into 2024-2025, where plans for moving of services across UHD will be realised. The public and patients of the hospitals have been extensively involved in decision making through the Clinical Services Review engagement, but this was several years ago. Therefore, this next phase will include being informed of the changes and provided with educational materials and workshops to understand what the transformation will mean to them. Involvement includes co-designed workshops for the transformation of services e.g. stroke services. Similar involvement of our patients is planned into future transformation, which will include larger scale workshops and smaller group work for particular changes.

2.1 Care Quality Commission (CQC)

During 2023/24 the CQC undertook short notice announced focused inspections to urgent and emergency care services (Emergency Departments at Poole Hospital and Royal Bournemouth Hospital) as well as Outpatients at Poole Hospital and the Outpatients Assessment Clinic at Dorset Health Village on 27 and 28 June 2023.

As it was a focused inspection, no ratings were produced but CQC focused on the key questions of well-led, safe and responsive for these services as well as caring for urgent and emergency services at both hospitals. University Hospitals Dorset NHS Foundation Trust is yet to receive a rating by CQC for its services or hospital locations.

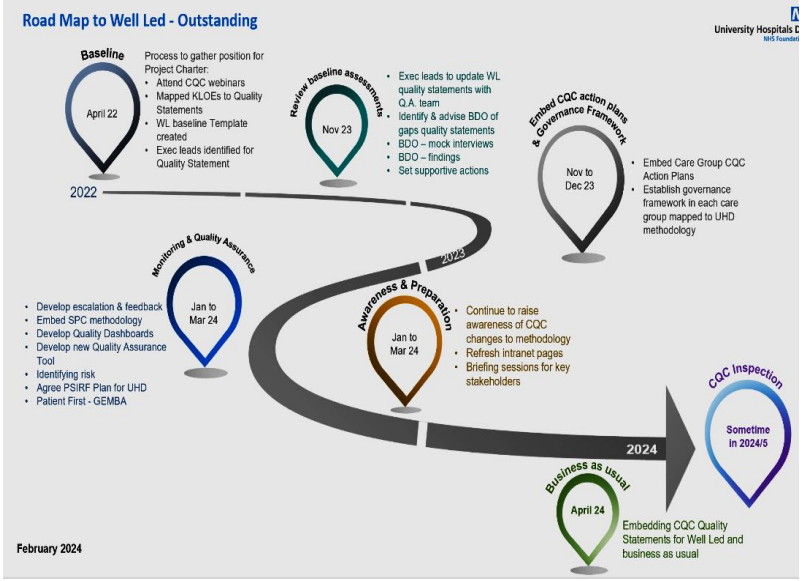
Poole Hospital remains rated 'Requires Improvement and Royal Bournemouth Hospital remains rated 'Good' overall. However, we aspire to be "Outstanding" and have established a corporate project and roadmap for success.

The project plan includes:

- Completion of a baseline assessment against the new Care Quality Commission Quality Statements for Well led
- Creation of well led action plan from the completed baseline assessments
- Provision of briefing sessions to staff to raise awareness about the new Care Quality Commission single assessment framework. Ensuring staff are aware of the new quality statements, evidence sources and assessment methodology that will be used for future inspections.
- Provision of resource materials to help teams discuss the new Care Quality Commission methodology and help teams prepare for the new style inspections.
- Utilise our Patient First work to support best practice, innovation and quality improvement
- Ensure ongoing monitoring of CQC action plans to address the issues highlighted in previous reports. The Trust Management Group and Quality Committee will

ensure oversight of effectiveness of the actions identified.

- Horizon scan reports published by external bodies such as the Care Quality Commission, NHS England and Health Services Investigations Body, to learn from others and aim for continuous improvement. External reports and reviews on our services, and the services of others, are an important part of the quality approach at UHD, and we will continue to use these to understand where further improvements to our services can be made.
- Develop and implement peer review and ward accreditation processes to support assurance against quality statements



3. Quality Outcomes and Safety

***True North Goal* – Save lives, Improve patient safety**	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – SMR) and patient safety (Patient Safety Incidents – PSIs)
Breakthrough Objectives	• Reduce HSMR <100 • Improve staff survey safety culture questions by 5% • Implement UHD PSaF
Corporate Projects	***Building a UHD Safety Culture (PSIRF) –*** Developing a culture and programme plan of safety that will deliver: • PSIRF – e-learning from deaths, formal investigator and compassionate engagement training. Patient Safety syllabus • LfPSE – Learning from Patient Safety Events • Safety skills and leadership training • Business Intelligence for quality and safety ***Implementing a new electronic health record (EHR)*** - To sign a contract with an EPR vendor by 31.3.2024 that enables UHD to begin its migration off the current EPR (which is expected to take at least 2 years).

3.1 Clinical Strategy

At a high level our Clinical Strategy is to deliver the Clinical Services Review from 2019. For UHD this is the creation of the planned and emergency hospitals by 2026, supported by £500m capital investment. The programme is a once in a generation change unlocking huge benefits. Implementation is already well underway (see Transforming Care Together, section 6.3). In 2014/15 key service changes include Pathology, Haematology, Stroke and Maternity and preparations for virtually every other service affected in 2025/2026.

Looking beyond that change, the need for a clinical strategy for the next 10 years, now needs to be developed. The critical phase of work in 2024/2025 will provide the framework. Alignment with clinical strategy development across Dorset and Hampshire will be required both through and with the Dorset Provider Collaborative. This will need to start with how best to meet our populations needs and to navigate the limited resources available. Exploiting opportunities, especially in technology, research and innovation will be important.

Workforce trends and developing staff, including with education providers, will assess opportunities for Dorset, including more Allied Health Professionals and a Medical School.

The clinical strategy will need to be meaningful and owned at specialty level for it to truly shape our future. This will mean significant time, and numerous iterative stages of work before completion, expected in 2025/2026.

3.2 Building a UHD Safety Culture

The corporate projects for 2024/2025 includes ***Building a UHD Safety Culture***

- Development of a patient safety strategy for UHD which focuses on using the experiences of staff and patients to identify opportunities for learning and improvement.
- Development of an implementation and transitional plan for the new Patient Safety Incident Response Framework (PSIRF)
- Development of an integrated framework for patient safety, quality improvement, transformation and innovation that maximises resources and reduces duplication
- Development of the UHD Patient Safety Culture Assessment Tool.

The Patient Safety Incident Response Framework (PSIRF) is a fundamental cultural safety change in the way we think, report and investigate incidents. Our Patient Safety Incident Response Plan, based on the NHS framework, focuses on **learning and improvement.** It is built on a culture in which people feel **safe**

to talk, and we will be working **in partnership with patients** to improve.

With compassionate engagement, we want to:

- Improve the experience for patients and families whenever a patient safety incident occurs.
- Reduce harm from patient safety incidents through learning and improvement.
- Support compassionate leadership, just culture and learning for improvement.
- Work with system partners to undertake thematic reviews of patient safety across care pathways.
- Improve the safety and care we provide to our patients.
- Maximise our resources to support quality and safety.
- Train staff in improvement methodologies.

We will be looking for themes and interconnected causal factors. This way, we aim to reduce repeat patient safety risks and focus on the quality, rather than the quantity, of patient safety investigations. Investigations will be viewed as improvement projects with clear plans.

Our Patient Safety Incident Response Plan (approved in December 2023) set out our Patient safety priorities for Team UHD for the next 12-18 months. We will focus on**:**

- Patient falls
- Medication safety
- Hospital Acquired Pressure ulcers
- Diagnostics processes, specifically the follow up of radiology and laboratory investigations
- Deteriorating patient management
- Mental health (management and reducing restrictive interventions)
- Post-partum haemorrhage
- Unexpected term admission to neonatal intensive care (NICU)
- Still births

We aim to engage with patients, carers, relatives and Patient Safety Partners in our improvement and learning responses to patient safety incidents and we will provide training for our staff in investigation skills, report writing and compassionate engagement. We will also look to improve how we support staff involved in a patient safety incident and create safe spaces for open and honest reporting and learning. We will develop additional feedback mechanisms to share learning and improvement across the Trust and within the wider community.

Measuring and improving safety culture within teams and across the trust is a key component of our Patient First strategy and Patient First objectives.

We have adapted some of the language used in the original 2006 Manchester Patient Safety Framework tool to create a bespoke UHD Patient Safety Assessment Culture Toolkit. The UHD PSaF Tool links to the UHD Trust values and Patient First objectives and will support staff to look think about the strengths and weaknesses of the patient safety culture in their teams and consider what a more mature safety culture might look. Teams will then use patient first improvement methodology to look at areas for improvement and also to share good practice. We aim to roll out UHD PSaF across the Trust over the next 12 months.

3.3 Implementing a new PAS/EHR

The UHD Board of Directors supported a decision in December 2023 for Dorset to collaborate with Somerset Foundation Trust in order to address the affordability of achieving an Electronic Health Record Solution (EHR) for each ICS. The collaboration will bring some savings in terms of the overall costs, e.g. a single instance across the regions, staffing costs associated with the configuration effort and third party systems costs. Following National and Regional advice it has been agreed to develop a single Outline Business Case (OBC) covering both Somerset and Dorset.

The OBC will be prepared for submission to NHS England by May. There is a five-month process for approval. This should lead to the procurement commencing in Autumn 2024. Contract award should be April 2025 with implementation from October 2026.

The scope of the EHR is all the patient related IT Systems in the Acute Trusts excluding the scanned records, PACS system and Pathology system. The increased scope includes Mental Health and Community being in the same solution, with future aspirations for Primary care and Social Care to move onto the same single system.

The joint EHR Programme will deliver transformational change to digitise and modernise our technology landscape to support higher quality care. It will also be a sustainable solution. By creating a joined-up electronic heath record and harmonising our care pathways, this delivers many benefits:

- eliminate unwarranted variation and waste,
- unlock efficiencies and financial savings,
- retain, and attract the best workforce,
- deliver the best care across our services.

All these achieve better patient outcomes.

The current plans for UHD are to continue to ensure that the existing systems in the Trust are kept up to date and supported, until the new system is implemented. The following programmes of work therefore are required:

- An upgrade to the order communications system along with looking at an interim solution for closed loop result management to reduce the risk of Serious Incidents associated with pathology and radiology results.
- Expansion from the proof of concept to the next stage of deployment of the Strategic Integrated Image Solution (SIIS) as part of the south-east three diagnostics network
- A systematic rolling stock replacement of all layers of our technical infrastructure and end-user devices
- Work to achieve a fully compliant Data Security and Protection Toolkit submission will also be continued.

4. Our People

True North Goal - Be a great place to work	To be a great place to work, attracting and retaining the best talent
Breakthrough Objectives	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a great place to work" > 65% • Staff Engagement Score >7.1/10
Corporate Projects	***Safer Staffing*** – **There is a need to establish baseline workforce data in order to improve confidence in workforce deployment, utilisation and planning** Agreed staff establishment is aligned financially and professionally Agreed process for identifying and changing future workforce and staff in post maintains currency and accuracy Systems use, Rostering process and quality assurance processes in place ensuring optimum use - including staff satisfaction Provision of management analytics to inform workforce deployment decisions and Board assurance

4.1 People Strategy

National guidance sets out the requirement to accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing, and safety of our staff. It sets out the need to invest in our workforce, with more people tackling substantive gaps in acute care. It emphasises new ways of working and strengthening the compassionate and inclusive culture needed to deliver outstanding care. Our people have remained under increasing pressure and have also been impacted by the cost-of-living crisis, workforce capacity issues and a need to focus on the large-scale integration and transformation plans that UHD have in place.

Our People Strategy has proved to be acutely important as it continues to drive the actions needed to keep our people safe, healthy and well, both physically and psychologically, and provide the necessary support and development needed to deliver patient care, and related services. Adopting the Patient First approach will help this further. This is needed as we work in an environment of high demand, and at a time of significant change in the way patient services are organised and delivered across Dorset.

Our overarching ambition and True North goal is to be within the top 20% of acute Trusts for the National staff engagement score along with increasing the number of staff who would recommend the organisation as a place to work. This will support us to improve our people's experience and ensure the Trust is a great place to work, attracting, developing and retaining the best talent.

We know there remains a shortfall of trained people to meet the rising demands for healthcare. We will need to be more flexible, creative and innovative in how we attract, retain and develop our people. This then enables us to fulfil our core purpose and achieve our vision. A key focus on workforce planning. Our work continues to be underpinned by the principles of the NHS Long Term Plan, the CQC Well Led domain and the NHS People Plan.

We recognise that there is a lot to do, and that we have some real strengths to build on, specifically the extraordinary commitment of our people to deliver excellent patient care.

Key Actions for 2024/25:

Compassionate and Inclusive Leadership

We will continue to place health and wellbeing at the heart of our line manager's duties, encouraging them to have meaningful conversations, giving feedback and communicate clearly and consistently about expectations and objectives. Ensuring the strong voice of staff is essential to ensure their involvement and innovation. We recognise colleagues that most need help are the most unlikely to speak up. We will also continue to face the inequalities agenda head-on, with a particular focus in 2024/25 on improving key Workforce Race

Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) indicators.

Key actions:

- Continue focussed work on the Trust's cultural development programme to embed organisational values and ensure the voice of our staff continues to be heard.
- Launch our new online *Thank You* tool, and a new annual staff award event to show staff how proud we are of everything they do for UHD.
- Continue focus on supporting our managers to have valued based appraisal conversations with a focus on individual development and aligning objectives to the Trust's True North.
- Further integrate our leadership and lifelong learning offers for staff including apprenticeship and accreditation opportunities in partnership with Bournemouth University and further developing a modular programme to support basic people management skills and competencies.
- Develop a Talent Management strategy aligned to *Patient First* and the needs of our workforce – a co-ordinated approach to attracting, developing and retaining our staff and harnessing their potential
- Review the 2023 staff survey results at team, directorate and care group level and design improvement interventions, including:
    - increase in % BAME composition target to improve leadership diversity by 2025
    - improvements in our Black, Asian and minority ethnic disparity ratio
    - continue to implement priorities within our *Leading for Equality, Diversity and Inclusion* plan and health inequalities within our staff groups.
- Continue to enhance staff network engagement and intersectionality to strengthen contribution to organisational decision-making process.

Systemic Wellbeing Offer

Our enhanced wellbeing service will continue to meet the need for staff access to immediate, acute psychology support. It will be integrated and coordinated for sustainability with a focus on prevention and organisational resilience. We will also focus on local interventions, supporting line managers to have 'psych savvy' health and wellbeing check-in conversations with staff.

Key actions:

- Further develop our Mental Health First Aid (MHFA) and Wellbeing Ambassador programmes.
- Embed a range of targeted resources, education and support for line-managers.

- Increase proactive health and wellbeing initiatives enabling staff to remain well at work.
- Review “hotspots” of MSK injury-reviewing processes and working patterns and continue to work closely with the ICS MSK team.
- Embed a speaking up culture and remove any barriers staff may face, through the support of our Freedom to Speak Up Guardians and ambassadors. To help support our leaders build working environments that are psychologically safe and based on respect and civility.

4.2 Workforce Planning and Data

Workforce Planning, Recruitment and Retention

During 2024/25 we will continue to focus on Workforce Planning by generating information, analysing it to inform future requirements of staff and skills and translating that into a set of actions that will develop and build on the existing workforce to meet UHD’s future resource requirements. Planning will also reflect patient pathways and care of the future.

Corporate Project – Workforce Baseline Data

We will ensure:-

- Agreed staff establishment is aligned financially and professionally
- Agreed processes for identifying and changing future workforce maintains currency and accuracy
- There is a provision of management analytics to inform workforce deployment decisions and Board assurance

Workforce plans are iterative and do change throughout the year but having robust multi-year plans are essential to have the right skills and people for the future.

Looking forward, the effectiveness of the workforce plan will be reviewed regularly by the Chief People Directorate in conjunction with the Trust Management Group, and a quarterly report will be presented to the People and Culture Committee. Trust Board will be assured of progress via the board committee which is chaired by a Non-Executive Director.

5. Population and Systems

True North Goal - See patients sooner	Consistently delivering timely appropriate, accessible care as part of a wider integrated care system for our patients.
Breakthrough Objectives	**Planned Care** - To achieve a minimum of 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance. **Emergency/Urgent Care:** >78% of patients treated within 4 hours through the emergency care pathway. Stretch target: • To have no patients waiting in excess of 52 weeks on an RTT pathway to be seen or treated by March 2025.
Corporate Projects	***Planned Care Improvement Programme*** To coordinate delivery of improvements in planned care in order that we meet patients' expectations and national constitutional standards for planned care and reduce inequalities in outcomes and access for patients whilst improving productivity and value. ***Hospital Flow Programme*** Single plan to coordinate delivery of improvements in Urgent and Emergency Care that will meet the constitutional standards for Urgent and Emergency Care and reduce inequalities in outcomes and access for patients whilst improving productivity and value.

Overarching aim:

Our True North goal for our Systems and Partnerships is to consistently deliver timely appropriate, accessible care as part of a wider integrated care system for our patients. For planned care our 2024/25 breakthrough is to achieve a 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance, and for emergency care that 78% of patients are consistently treated within 4 hours in Emergency Care Services.

How to achieve this:

We will plan to increase the amount of elective activity we undertake compared to 2019/20. Our Planned Care Improvement Corporate Project is helping us focus our efforts to achieve this.

In the challenging context of recovering services following the COVID-19 pandemic and continuing high demand for hospital services, we are working to achieve these targets by first ensuring that no patients wait in excess of 65 weeks on an open RTT pathway by September 2024 and in excess of 52 weeks by March 2025. Our breakthrough objective for Emergency/Urgent Care relates to reducing the number of patients waiting in our emergency departments in excess of 4 hours to be treated and either admitted or discharged. Our Hospital Flow Programme supports the work needed to achieve this.

Our population and system goals are also supported by our Transforming Care Together programme. This is a £501million capital investment programme that includes the establishment of the Bournemouth Emergency Hospital and Poole Planned Care Hospital in December 2025.

5.1 Planned Care

Our Planned Care Improvement Programme focuses on knowing what our population needs and delivering the best care and support to our population within the facilities, budget and workforce available. This covers patients requiring cancer treatment, outpatient care, patients needing surgery, diagnostic and therapy services. To see or treat people in a timely way we need to fully understand the demand for services through a fully validated waiting list and referral data, and what productive capacity we will need to meet this demand.

The planned care programme is closely aligned to the Hospital Flow programme ambitions to reduce the average length of stay, bed occupancy and the number of patients in hospital with no criteria to reside. It is also aligned to the ICP three strategic priorities: prevention and early help, thriving communities and working better together.

Planned care - Activity

Guidance issued by NHS England in 2023/24 asked the Trust to seek to increase activity levels to above those we delivered in 2019-20 levels, to increase the amount of day case activity, improve our use of theatre capacity, and to free up slots for outpatient treatment by reducing unnecessary follow-up treatment. This remains the ask in 2024/25. This table summarises how the Trust performed against this ask and the level of activity we are committed to delivering in 2024-25.

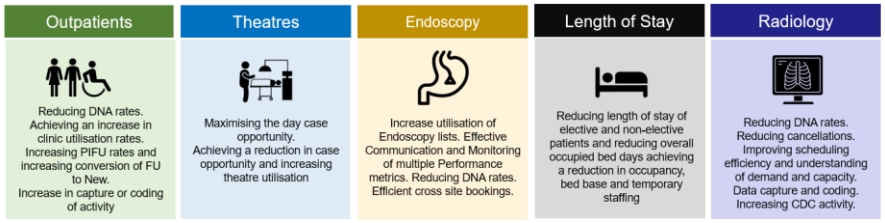
Activity Type	2019-20 Baseline	2023-24 Forecast outturn	2023-24 % Increase	Planned % Increase 2024/25
Ordinary spells	12,837	13,202	13,587	105.8%
Day cases	84,630	77,771	90,382	106.8%
Outpatient procedures	71,743	71,753	73,853	102.9%
Outpatient first attendances without a procedure	198,425	209,940	212,685	107.2%
Outpatient follow up attendances without a procedure	295,290	281,511	305,714	103.5%

How we will achieve it:

The Trust plans to increase its planned care activity by:

- Increasing productivity of services to operate within existing capacity. The Trust has identified five areas of

focus: outpatients, theatres, endoscopy, reducing length of stay in hospital and radiology.



- Increasing the provision of High Volume Low Complexity (HVLC) outpatient clinics and theatre sessions. This will include HVLC pathways for upper limb surgery in trauma and orthopaedics and expansion of HVLC pathways in ENT, Oral Maxillofacial Services and Ophthalmology.
- Continuing to reduce unwarranted variation in clinical standards and outcomes through the adoption of best practice outlined in the Getting It Right First Time (GIRFT) programme. This includes implementing a day case arthroplasty pathway and reducing length of stay for hip and knee replacements. The Trust will also seek to rapidly adopt best practice outlined through the Further Faster programme speciality handbooks where it has not done so already.
- Full implementation of National evidence-based intervention guidance to improve the quality of care being offered to patients by reducing unnecessary interventions and freeing up resources that can be put to use elsewhere.
- Increasing the use of one-stop ambulatory pathways supported by diagnostic teams.
- Enhancing use of the Outpatient Assessment Centre, in Poole and efficient use of theatre capacity including transfer of activity and capacity from Wimborne to UHD Theatres. We will also improve efficiency and utilisation in the Cardiac Cath Labs via scheduling improvements.
- We will continue the work started in 2023-24 to ensure we meet national standards on data quality and that all inpatient, outpatient and day case activity is suitably recorded and reported against.

With the support of the Clinical Acute Networks Dorset (CANDo) programme, we will work with Dorset County Hospital and other relevant partners to improve the resilience and sustainability of services by:

- Implementing a single service across Dorset for Orthodontics and Rheumatology.
- Increase the frequency of HVLC cataract lists and increased Glaucoma follow ups.
- Establish Networks across nine specialities, including Gastroenterology, Ear, Nose and Throat Services, Gynaecology, General Surgery, Urology, Trauma & Orthopaedics, Dermatology, Ophthalmology and Respiratory

- Establish a single Orthopaedic hand service across Dorset.
- Designing and implementing a community-oriented model for Dermatology.
- Optimising treatment in acute care for Respiratory.

Planned Care – Referral to Treatment Times

National planning guidance sets out that patients waiting more than 65 weeks should be seen by September 2024 and one of the stretch ambitions within the Trust is to eliminate waits over 52 weeks by March 2025.

How we will achieve it:

In 2023-24 the Trust improved its referral to treatment times and has significantly reduced the numbers of patients waiting more than 65 weeks for planned care. The number of patients who potentially would wait over 65 weeks if not seen in the year reduced from just over 40,000 to below 330 between April 2023 and March 2024.

The Trust plans to achieve zero patients waiting more than 65 weeks for treatment or outcome by September 2024. Our modelling of our capacity to reduce 52 week waits, including the impact of increased productivity and increasing planned care activity, indicates that the Trust will not reduce these to zero by March 2025 without delivering more activity. The Trust would need to exceed the national activity targets to be able to deliver this, such that Trust plans to deliver 109% of the baseline (2019/20) activity in 2024/25 to bring about a reduction in waits exceeding 52 weeks.

We will achieve this reduction by implementing efficiency and productivity improvements. This will include, ensuring only the patients who need our services are referred, effective management of referrals, outpatient and diagnostic clinic capacity, follow up (including increasing patient initiated follow up pathways) and discharge. We will also work to reduce lost capacity through missed appointments.

In theatres, we aim to reduce our dependency on agency staff and insourcing/outsourcing by encouraging workers back into substantive and bank roles. The Trust aims to deliver an improvement in the time our surgeons spend operating by increasing theatre utilisation rates to be in line with national best practice at 80% by March 2025, moving to 85% in some specialities. The number of theatre sessions run will also increase returning to 93% against the template operating in 2019/20.

We forecast that there will be areas where increased productivity alone will not deliver the reduction planned in the waiting list or the length of time patients wait. In these areas, we will consider ways of investing that delivers the best value for patients.

We will ensure waiting lists are validated achieving 90% validation of pathways greater than 12 weeks, supported by the

expansion of digital first validation. The Trust developed an RTT waiting list management training programme for staff in 2023-24 and will continue to roll this out in 2024-25 to promote evidence based best practice.

Diagnostics and Community Diagnostic Centres

The national planning guidance requires trusts to maximise the roll out of community diagnostic capacity with new community diagnostic centres (CDCs). Trusts are also asked to increase the percentage of patients that receive a diagnostic test within six weeks compared to 2023/24; to 95%.

The Dorset CDC Programme is responsible for rolling out additional diagnostic across Dorset in line with the 2020 Richards' Review and Dorset's strategy for delivery. Over the last 12 months the Trust has made progress in the following areas:

- Ultrasound, Dexa scanning and phlebotomy services have commenced at the Outpatient Assessment Centre, Poole.
- We have increased colposcopy services, delivered additional endoscopy (including Cytosponge and TNE) and increased CT capacity in Poole hospital.
- Mobile MRI services in AECC, Boscombe are in place until end of March 2024.

In 2024/25 the Trust will continue its roll out programme to increase diagnostics capacity by:

- Completion of AECC, Boscombe CT and ultrasound room build in order to deliver an increase in capacity.
- Provision of additional Echocardiograms, MRI and familial health breast surveillance capacity at Poole.
- Provision of additional fibroscan capacity at the Outpatient Assessment Unit, Poole.
- Completion of an endoscopy modular build at Poole by 2025.
- Roll out of tele-dermatology pre and post referral pathways across all CDC sites.

The increased capacity will provide additional diagnostics in a range of locations across Dorset enabling a reduction in wait times for tests and development of one stop clinics.

Two of the CDC sites in Dorset are in known areas of deprivation, thus providing tests closer to home and supporting a reduction in health inequalities.

Transforming Outpatient Care

The planning guidance sets out continuing to further improve outpatient services. Trusts are also asked to increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff. For UHD this target is 49% across 2024/25

How we will achieve it:

The overarching aim is to work towards operating models, capacity and scheduling that deliver clinically effective and efficient outpatient care and reduces waiting times across our sites, optimising opportunities for transformation that includes digital models of care and better space utilisation. The Trust will achieve this by:

- Continuing to deliver safe, high quality patient care for our outpatients and scaling up on actions to reduce health inequalities in patient access and experience of outpatients.
- Providing a sustainable nursing, administrative and Phlebotomy workforce now and into the future.
- Digitally transforming services that will enable improved patient access and experience, and responsive and effective ways of working, increasing productivity and workforce retention. This includes moving to paper free booking methods, expanding the use of DrDoctor patient facing digital capabilities including the coverage of text reminders, video consultations and implementing two-way bookings. The Trust will roll out e-outcomes for capturing the outcomes of clinics and e-assessment pathways.
- Optimising clinic templates and clinic room utilisation, supporting elective recovery plans.
- We will continue to support a reduction in the number of patients waiting a follow up appointment through validation and increased clinic utilisation.
- Providing a more personalised approach to outpatients by expanding the use of patient-initiated follow-up (PIFU) to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2025.
- Using an approach to understanding where efficiencies in our outpatient processes can be made through deploying process mining and intelligent workflow analysis.
- Increasing the reach of Specialist Advice and Guidance (Vascular, UGI) and reducing response times to ensure General Practitioners receive advice when they need it and to reduce referrals into secondary care.

Timely Access to Cancer Care

The Trust continues to work as an integral part of the Dorset ICS Cancer Programme alongside the Wessex Care Alliance (WCA) to ensure key priorities are met in the national planning guidance.

The national planning guidance specifies for Trusts to recover the 62 Day Standard to 70% by March 25 and for the 28 Day Faster Diagnosis Standard to achieve 77% by March 2025.

We will also maintain the number of people waiting no longer than 62 days (including 104 backstops) below 220 patients (nationally agreed target in 23/24).

How we will achieve it:

In 23/24, UHD signed up to the Cancer Recovery and Improvement Programme that was led by the Dorset ICS Cancer Programme to recover cancer performance to meet the national targets, whilst implementing new and best practice pathways to support rapid diagnosis and treatment.

For 24/25, the programme is moving away from 'recovery' internally at UHD, to a programme of sustainability and improvement across the entire remit of Cancer Services.

The priorities for 24/25 consist of sustaining the performance priorities whilst working to meet the requirements in the planning guidance. The following pillars make up the wider Cancer Improvement Programme at UHD to aspire towards becoming a Centre of Excellence for Cancer:

- Developing a Clinical Strategy for Cancer as the 12th large treating hospital in the UK.
- Articulating and supporting our cancer workforce to be fit for the future.
- Transforming MDT meetings and processes to maximise digital opportunities and to use our clinical resources efficiently.
- Quality, Safety and Patient Experience – driven through the development of the Personalised Care programme.
- Work collaboratively with the ICS to confirm commissioning and financing arrangements for the future.
- Establish the Cancer Improvement Programme at UHD
- Appoint a Clinical Director for Cancer Services
- Implement the Best Practice Timed Pathways, including maintaining priority pathway changes for prostate cancer.
- Fully implement Tele-dermatology
- Develop and embed process to identify and support patients on an open cancer pathway who are impacted by health inequalities.
- Grow links with the VCS to enhance experiences for patients and to support clinical teams.
- Ensure the counting and coding opportunities are maximised for new work such as Personalised Stratified Follow Up (PSFU) pathways.
- Roll out Rhabdomyosarcoma (RMS) treatments to Lung, Thyroid, Renal and Skin if there is agreement for sustainable commissioning of this service.

5.2 Hospital Flow Programme

Key Challenges

Long waiting times in Emergency Departments have a potential to cause harm and a negative impact on patients and staff experience. This increases risk across the organisation of a longer length of stay in hospital, less access to care by our community and Ambulance waits at our front door. Our patients have an expectation and constitutional right to receive Urgent and Emergency care in line with National Standards, and our Trust along with every other hospital, is challenged to deliver these standards consistently. These standards are

agreed by clinical experts who evidenced receiving care in a timely manner improved quality of care and mortality rates and will increase staff morale and experience.

The creation of the emergency hospital in 2025/2026 is a major step towards meeting these challenges. Planning for transition to the new configuration of services is where this programme and Transforming Care Together are joined up.

At any time, more than 20% of UHD beds in 23/24 continued to be occupied by patients that have No Criteria to Reside (NCtR) in hospital but who have an ongoing health or social care need that requires support. UHD has remained one of the most challenged Trusts for the numbers of patients wating to leave that no longer require a hospital bed. This may delay physical rehabilitation or support to undertake daily activities at home. The lack of availability of resources to care for people out of hospital often delays patients' discharge, sometimes for a considerable period. This pressure is felt throughout the Urgent and Emergency Care Pathway, and manifests as increased bed occupancy and increased escalation beds being opened (planned and unplanned surge beds). At its worst it results in crowded Emergency Departments and delayed Ambulances in the departments.

In 2023 UHD returned to reporting the 4-hour standard as the key Emergency Department metric. Previously UHD had been part of a national pilot for a different set of metrics set by NHS England. This change of metrics has embedded through 2023 in to 2024. Achievement of 76% of patients being seen and discharged from the Emergency department within 4 hours is proving challenging to achieve. Work will continue through 24/25 towards achieving and increasing performance against the 4-hour standard.

The challenges faced by UHD are not unique and sites with Emergency Care Pathways throughout England are facing similar issues. The most recent National UEC Delivery Plan for Recovering Urgent and Emergency Care Services was published at the end of January 2023 and links with plans for the NHS with those of the Department of Health and Social Care. Many of the actions in the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services focus on challenges and factors outside of the Acute Hospital. While the Dorset ambition to reduce NCtR by 50% was not achieved in 23/24 UHD remains committed to working as part of the Integrated Care System and with our partners from Local Authorities and other sectors to achieve the benefits for our patients as laid out in the plan.

For the in-hospital actions the previous UHD Hospital Flow Improvement Group became the Urgent and Emergency Care (UEC) programme board in October 2023 and refreshed its Terms of Reference to meet fortnightly to oversee plans to deliver productivity and transformational change to support the

delivery of the 4-hour standard and UEC pathway improvements. The UEC programme board reports to our Executive led Trust Management Group. There are four Key Lines of Enquiry:

- 4-hour Safety Standard,
- efficient hospital pathways,
- discharge, and
- operational flow.

These report to a single steering group. Each workstream is led by a senior team that are accountable for delivering transformational change required to achieve the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services.

Risks and Issues

- Change management requirements to embed the 4-hour standard and achieve the step change in performance.
- Face to Face Access in Primary Care, and access to primary care appointments from NHS111 or from UHD.
- Workforce recruitment into posts of all types
- Capacity and technology to divert patients to Minor Injuries Units (MIUs) or other appropriate services.
- Timely availability of booked appointments.
- Increasing NHS111 disposition to Emergency Department
- Ability of partners to respond to demand pressures and avoid additional impact on UHD.
- Cultural shift from 'ED work' to 'system work' (internal and external to organisations).

Assumptions

- Dorset system plans to achieve 50% reduction in NCtR is achieved.
- UTCs are funded and are developed to fully integrate into the core Urgent and Emergency Care front door in 2024/25
- Transformation initiatives and funding support for schemes will facilitate deliverables, safe care and progress against key standards.

Patient Flow & Bed Capacity

In 2022/23, investment was made in key areas to improve flow and increase inpatient capacity. Funding for 23/24 was minimal and provided a small element of escalation bed funding. In 2023/24 the teams enhanced and developed services with SDEC services across both sites, introducing highly successful Departure Lounges, and recruitment of Discharge Facilitators. In 2024/25 our teams will continue to develop schemes to improve productivity and efficiency in patient pathways, for both elective and emergency patients. This also puts us on the trajectory for the reconfigured planned / emergency hospitals.

Underpinning the Trust's surge and capacity planning is our bed modelling. The UHD bed modelling tool is being adopted

by the Dorset system in 24/25 to underpin the overall capacity requirements for Dorset and adopt system wide assumptions. UHD used high levels of 'escalation' beds, above core for initial months post winter pressures, at considerable cost. A key assumption in our modelling, as well as our bed gap mitigation plans, is the role of the system-wide community capacity and the Discharge to Assess (D2A) programme. In addition to supporting our system-wide work, internally, our focus is on planning for discharge from admission and Pathway 0 discharges, which form 88% of all discharges daily.

Further work continues with clinical teams to develop flow across the hospitals:

- Review of speciality pathways and cross site bed capacity demands for opportunities to optimise bed capacity.
- Alternative care models which support admission avoidance, including Same Day Emergency Care (SDEC) to avoid unnecessary overnight stays and/or reduced length of stay for patients.
- Work internally and with Dorset System partners to optimise the Criteria to Reside framework and Discharge to Assess programme.
- Review and refinement of our UHD-wide escalation plans and associated risk assessments.

Discharge to Assess (D2A)

The Dorset system implemented a simplified discharge pathway in 23/24 which continues to embed. This is supported by a Discharge to Assess (D2A) model for those patients who are unable to be discharged to their usual place of residence due to new care needs. The model aims to optimise patient rehabilitation and recovery and complete assessments for their longer term needs outside of the acute hospital. 23/24 has seen challenges as patients have not moved through the D2A pathway as efficiently as planned or required for a successful impact to be felt at UHD. Delivery of this model remains a priority for the Dorset system for 24/25.

Key Benefits once achieved

- It is good for patients – helps to ensure right care, best place at the right time. Reduces the clinical risk of hospital acquired infection and deconditioning by reducing unnecessary longer stays in hospital, supporting best patient outcomes.
- It allows patients to optimise their rehabilitation and recovery and allow the assessment of their longer term needs to take place in a more appropriate setting.
- It reduces pressure on staff, wards and the front door; allowing our sickest patients to be admitted more quickly.

Further system-wide improvement work includes:

- Ensuring flow through the D2A capacity and that it does not become blocked.
- Continuing to expand community capacity.
- Review of pathways and commissioning for complex and specialist patient needs.
- 'Front door' pathways for unnecessary admission avoidance.
- 7-day discharge planning and discharges – UHD now have a 7-day service but this is not in all providers.
- Transport services that support discharge, a new transport provider will be announced in 24/25 for routine transport.
- Planning for the high level and increasing number of frail older patients in Dorset, including over 85s.

Discharge Planning – Planning to leave from point of admission

Our internal work on early planning and reduced discharge delays is being driven by our Urgent and Emergency Care (UEC) programme board. The workstream's next phase of work is focused on:

- Estimated Date of Readiness (EDR) - rollout of our Best Practice Toolkit for early and effective discharge planning and processes, supported by developments to our Health of the Ward bed management system. This aims to optimise the time our patients spend in our hospitals, reduce long lengths of stay, increase P0 discharges and provide early information to our system partners to support discharges and capacity planning.
- Developing pathways and processes on our wards that support the Discharge to Assess (D2A) model.
- 7-day discharges/discharge planning so patients are discharged when they are medically optimised.
- Streamlining assessment and referral pathways including the development of digital solutions that release time to therapy.
- Develop our Health of the Ward bed management system as central conduit for digitally sharing timely information and to support our data driven intelligence and reporting internally, across the system and nationally.

Risks and Issues

- Demand (non-elective and/or elective) exceeds bed modelling scenario assumptions.
- 'Staycations and visitors to Dorset result in surge demand at peak periods.
- Increase in the number of patients ready to leave requiring step down to community services.

- Discharge to Assess capacity and pathways are unable to deliver further reductions in Length of Stay to offset the acute bed capacity gap.
- Workforce gaps, particularly in therapy and care capacity, impacting on service and system delivery.
- Inability of system partners to meet demands on services – health and social care out of hospital.

5.3 Health Inequalities

Covid-19 has shone a light on inequalities and highlighted the urgent need to strengthen action to prevent and manage ill health in deprived and ethnic minority communities. Narrowing the gap in health inequalities and improving health outcomes is a golden thread woven throughout all aspects of our plan.

In 2023/24 we sought to strengthen our use of population health management to narrow the gap in health inequalities and improve health outcomes. We built on work to proactively identify the health inequalities of our population to inform service design and policy development. Our Population Health and System Committee of the Trust Board was established to support the Trust in achieving its strategic objective, to transform and improve our services in line with the Dorset ICS Long Term Plan.

In 2024/25 the Committee will continue to do this through:

• Providing oversight of the implementation by the Trust of its responsibilities pursuant to the system Making Dorset the healthiest place to live - Joint Forward Plan: 2023-2028.

• Assisting the Trust's Board of Directors in its oversight of achievement of breakthrough objectives and strategic initiatives relating to population health and health inequalities.

• Receiving and reviewing information and data relating to population health and health inequalities and reporting to the Board.

We will frame our vision for addressing health inequalities around: patients and families, our workforce and our leaders. This will include:

- A focus on reducing variation in access to elective health care and reducing Hospitalised Standardised Mortality Ratios (HSMR). We will take a particular focus on Children and Young People in reducing DNA rates in our ENT services.
- Ensuring accessible information related to care and treatment. Including ensuring our Transforming Care Together programme considers accessibility and signage.
- Building on our patient experience and community networks in co-designing improvements; including capturing the views of our staff living in Dorset.
- Embedding health inequalities in our Patient First methodology for improvement.
- Reviewing our Equality Impact Assessment to ensure it comprehensively considers the impact on health inequalities.
- Expanding opportunities for staff to access training on health inequalities and building an informed workforce that understands their role in reducing health inequalities. We will also work with the ICS to develop a

communications plan to support staff to deliver public health messages.
- Increasing our staff's access and use of data to better understand unwarranted variation.

In our approach, we will continue build upon the strong foundations provided by the Dorset Intelligence and Insight Service (DiiS) population health management (PHM) tools, which give access to comprehensive, good quality data and linked data sets from many care settings including acute care, primary care, mental health and social care in Dorset. Including:

- Against the 24 Domains introduced in NHS England's statement on information on health inequalities published in November 2023, we will make available in our Annual Report an assessment of variation and identify the areas requiring strengthening.
- Working in partnership with the system and its health inequalities delivery programme, we have identified data as a priority, including further rapid development of indicator definitions for the collection above and development of dashboards in relation to the Core20Plus5 national framework for adults and children.
- We will use this data to identify the needs of our communities' experiencing inequalities in access, experience and outcomes in relation to their health, so that we can respond with tailored strategies for addressing inequalities and track the impact of these strategies.

We will work collaboratively across the Dorset ICP to adopt the Core20PLUS5 approach and to deliver the ICP Working Better Together Strategy. In doing so, we will made specific consideration of Black and minority ethnic populations and the bottom 20% by IMD for clinically prioritised cohorts.

Building on the work undertaken in 2023/24 to evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists we will continue to spread the learning to date to other prioritised cohorts. Including a focus on reducing DNA rates and increasing health literacy.

Our strategy will relate to addressing health inequalities for both patients and staff. Our Equality, Diversity and Inclusion Group and Healthy Working Lives Group will be asked to set out its priorities in tackling health inequalities as they directly relate to staff and to review the strategy to ensure activities are viewed through a health inequalities lens.

To reflect our position as one of the biggest employers in Dorset, we will consider adoption of the Anchor Institute approach and be an active member of the Dorset Anchor Institution's Network.

6. Sustainable Services

True North Goal - Use every NHS pound wisely	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.
Breakthrough Objective	To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently.
Corporate Projects	***Efficiency Improvement Programme (including One Dorset Procurement***) – Full delivery of planned CIP targets, with at least 80% achieved recurrently ***Transforming Care Together Programme (Build Ready and Service Ready Programmes) -*** **Build ready:** • Completion of BEACH building • Completion of NHP funded Wards and Theatres • Completion of associated enabling works • Completion of Poole's new Endoscopy Unit **Service Ready:** • Teams Integrated, new clinical models in place. • Move plans implemented and services safely moved. **Staff Ready:** • Engagement • Workforce planning

6.1 Financial Strategy

Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services, and a significant number of patients in acute hospitals who are medically ready for discharge. At the same time, there is a continued focus on recovering the backlog of elective patients who are waiting too long for their operations. Within the Trust, both Emergency departments continue to operate under extreme pressures; and we continue to care for over 200 patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate at Operational Pressures Escalation Level (OPEL) 3 with bed occupancy frequently exceeding 100%.

Operating under this pressure requires a relentless focus from all teams to ensure patients receive safe care. Having to operate under this pressure for such a sustained period has obviated the Trusts ability to progress transformation and efficiency schemes at pace. This has limited the Trusts ability to improve productivity and reduce expenditure and when compounded with the significant workforce challenges including Industrial Action, has resulted in a significant recurrent underlying deficit.

Revenue

Considerable financial planning and detailed financial modelling has been undertaken within the Trust. This reflects the national planning guidance together with the agreements reached within the Integrated Care System in relation to the distribution of funding across partner NHS organisations.

Whilst the plan reflects a financial break-even position, a number of financial risks remain which could, if unmitigated, drive an in-year deficit. The most significant risks are:

- An efficiency requirement of 5% has been included within the Trusts budget, equating to £42m. Good progress has been made in identifying and developing plans to achieve this, however, there remains a shortfall of £10m representing a risk to the achievement of the plan overall.
- Recovering elective services to the required and budgeted 109% threshold may cost more than the funding available, or funding may be clawed back for failing to achieve this threshold. This could present a risk of circa £7.5m.
- The plan assumes that the Trust will operate within 20 funded escalation beds. During the last 12 months an average of 65 have been required peaking at 115 in January. Improving the timely discharge of patients who

no longer require acute care will be vital in mitigating this risk.

- Pay costs have been budgeted based on the substantive cost, with only a small amount budgeted for the premium cost of agency cover. If the current agency expenditure run rate continues there is an additional risk of up to £5 million.

These risks, together with the wider financial governance procedures will be managed through the Trust Management Group (supported by the Financial Planning Group) and assured by the Finance and Performance Committee and ultimately the Board.

Capital

The Trust has a comprehensive medium-term capital programme, developed as part of the acute reconfiguration business case and fully aligned to the outcome of the Dorset Clinical Services Review.

This very significant and ambitious programme totals almost £0.5 billion with budgeted spend of £166 million during 2024/25 (assuming final approval of the New Hospitals Programme business case) comprising three key elements:

- Estates Development (section 6.2);
- Digital Transformation; and
- Medical Equipment replacement programme.

This programme sits within the aggregate Dorset ICS capital programme which lives within the ICS capital allocation.

The Trust has a strong track record of successfully managing its capital budget. This will remain a focus through the Trust Management Group (supported by the Capital Management Group) and assured by the Finance and Performance Committee and ultimately the Board.

Cash

The trust continues to hold a significant cash balance which has been strategically built up over many years and is fully committed, supporting the medium-term capital programme.

However, this will be materially depleted if the Trust cannot mitigate the expected revenue deficit, resulting in a requirement to borrow cash in future years. This plan seeks to avoid that situation.

2024/25 Financial Priorities

The Trust's absolute priority during 2024/25 is to deliver within its agreed budget. Achieving this will reduce the underlying recurrent revenue deficit and support the vision to return to recurrent financial balance from 2026/27.

6.2 Transforming Care Together Programme

The existing healthcare facilities in east Dorset are insufficient to cater to the rising healthcare demands of our ageing community. To ensure access to timely, high-quality healthcare services for our residents, we need to transform services and separate planned and emergency care per the Clinical Services Review.

This requires the planning and construction of the £201m BEACH (Births, Emergency care, And, Critical care and child Health) building and £262m NHP funded wards and buildings on the Bournemouth Hospital Site to create the Emergency Hospital. On the Poole Hospital site, new theatres, wards and a new Endoscopy building will create the Planned Care Hospital. This modern, fit for purpose estate will have advanced construction, adequate bed capacity, and the capability to offer comprehensive healthcare services.

These changes will help to meet the needs of our population and deliver the overarching benefits of improved outcomes due to centralised emergency and specialised services, shorter waiting times, reduced cancellations and clinical/financial sustainability.

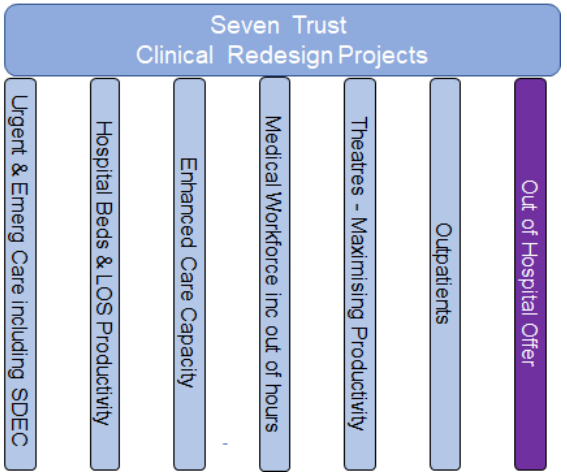
Our Transforming Care Together Programme will be delivered by our Service Ready and Build Ready projects.

Service Ready

Establishing the Planned and Emergency Hospitals means changes to the majority of our clinical services. Our scope is made up of:

- 7 clinical redesign projects
- 23 specialties going from two teams to one
- 31 specialties moving site
- 3 teams going from single site working to split site planned / emergency

Our clinical redesign projects are outlined below:



This will necessitate the development of new clinical and operational models and the integration of teams where the same service is currently supplied over different sites.

Our headline dates for the movement of services are outlined below:

- Phase 1 - Q4 2023/4 & Q1 2024-5: TIU, Haem, Surgical moves, Pathology hub opens
- Phase 2 – Q1 2025/6 – BEACH opens, Maternity, RBH-CC and RBH-ED move
- Phase 3 – Q3-Q4 2025/6 – Planned and Emergency separation
- Phase 4 – Q3-Q4 2026/7 – Final moves and completion

The Transforming Care Together programme will deliver:

1) Clinical excellence delivered from fit for purpose estate
2) Improved patient safety and infection control
3) Shorter waiting times and reduced cancellations
4) Clinically and financially sustainable services

This is a huge programme of change for all our staff and patients and as such there are several risks to manage:

a) Build ready delays (funding and/or construction) – successful management of the construction critical path will help to mitigate these risks

b) Service ready delays (Integration of teams, clinical/operational models, possible workforce shortages) – successful critical path management, staff engagement, workforce and OD support will help to mitigate these risks.

The completion of the Transforming Care Together Programme will deliver:

- Clinical, Financial and Societal benefits as determined in the STP and NHP business cases.
- STP (BEACH) - £21.6m cost savings, 5 specialties with quantified benefits, 6 speciality benefits for up to 150,000 patients per year from planned and emergency separation, societal benefits of £11.4m
- NHP funded Schemes - £6.1m of cash releasing benefits, £8.0m of non-cash releasing benefits and £12.2m societal benefits

Together these benefits will deliver the vision and ensure clinically and financially sustainable services for the UHD service users.

Build Ready

As in previous years, the creation of the planned care hospital at Poole and the emergency hospital on the Royal Bournemouth site remains the centre piece of the Clinical Services Review (CSR) agreed by the Secretary of State for

Health in 2019, following three years of public, staff and partner engagement.

The benefits and reconfiguration changes are set out in our Future Hospitals Website: Investing in our hospitals (uhd.nhs.uk). The links on the website layout the changes across all the UHD sites, with funding coming from a range of sources including the New Hospitals Programme, Sustainability & Transformation Programme as well as other capital investment schemes.

The Estates masterplan provides visuals and the timeline for the major changes that complete in 2026/27:

- The first clinical changes commenced in 2023/24 covering Stoke, Cardiology and the opening of the Pathology Hub.
- The next significant changes are planned for the start of 2024/25 when the new catering block will come online.
- The BEACH building will be handed over to the Trust for commissioning in Oct 2024.
- The initial clinical opening of the BEACH building will be in April 2025 providing Births (Maternity), Emergency Care (Bournemouth ED will move into the new facility; however Poole ED will remain the designated Trauma unit), Antenatal, Bournemouth Critical Care will also move into the new facility.
- All other changes will move as part of the Major Reconfiguration in Q3 2025/26.

There are other extensive changes across both Poole & Bournemouth including the work related to the New Hospitals Programme, the Wessex Fields Access Road and the commencement of the Clinical Diagnostic Hub (CDC) for Endoscopy in Poole.

In 2024/25, there are six strategic changes:

1. Our **Dorset Pathology Hub moves complete**. This is the completion of the state-of-the-art building with digital Pathology, able to serve the whole of Dorset and beyond.

2. **BEACH Building completes** in November 2024, with Trust commissioning finishing by the end of March 2025. The first services will move into the BEACH in April 2025

3. **Wessex Fields Access Road completes** in September 2024, at which UHD staff will be able to enter and exit the site directly from the South Bound Wessex Way carriageway

4. **CDC in Poole commences** in Spring 2024 with plans to complete in early 25/26

5. **New Hospitals Programme (New Ward Block and Catering commences)** is due to complete in November 2025 with commissioning running into December 2025.

6. **Catering.** The Central Production Kitchen (CPK) will be fully open, allowing a totally new, improved catering offer. This will offer more choice, be more sustainable, provide greater resilience and provide future opportunities for revenue growth by providing catering to partners.

These six significant service changes will happen in 2024/25 but across all our sites, small and medium sized building works in preparation for major reconfiguration in 2025/26 will continue and step up. The enabling works for the New Hospital Programme will continue, and the Full Business Case for the New Hospitals Programme is expected to be approved in the summer of 2024. Other capital projects will also be progressed, including back log estates works across the Trust.

Taken together the five-year capital programme represents over £500m of investment in Dorset NHS Estates. This is the largest such investment ever, and only comparable to the late 1980s when Royal Bournemouth Hospital was built. All this building work is only an enabler, to support clinical services be reconfigured to deliver integrated teams, better able to provide specialist care seven days a week, and to ringfence planned care, free of emergency care pressures.

Work to ensure the environmental sustainability of the buildings, improved transport, and that information technology is fully harnessed for better patient care, are set out in different parts of this plan.

6.3 Environmental Sustainability

The UHD sustainability strategy aligns with the requirements set out in the NHS national plan, delivering a “Net Zero” national health service and the Health Care Act 2022.

Our green plan can be found on: uhd_green_plan_1.pdf.

The Sustainability Strategy, or Green UHD Plan, sets out our:

- **Vision** - to provide excellent healthcare to our patients and wider community and be a great place to work, now *and for future generations*
- **Green objectives** – to deliver healthy lives, a healthy community and a healthy environment.
- **Cornerstone targets** –
    - To reduce UHD’s core carbon footprint to 80% by 2030 (against 1990 baseline) and to net zero by 2040.
    - Carbon footprint plus to be net zero by 2045.
    - To become an excellent rated clean air hospital by 2026, reduce single use plastics, generate zero waste to landfill and consume 100% renewable energy.
    - The trust also uses a sustainable development assessment toolkit with circa 500 criteria and aims to score 100% by 2030.

To realise our green plan there are twelve areas of activity that cover all the aspects of services within UHD:-

- Workforce and leadership
- Sustainable models of care
- Digital transformation
- Travel and transport
- Waste
- Capital projects
- Utilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation
- Greenspace and biodiversity.

We also have two additional ‘summary areas of activity’ to help roll up, capture and manage the total contribution towards carbon and social value targets.

- Carbon
- Social value / anchor institution

Our Green Plan aligns the Trust with NHS net zero targets. Given the unprecedented nature of the challenges being addressed, the measures taken to achieve the Green Plan and the Green Plan itself will require regular review and revision along this journey.

In 2024/25, we will build on work through 23/24 and continue to give particular focus to three areas:

- **Decarbonisation of the energy consumed by our estate.** This includes major investment to increase the electrical supply capacity, increase renewable generation on site and detailed planning for heat decarbonisation.

- **Green travel.** The delivery of a detailed sustainable travel plan in 2023/24 was a significant milestone. 2024/25 will see the implementation of several projects needed to deliver against this plan. This includes the introduction of Mobilityways which will provide staff with personalised travel plans and provide the trust with a powerful modelling tool to better assess staff travel needs and support them with sustainable travel solutions. Our aim to ensure staff travel is both easier and more enjoyable (as well as cheaper, healthier and greener).

- **Sustainable quality improvement.** During 2023/24, UHD started on our transformational journey to embrace the “Patient First” quality improvement approach, with the first cohort of staff including 200 managers beginning their training. Through 2024/25 we will ensure environmental sustainability is integrated with Patient First and reconciled with our target to mainstream sustainable quality improvement throughout the trust. Progress is already starting with our Green Theatres work.

The Green Plan is aligned with our work across Dorset ICS, the SW region and fits with our ambitious, bet essential, vision for future generations to benefit from our work today.

7. Corporate Governance

7.1 System partnerships

Integrated Care System (ICS)

The ambition for Dorset to be the healthiest place to live in the UK fits UHD's ambition for our population, and our place as a team player within our ICS. NHS Dorset Integrated Care Board as the key organisation, is leading this work, and their plans on behalf of the system align within ours. In turn these fit within wider national strategies.

For more detail on the Dorset ICS strategy see website (link). UHD's contributions are summarised with the driver diagram overleaf.

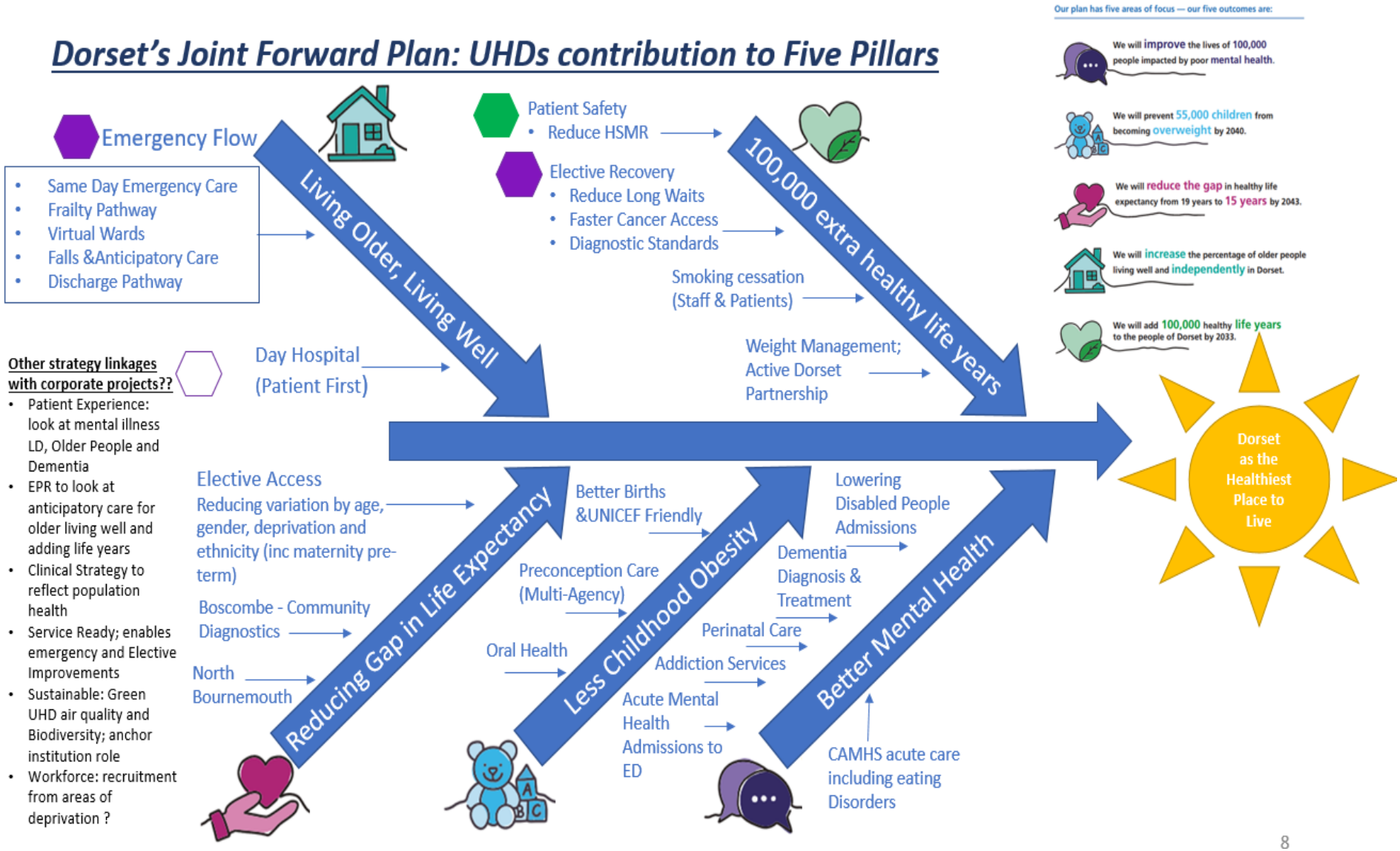
Wider determinants of health

This plan is set within the context that a predominately hospital based healthcare provider is only a small part of an individuals', and populations health and happiness. Therefore our work as an "anchor institution", as an employer, landowner, purchaser of goods and services, and focal point for a community are also important. The progress against what good looks like as an anchor institution, is tracked via our Green UHD plan. In addition we are active members of numerous networks, and partnerships both as a Trust and through the ICS, including for example with the voluntary sector.

University Partnership

A key formal partnership is with Bournemouth University, a highly ranked institution. Over the last three years our partnership has supported education, research, joint appointments and a range of projects, including in leadership development. The strategy will be updated in 2024. One area to explore will be development of a medical school for Dorset, alongside expanding existing programmes including physicians' assistants.

Dorset's Joint Forward Plan: UHDs contribution to Five Pillars



8

7.2 Membership and Governors

Member Engagement

The Trust currently has over 14,000 public members, with staff and volunteer members being in the region of 10,000. All individuals in our staff constituency automatically become members unless they choose to opt out. In 2024/25, Governors will further develop upon successful events, communication and outreach, supporting their role of representing the interests of members and the public.

The vision set out in the Trust's Membership Engagement Strategy is to build on the engagement with Trust members to create an active and vibrant membership community, representative of the diverse population the Trust serves and of the staff who work here, that has a real voice in shaping the future of the Trust and the services it provides. To achieve this, the Membership Engagement Strategy sets out three overarching aims:

1. To build representative membership that reflects our whole population of Dorset and West Hampshire;
2. To improve the quality of mutual engagement and communication so that our members are well informed, motivated and engaged;
3. To ensure our staff members have opportunities to be become more actively engaged as members.

Council of Governors (CoG)

In the absence of vacancies, the Council of Governors currently comprises the following:

- 6 Public Governors from the Bournemouth Constituency;
- 6 Public Governors from the Poole & Rest of Dorset Constituency;
- 5 Public Governors from the Christchurch, East Dorset & Rest of England Constituency;
- 5 Staff Governors, each representing a staff class:
    - Medical and Dental;
    - Nursing, Midwifery & Healthcare Assistants;
    - Allied Health Professions, Scientific & Technical;
    - Administrative, Clerical and Management;
    - Estates and Ancillary Services
- 4 Appointed Governors, each representing a partnership organisation:
    - Bournemouth, Christchurch & Poole Council;
    - Dorset Council;
    - Bournemouth University;
    - University Hospitals Dorset Volunteers

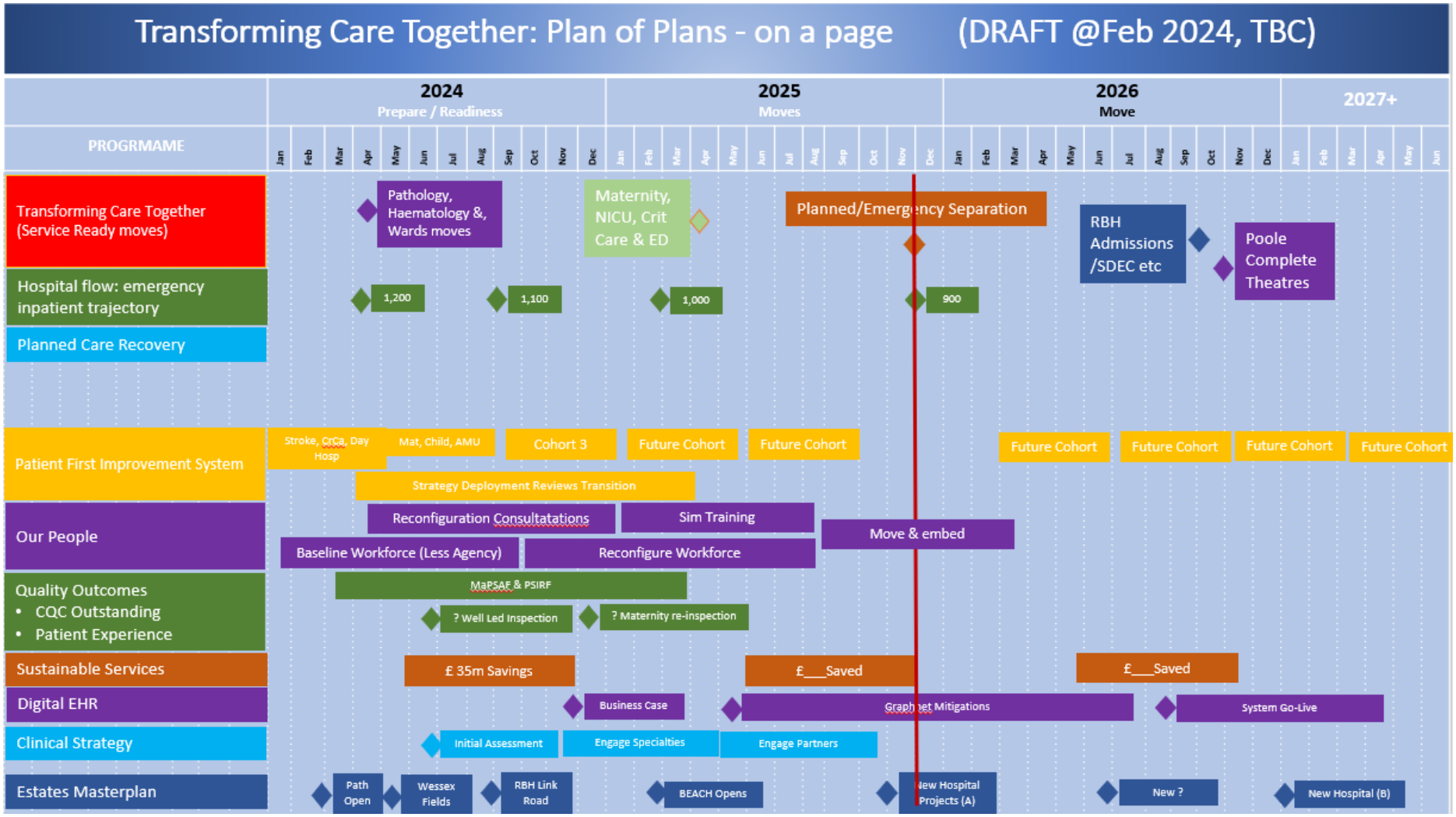
More information about our Council of Governors can be found here

Informal Groups

The Council of Governors has established four informal groups:

- **Membership & Engagement Group** – a forum for discussion on membership, engagement, development and recruitment of members;
- **Effectiveness Group –** a forum for discussion on the effectiveness of the Council of Governors and to informally oversee the development and implementation of plans to enhance this;
- **Quality Group –** a forum for discussion on matters relating to quality and the Quality Account;
- **Constitution Review Group:** a forum for discussion on matters relating to the review and updating of the Trust's constitution triennially. The process for the constitution review is underway and will conclude in 2024/25.

Appendix A – Overarching Transformation Plan



COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 6.1

Subject:	Trust Constitution - update
Prepared by:	Company Secretary Team, Constitution Review Group
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of this paper is to present to the Council of Governors the proposed amendments to the Trust's Constitution for review and if thought fit approval.
Background:	**CONTEXT:** Under the current Constitution, the document must be reviewed every three years. At its meeting in October 2023, the Council of Governors agreed to extend the review period by one year to allow system working to be further embedded and to give internal stakeholders additional time to complete the review. **PROCESS:** At its July 2023 meeting, the Council of Governors agreed to establish the Informal Governors' Constitution Review Group. Rob Whiteman chaired the Group, comprising four Governors: Robert Bufton, Rob Flux, Carrie Stone, and Michele Whitehurst. Non-Executive Directors Judy Gillow, John Lelliott also significantly contributed to the Group and its review. The Company Secretary Team provided support and guidance to the Group throughout the review process. The Group met on eight occasions and discussed the proposed changes to the Constitution in detail. As part of its work, the Company Secretary Team shared with the Group learning and approaches taken by other

	organisations, including examples of Constitutions from five trusts which achieved "outstanding" for well-led, as well as the model core constitution. **OUTCOME:** The attached Trust Constitution – draft July 2024 reflects the proposed changes (which are tracked). The main proposed amendments relevant for the Council of Governors include, but are not limited to: • Changes to the composition of the Council of Governors including by adding for the possibility of one appointed Governor from a voluntary organisation • Changes to the staff constituency by having two staff classes: clinical and non-clinical, with three Governors representing each class • Specific rights and duties of the Council of Governors listed in clause 15 • Specific provisions related to the process for removal (were this to arise) of the Trust Chair and Non-Executive Directors
Key Recommendations:	To consider and if thought fit to approve the proposed amendments to the Trust Constitution. Next steps are for this to be presented to the Board of Directors for review and if thought fit approval.
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Informal Constitution Review Group	Various	As above.

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality Patient confidentiality Staff confidentiality Other exceptional reason	☐ ☐ ☐ ☐

University Hospitals Dorset
NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust Constitution

Version 2

DOCUMENT DETAILS

Document History				
Date of Issue:	**Version No:**	**Date Approved:**	**Director responsible for Change:**	**Nature of Change:**
October 2020	1	February 2020	Company Secretary	New document
November 2022	1.1	November 2022	Company Secretary	• Removal of Chairman's casting vote in relation to the composition of the Board. (21.2.1 and Annex 7, 3.1.1 (a)) • Change in the composition of the Board to no more than 8 other non-executive directors in addition to the Chairman. (21.2.2 and Annex 7, 3.1.1 (b))
September 2024	*2*	*September 2024*	*Company Secretary*	*Full review*

TABLE OF CONTENTS

Formatted: Heading 2

1 Interpretation and definitions

1.1 Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Acts 2012 and 2022.

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

1.3 References in this Constitution to legislation include all amendments, replacements or re-enactments made or any regulations, statutory guidance or directions made under it.

1.4 References to Clauses and paragraph numbers are references to clauses and paragraphs of this Constitution unless the context provides otherwise.

1.5 Headings are for ease of reference only and are not to affect interpretation.

1.6 If there is a conflict between the provisions of this Constitution and the provisions of any document referred to herein then the provisions of this Constitution shall prevail unless the law requires otherwise.

1.7 In this Constitution:

"2006 Act"	means the National Health Service Act 2006;
"2012 Act"	means the Health and Social Care Act 2012;
"2022 Act"	Means the Health and Care Act 2022;
"Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"Annual Members' Meeting"	is defined in Clause 10 of this Constitution;
"Appointed Governors"	~~means the CCG Governor, the Local Authority Governors and the Partnership Governors;~~is defined in Annex 3 of this Constitution;
"Area for a Public Constituency"	means each of the areas specified as an area for a Public Constituency in Annex 1;
"Area of the Trust"	means the area consisting of all the areas specified in Annex 1 as an Area for a Public Constituency;
"Board of Directors"	means the Board of Directors of the Trust as constituted in accordance with this Constitution and referred to in

	Clause 21 of this Constitution and "**Board**" shall be construed accordingly;
~~"CCG"~~	~~means a Clinical Commissioning Group established in accordance with Chapter A2 of Part 2 of the 2006 Act;~~
~~"CCG Governor"~~	~~means a member of the Council of Governors appointed in accordance with the provisions of this Constitution by the CCG specified in Annex 3;~~
"Chair~~man~~"	means the chair~~man~~ of the Trust appointed in accordance with Clause ~~21~~ 24 of this Constitution;
"Chief Executive"	means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with Clause 26 of this Constitution;
Code of Conduct for Governors	means the Code of Conduct applicable to Governors of the Trust;
Code of Governance	means the Code of Governance for NHS Provider Trusts published by NHS England in April 2023;
"Company Secretary"	means the Company Secretary of the Trust or any other person appointed to perform the duties of the secretary of the Trust;
"Constituencies"	means the Public Constituencies and the Staff Constituency;
"Constitution"	means this Constitution of University Hospitals Dorset NHS Foundation Trust and all annexes to it;
"Council of Governors"	means the Council of Governors of the Trust as constituted in accordance with this Constitution;
"Director"	means a ~~director on~~ member of the Board of Directors;
"Elected Governors"	means the Public Governors and the Staff Governors collectively;
"Executive Director"	means an Executive Director of the Trust;
"~~Director of Finance~~Chief Finance Officer"	means the person who from time to time is appointed by the Trust to discharge the usual functions of its chief finance officer;
"Financial Year"	means a period of 12 months ending with 31 March in any year;

~~"Governors' Meetings"~~	~~means a meeting of the Governors;~~
"Governor"	means a member of the Council of Governors, being either an Elected Governor or an Appointed Governor;
~~"Initial Governor"~~	~~means an initial Governor of the Trust who has been elected to office for a period that is determined in accordance with Annex 10;~~
~~"Interim Directors"~~	~~means the individuals who were executive or non-executive directors of the Predecessor Trusts immediately prior to their dissolution;~~
"ICB"	means an integrated care board established pursuant to the Health and Social Care Act 2022;
"Lead Governor"	means one Governor appointed by the Council of Governors to communicate directly with ~~Monitor~~ NHS England in certain circumstances;
"Local Authorities"	means those Councils specified in ~~Annex 2~~Annex 2, all of which are Councils for an area which includes the whole or part of the Area of the Trust, and "**Local Authority**" shall be construed accordingly;
"Local Authority Governor"	means a member of the Council of Governors appointed by a Local Authority in accordance with the provisions of this Constitution and as specified in Annex 3;
"Member"	means a Member of the Trust as determined in accordance with Clause 6 and Annex 8 of this Constitution;
"Membership"	means membership of the Trust through being a Member of one of its Constituencies;
~~"Monitor"~~	~~means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act, which operates with the National Health Service Trust Development Authority as NHS Improvement;~~
"Model Election Rules"	means the model form rules for the conduct of elections published from time to time by NHS Providers;
NHS England	means the body corporate known as NHS England, which expression shall include its successors from time to time;

~~**"NHS Foundation Trust Code of Governance"**~~	~~means the Code of Governance published by Monitor in July 2014 or such similar or further guidance as Monitor may publish from time to time;~~
"Nominations, Evaluation and Remuneration Committee"	means the Nominations, Remuneration and Evaluation Committee established by the Council of Governors in accordance with ~~Annex 5~~19 of Annex 5;
"Non-Executive Director"	means a Non-Executive Director of the Trust including the Chair~~man~~;
"Partnership Governor"	means a member of the Council of Governors appointed by a Partnership Organisation specified in Annex 3;
"Partnership Organisations"	means those organisations designated as partnership organisations for the purposes of this Constitution specified in Annex 3;
~~**"Predecessor Trusts"**~~	~~means Poole Hospital NHS Foundation Trust and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust which were dissolved by order of Monitor on 1 October 2020 under section 56 of the 2006 Act;~~
"Public Governor"	means a member of the Council of Governors elected by the Members of the Public Constituency;
"Public Constituencies"	means that part of the Trust's membership consisting of Members living in an Area of a Public Constituency;
"Relevant Body"	means for the purposes of Clause 4, NHS England, an ICB, an NHS trust, an NHS foundation trust (including, but not limited to, the Trust) or such other body as may be prescribed pursuant to section 65Z5(2) to the 2006 Act. "Relevant bodies" means two or more of such organisations, as the context requires;
"Secretary of State"	means the Secretary of State for Health and Social Care;
"Senior Independent Director"	means the Non-Executive Director appointed by the Board of Directors in accordance with Clause ~~3.1.1~~3.7 of Annex 7 ~~-~~of this Constitution;
"Staff Classes"	means the classes of the Staff Constituency as specified in Annex 2;
"Staff Constituency"	means that part of the Trust's membership consisting of the staff of the Trust and other persons as more particularly provided for in Clause 8 of this Constitution and which is divided into the staff classes as specified in Annex 2;

"Staff Governor"	means a member of the Council of Governors elected by a Staff Class;
"Trust"	m~~M~~eans University Hospitals Dorset Hospitals NHS Foundation Trust;
"Trust's Hospital"	means any premises used by the Trust for the provision of goods and services for the purposes of the health service in England falling within the definition of "hospital" in Section 275 of the 2006 Act;
"Vice Chair~~man~~"	means the Vice Chair~~man~~ of the Trust;
"Voluntary Organisation"	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2 Name

The name of the foundation trust is University Hospitals Dorset NHS Foundation Trust.

3 Principal purpose

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

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

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

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

3.3.2 the promotion and protection of public health.

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

4 Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

Formatted: Heading 2

4.4 The Trust may enter into arrangements for the carrying out, on such terms as it considers appropriate, of any of its functions jointly with any other person.[1]

4.5 The Trust may arrange for any of the functions exercisable by it to be exercised by or jointly with any one or more of the following[2]:

4.5.1 A Relevant Body;

4.5.2 A local authority within the meaning of section 2B of the 2006 Act;

4.5.3 A combined authority.

4.6 The Trust may also enter into arrangements to carry out the function of another Relevant Body, whether jointly or otherwise.

4.7 Where a function is exercisable by the Trust jointly with one or more of the other organisations mentioned at Clause 4.5, those organisations and the Trust may:

4.7.1 Arrange for the function to be exercised by a joint committee of theirs;

4.7.2 Arrange for the Trust, one or more of those other organisations, or a joint committee of them, to establish and maintain a pooled fund

In accordance with section 65Z6 of the 2006 Act.

~~4.3~~

~~4.4~~

5 Membership and Constituencies

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

5.1 a Public Constituency; or

5.2 the Staff Constituency.

6 Application for membership

6.1 An individual who is eligible to become a Member of the Trust may do so on application to the Trust, ~~save as provided for in Clause 8 of this Constitution.~~or by being invited by the Trust to become a Member of a Staff Class of the Staff Constituency in accordance with Clause 8.

6.2 Applications for Membership shall be dealt with by the Trust in accordance with the provisions of Annex 8.

[1] Section 47A, 2006 Act

[2] Section 65Z6, 2006 Act

Formatted: Heading 3, Indent: Left: 1.27 cm

Formatted: Default Paragraph Font

Formatted: Normal

Formatted: English (United Kingdom)

Formatted: English (United Kingdom)

~~6.2~~6.3 The Company Secretary shall make the final decision as to which constituency, and to which class of a constituency, an individual is eligible to be a member.

7 Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an a~~A~~rea for a Public Constituency may become or continue as a Member of the Trust.

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

7.3 The minimum number of members in each area for a Public Constituency is specified in Annex 1.

7.4 Further provisions relating to Membership of the Public Constituencies are set out in Annex 7.

8 Staff Constituency

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

8.1.1 that individual is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 that individual has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, other than under a contract of employment with the Trust and who are acknowledged in writing by the Trust as falling within the parameters of this paragraph 8.2, may become or continue as Members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for Membership of the Trust by reason of the previous provisions of this Clause 8 ~~of the Constitution~~ are referred to collectively as the Staff Constituency.

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

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

8.6 An individual who is:

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

8.6.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate Staff Class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless the individual informs the Trust otherwise.

8.7 The process by which an individual shall be invited to become a member of the Staff Constituency shall be in accordance with the provisions of Annex 8.

9 Restriction on membership

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

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

9.3 An individual must be at least 16 years old to become a member of the Trust.

9.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8 – Further Provisions.

10 Annual Members' Meeting

~~9.5~~10.1 The Trust shall hold an annual meeting of its members ~~(the Annual Meeting)~~. The Annual Members' Meeting shall be open to members of the public.

~~9.6~~10.2 Further provisions about the Annual Members' Meeting are set out in Annex 8 ~~– Annual Meeting~~.

~~10~~11 Council of Governors – composition

~~10.1~~11.1 The Trust shall have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

~~10.2~~11.2 The composition of the Council of Governors shall be as specified in Annex 3.

~~10.3~~11.3 The members of the Council of Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency.

~~10.4~~11.4 The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

~~11~~12 Council of Governors - election of Governors

~~11.1~~12.1 Elections for Elected Governors of the Council of Governors shall be conducted in accordance with the Model Election Rules using the first past the post voting method and the Model Election Rules shall be construed accordingly.

Formatted: Indent: Left: 2.5 cm

~~11.2~~12.2 The Model Election Rules ~~as published from time to time by NHS Providers form part of this Constitution~~for use in elections to NHS foundation Trust councils of governors, being those current at the date of adoption under this Constitution, are attached at Annex 9. ~~The Model Election Rules current at the date of their adoption under this Constitution are included in Annex 9.~~

~~11.3~~12.3 A subsequent variation of the Model Election Rules by NHS Providers, or any other subsequent body with authority to do so, shall not constitute a variation of the terms of this Constitution for the purposes of Clause 41. For the avoidance of doubt, the Trust cannot amend the Model Election Rules.

~~11.4~~12.4 An election, if contested, shall be by secret ballot.

~~12~~13 Council of Governors – tenure

~~12.1~~13.1 An Elected Governor shall hold office for a period of up to three years.

~~12.2~~13.2 An Elected Governor shall cease to hold office if ~~that Governor~~ they cease~~s~~ to be a member of the constituency or class by which ~~that Governor was~~they were elected.

~~12.3~~13.3 Subject to clause 13.7, ~~An~~ an Elected Governor shall be eligible for re-election at the end of that Governor's term.

~~12.4~~13.4 An Appointed Governor shall hold office for a period of up to three years.

13.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its ~~sponsorship~~appointment of them or if any such appointing body ceases to exist and there is no successor in title to its business.

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

13.7 An Elected Governor or an Appointed Governor may not hold office more than three consecutive terms. For the avoidance of doubt, this shall not preclude service of more than three non-consecutive terms.

13.8 For the avoidance of doubt, any Governor elected for a term under the conditions established by a previous iteration of the Constitution shall be entitled to serve the remainder of their term.

13.9 The continued holding of office and eligibility for re-election or re-appointment shall be save as otherwise provided in this Constitution (including, but not limited to, as set out in Clause 14 below).

~~13~~14 Council of Governors - disqualification and removal

~~13.1~~14.1 The following may not become or continue as a member of the Council of Governors:

~~13.1.1~~14.1.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

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

14.1.3 a person who has made a composition or arrangement with, or granted a Trust deed for that person's creditors and has not been discharged in respect of it;

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

14.1.5 a person who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;

14.1.6 Disclosure and Barring Service checks (or any other checks required by the Trust from time to time as being consistent with its licence conditions or good governance arrangements) have not been undertaken concerning that person or that based upon the results received by the Trust, they are not considered to become or continue as a Governor by the Chair. ~~are not acceptable in all respects by the Trust.~~

~~13.2~~14.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

~~13.3~~14.3 Further provisions as to the circumstances in which an individual may not become or may be removed as a member of the Council of Governors are set out in Annex 4.

15 Council of Governors - duties of Governors

~~13.4~~15.1 The general duties of the Council of Governors are:

~~13.4.1~~15.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

~~13.4.2~~15.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

15.2 The specific rights and duties of the Council of Governors are:

15.2.1 To appoint or remove the Chair and the other non-executive Directors of the Trust (as referred to in Clause 24).

15.2.2 To approve the appointment of the Chief Executive of the Trust by the Non-Executive Directors (as referred to in Clause 26);

15.2.3 To determine the remuneration and allowances and other terms and conditions of office of the Non-Executive Directors (as referred to in Clause 31);

15.2.4 To appoint or remove the Trust's external auditor (as referred to in Clause 35);

15.2.5 To receive and consider the Trust's annual accounts, any auditor's reports on those annual accounts and the annual report from the Board of Directors (as referred to in Clause 39)

15.2.6 To be consulted by the Board of Directors regarding the Board of Directors' preparation of the forward planning information (as referred to in Clause 38);

15.2.7 To determine whether it is satisfied that the carrying on of any proposed activities other than the provision of goods and services for the purposes of the health service in England will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose (as referred to in Clause 38);

15.2.8 To approval any proposal to increase by 5% or more the proportion of the Trust's total income in any Financial Year attributable to Non-Principal Purpose Activities (as referred to in Clause 38);

15.2.9 To approve any Significant Transaction (as referred to in Clause 42);

15.2.10 To respond as appropriate when consulted by the Board of Directors;

15.2.11 To require one or more Directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (as referred to in Clause 16.3);

15.2.12 To approve any merger, acquisition, separation or dissolution (as referred to in paragraph 42);

15.2.13 To exercise such other powers and to discharge such other duties as may be conferred on the Council of Governors under this Constitution.

15.3 If NHS England has appointed a panel for advising governors, a Governor may refer a question to that panel as to whether the Trust has failed or is failing to act in accordance with this Constitution or Chapter 5 of the 20006 Act. A Governor may only refer a question under this paragraph if more than half of the members of the Council of Governors voting approve the referral.

15.4 All Governors shall comply with the Code of Conduct for Governors.

Formatted: Heading 2

Formatted: Default Paragraph Font

~~13.5~~15.5 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

~~14~~16 Council of Governors - meetings of Governors

~~14.1~~16.1 Subject to paragraph 7 of Annex 5, ~~of the Standing Orders for the Council of Governors at Annex 5 of the Constitution~~ the ~~Chairman of the Trust~~Chair (i.e. the Chair~~man~~ of the Board of Directors, appointed in accordance with the provisions of Clause 24 of this Constitution) or, in the Chair~~man~~'s absence the Vice Chair~~man~~ appointed in accordance with the provisions of Clause 25 of this Constitution, shall preside at meetings of the Council of Governors.

~~14.2~~16.2 Meetings of the Council of Governors shall be open to members of the public save that members of the public may be excluded from a meeting for special reasons outlined in Annex 5. ~~, examples of which are provided in Annex 4.~~

~~14.3~~16.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Director's performance), the Council of Governors may require one or more of the Directors to attend a meeting of the Council of Governors.

17 Council of Governors - standing orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 5.

~~15~~18 Council of Governors - conflicts of interest of Governors

~~15.1~~18.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as the Governor becomes aware of it.

~~15.2~~18.2 The Standing Orders for the Council of Governors (Annex 5) shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

~~16~~19 Council of Governors – travel expenses

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

~~17~~20 Council of Governors - further provisions

~~17.1~~20.1 Further provisions with respect to the Council of Governors are set out in Annex 4.

~~18~~21 Board of Directors - composition

~~18.1~~21.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

~~18.2~~21.2 The Board of Directors is to comprise:

~~18.2.1~~21.2.1 a non-executive Chair~~man~~;

~~18.2.2~~21.2.2 ~~N~~no more than eight other Non-Executive Directors; and

21.2.3 ~~N~~no more than eight Executive Directors.

~~18.2.3~~ provided that at least half of the Board of Directors, excluding the non-executive Chair, shall at all times comprise Non-Executive Directors.

Formatted: Normal, Indent: Left: 1.25 cm

Formatted: Default Paragraph Font

~~18.3~~21.3 One of the Executive Directors shall be the Chief Executive.

~~18.4~~21.4 The Chief Executive shall be the Accounting Officer.

~~18.5~~21.5 One of the Executive Directors shall be the ~~Director of Finance~~Chief Finance Officer.

~~18.6~~21.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

~~18.7~~21.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

~~19~~22 Board of Directors - general duty

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

~~20~~23 Board of Directors - qualification for appointment as a Non-Executive Director

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

~~20.1~~23.1 that person is a member of the Public Constituency; or

~~20.2~~23.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, that person exercises functions for the purposes of that university; and

~~20.3~~23.3 that person is not disqualified by virtue of Clause 27 of this Constitution.

~~21~~24 Board of Directors - appointment and removal of Chair~~man~~ and other Non-Executive Directors

~~21.1~~24.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair~~man~~ of the Trust and the other Non-Executive Directors.

24.2 Removal of the Chair~~man~~ or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

24.3 The Council of Governors should raise issues to the Chair or in the case of the Chair to the Senior Independent Director prior to formal action to remove the Chair or a Non-Executive Director.

~~21.2~~24.4 Further provisions as to the process of appointment or removal of the Chair and other Non-Executive Directors are set out at Annex 5.

~~22~~25 Board of Directors - appointment of Vice Chair~~man~~

25.1 A Non-Executive Director shall be appointed the Vice Chair in accordance with the following procedure:

25.1.1 A recommendation as to an appropriate Non-Executive Director candidate for the position of Vice Chair shall be made by the Non-Executive Directors to the Board of Directors;

25.1.2 The Board of Directors shall consider the Non-Executive Directors' recommendation before compiling a formal proposal to the Nominations, Remuneration and Evaluation Committee;

25.1.3 Having considered the Non-Executive Directors' recommendation and the Board of Directors' proposal, the Nominations, Remuneration and Evaluation Committee shall make its recommendation of the Non-Executive Director candidate for the position of Vice Chair to the Council of Governors.

25.1.4 The Council of Governors at a general meeting o~~f the Council of Governors~~ shall appoint one of the Non-Executive Directors as a Vice Chair~~man~~ of the Trust.

Formatted: Heading 3, Indent: Left: 2.5 cm, Hanging: 1.25 cm, Tab stops: 3.75 cm, List tab

~~23~~26 Board of Directors - appointment and removal of the Chief Executive and other executive directors

~~23.1~~26.1 A committee consisting of the Chair~~man~~ and the other Non-Executive Directors shall appoint or remove the Chief Executive.

~~23.2~~26.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

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

~~23.3~~26.4 The Chief Executive may appoint one of the Executive Directors as deputy Chief Executive.

~~24~~27 Board of Directors - disqualification

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

~~24.1~~27.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

~~24.2~~27.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part7A of the Insolvency Act 1986);

~~24.3~~27.3 a person who has made a composition or arrangement with, or granted a trust deed for that person's creditors and has not been discharged in respect of it;

~~24.4~~27.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

~~24.5~~ Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Directors are ~~a person who falls within the further grounds for disqualification~~ set out in Annex 7.

Formatted: Indent: Left: 1.25 cm, No bullets or numbering

~~25~~28 Board of Directors – meetings

~~25.1~~28.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

~~25.2~~28.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting in public, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

~~26~~29 Board of Directors - Standing Orders

The Standing Orders for the practice and procedure of the Board of Directors are attached at Annex 7.

30 Board of Directors - conflicts of interest of Directors

~~26.1~~30.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

~~26.1.1~~30.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust;

~~26.1.2~~30.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

~~26.2~~30.2 The duty referred to in Clause 30.1.1 is not infringed if:

~~26.2.1~~30.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

30.2.2 the matter has been authorised in accordance with the Constitution

~~26.3~~30.3 The duty referred to in Clause 31.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

~~26.4~~30.4 In Clause 30.1.2, "third party" means a person other than:

~~26.4.1~~30.4.1 the Trust, or

~~26.4.2~~30.4.2 a person acting on its behalf.

~~26.5~~30.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

~~26.6~~30.6 If a declaration under this Clause proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

~~26.7~~30.7 Any declaration required by this Clause must be made before the Trust enters into the transaction or arrangement.

~~26.8~~30.8 This Clause does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

~~26.9~~30.9 A Director need not declare an interest:

~~26.9.1~~30.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

~~26.9.2~~30.9.2 if, or to the extent that, the Directors are already aware of it;

~~26.9.3~~30.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

~~26.9.3.1~~30.9.3.1 by a meeting of the Board of Directors, or

~~26.9.3.2~~30.9.3.2 by a committee of the Directors appointed for the purpose under the Constitution.

~~27~~31 Board of Directors - Remuneration and Terms of Office

~~27.1~~31.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair~~man~~ and the other Non-Executive Directors.

~~27.2~~31.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

~~28~~32 Registers

The Trust shall have:

~~28.1~~32.1 a register of members showing, in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which that member belongs;

~~28.2~~32.2 a register of members of the Council of Governors;

~~28.3~~32.3 a register of interests of Governors;

~~28.4~~32.4 a register of Directors; and

28.532.5 a register of interests of the Directors.

2933 Registers – inspection and copies

33.1 The Trust shall make the registers specified in paragraph 32 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

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

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

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

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

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

3034 Documents available for public inspection

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

30.1.134.1.1 a copy of the current Constitution;

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

30.1.334.1.3 a copy of the latest annual report;

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

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

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

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

30.2.434.2.4 a copy of any draft report published under Section 65F (administrator's draft report) of the 2006 Act;

~~30.2.5~~34.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

~~30.2.6~~34.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

~~30.2.7~~34.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

~~30.2.8~~34.2.8 a copy of any final report published under section 65I (administrator's final report);

~~30.2.9~~34.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act;

~~30.2.10~~34.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

~~30.3~~34.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

~~30.4~~34.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

~~31~~35 Auditor

~~31.1~~35.1 The Trust shall have an auditor.

~~31.2~~35.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

~~32~~36 Audit Committee

The Trust shall establish a committee of at least three Non-Executive Directors (at least one of whom has recent and relevant financial experience) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

~~33~~37 Accounts

~~33.1~~37.1 The Trust must keep proper accounts and proper records in relation to the accounts.

~~33.2~~37.2 NHS England may with the approval of ~~The~~ the Secretary of State ~~may with the approval of Treasury~~ give directions to the Trust as to the content and form of its accounts.

~~33.3~~37.3 The accounts are to be audited by the Trust's auditor.

~~33.4~~37.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as ~~Monitor~~ NHS England may with the approval of the Secretary of State direct.

~~33.5~~37.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

~~34~~38 Annual report and forward plans and non-NHS work

~~34.1~~38.1 The Trust shall prepare an annual report and send it to ~~Monitor~~NHS England.

~~34.2~~38.2 The Trust shall give information as to its forward planning in respect of each financial year to ~~Monitor~~NHS England.

~~34.3~~38.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

~~34.4~~38.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

~~34.5~~38.5 Each forward plan must include information about:

~~34.5.1~~38.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

~~34.5.2~~38.5.2 the income it expects to receive from doing so.

~~34.6~~38.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in Clause 38.5.1 the Council of Governors must:

~~34.6.1~~38.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

~~34.6.2~~38.6.2 notify the Directors of the Trust of its determination.

Formatted: Default Paragraph Font

38.7 ~~A Trust which~~ If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, it may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

~~34.7~~

~~35~~39 Presentation of the annual accounts and reports to the Governors and Members

~~35.1~~39.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

~~35.1.1~~39.1.1 the annual accounts

~~35.1.2~~39.1.2 any report of the auditor on them

~~35.1.3~~39.1.3 the annual report.

~~35.2~~39.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

~~35.3~~39.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of Clause 39.1 with the Annual Members' Meeting.

~~36~~40 Instruments

~~36.1~~40.1 The Trust shall have a seal.

~~36.2~~40.2 The seal shall not be affixed except under the authority of the Board of Directors.

~~37~~41 Amendment of the Constitution

~~37.1~~41.1 The Trust may make amendments of its Constitution only if:

~~37.1.1~~41.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

~~37.1.2~~41.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

~~37.2~~41.2 Amendments made under Clause 41.1 take effect as soon as the conditions in that Clause are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

~~37.3~~41.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

~~37.3.1~~41.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

~~37.3.2~~41.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

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

~~37.4~~41.4 Amendments by the Trust of its Constitution are to be notified by ~~Monitor~~NHS England. For the avoidance of doubt, ~~Monitor's~~ NHS England's functions do not include a power or duty to determine whether or not the Constitution as a result of the amendments, accords with schedule 7 of the 2006 Act.

~~38~~42 Mergers, etc and Significant Transactions

~~38.1~~42.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

~~38.2~~42.2 The Trust may only enter into a significant transaction if more than half of the members of the Council of Governors voting approve entering into the transaction.

~~38.3~~42.3 "**Significant Transaction**" means:

~~38.3.1~~42.3.1 the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's gross assets before the acquisition; or

~~38.3.2~~42.3.2 the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's gross assets before the disposition; or

~~38.3.3~~42.3.3 a transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trust's gross assets before the transaction.

~~38.4~~42.4 For the purpose of this Clause 42:

~~38.4.1~~42.4.1 "gross assets" means the total of fixed assets and current assets;

~~38.4.2~~42.4.2 in assessing the value of any contingent liability for the purposes of Clause 42.3.3, the Directors:

~~38.4.2.1~~42.4.2.1 must have regard to all circumstances that Directors know, or ought to know, affect or may affect, the value of the contingent liability; and

~~38.4.2.2~~42.4.2.2 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

~~38.4.2.3~~42.4.2.3 may take account of the likelihood of the contingency occurring.

~~38.4.3~~42.4.3 A statutory transaction under Clause 42.1 is not a significant transaction for the purposes of Clause 42.2.

~~39~~43 Indemnity

Members of the Council of Governors and the Board of Directors and the Company Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

~~40~~44 Validity of actions

No defect or deficiency in the appointment or composition of the Council of Governors or the Board of Directors shall affect the validity of any decision or action taken by them.

~~41 Interim Directors~~

~~Annex 10 makes provision for how the Interim Directors shall exercise the functions of the Trust on its behalf until such time as the Board of Directors is appointed in accordance with this Constitution.~~

Annex 1– The Public Constituencies

Name of the Public Constituency	Area of the Public Constituency	Minimum number of Members	Number of Governors ~~to be elected~~
Bournemouth	The following electoral wards: • Boscombe East & Pokesdown • Boscombe West • Bournemouth Central • East Cliff & Springbourne • East Southbourne & Tuckton • Kinson • Littledown & Iford • Moordown • Muscliff & Strouden Park • Queen's Park • Redhill & Northbourne • Talbot & Branksome Woods • Wallisdown & Winton West • West Southbourne • Westbourne & West Cliff • Winton East	**50**	**6**
Christchurch, East Dorset and Rest of England	The following electoral wards and all electoral wards in the rest of England not included in any other Area for the Public Constituency set out in this table: • Burton & Grange • Christchurch Town • Commons • Highcliffe & Walkford • Mudeford, Stanpit & West Highcliffe • Colehill & Wimborne Minster East • Corfe Mullen • Cranborne & Alderholt • Cranborne Chase • Ferndown North • Ferndown South • St Leonards & St Ives • Stour & Allen Vale • Verwood • West Moors & Three Legged Cross • West Parley	**50**	**5**

	• Wimborne Minster		
Poole and the Rest of Dorset	The following electoral wards: • Alderney & Bourne Valley • Bearwood & Merley • Broadstone • Canford Cliffs • Canford Heath • Creekmoor • Hamworthy • Newtown & Heatherlands • Oakdale • Parkstone • Penn Hill • Poole Town • Beacon • Beaminster • Blackmore Vale • Blandford • Bridport • Chalk Valleys • Charminster St Mary's • Chesil Bank • Chickerell • Crossways • Dorchester East • Dorchester Poundbury • Dorchester West • Eggardon • Gillingham • Hill Forts & Upper Tarrants • Littlemoor & Preston • Lyme & Charmouth • Lytchett Matravers & Upton • Marshwood Vale • Melcombe Regis • Portland • Puddletown & Lower Winterborne • Radipole • Rodwell & Wyke • Shaftesbury Town • Sherborne East • Sherborne Rural • Sherborne West • South East Purbeck • Stalbridge & Marnhull • Sturminster Newton • Swanage • Upwey & Broadwey • Wareham • Westham • West Purbeck	**50**	**6**

	• Winterborne & Broadmayne • Winterborne North • Yetminster		

Annex 2 – THE STAFF CONSTITUENCY

Classes within the Staff Constituency	Minimum number of Members	Number of Governors ~~to be elected~~
~~Medical and Dental~~Clinical (which shall comprise the former Medical and Dental; Allied Health Professions, Scientific and Technical; Nursing, Midwifery and Healthcare Assistants Classes)~~]~~	504	31
~~Allied Health Professions, Scientific and Technical~~Non-Clinical (which shall comprise the former Administrative, Clerical and Management; Estates and Ancillary Services Staff Classes)	504	~~2~~31
~~Nursing, Midwifery and Healthcare Assistants~~	~~4~~	~~1~~
~~Administrative, Clerical and Management~~	~~4~~	~~1~~
~~Estates and Ancillary Services~~	~~4~~	~~1~~

Annex 3– Composition of Council of Governors

1 **Majority of Public Governors**

1.1 The aggregate number of Public Governors must be more than half of the total number of members of the Council of Governors.

1.2 The Council of Governors shall comprise of Governors who are:

1.2.1 elected by the respective Constituencies in accordance with the provisions of this Constitution; or

1.2.2 appointed in accordance with paragraph 2 of this Annex.

2 **Bodies entitled to appoint a member of the Council of Governors**

2.1 ~~NHS Dorset CCG shall be entitled to appoint one Governor in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not preclude NHS Dorset CCG from appointing its Governor provided the appointment is duly made in accordance with the CCG's own internal processes.~~

2.2 Dorset Council and Bournemouth, Christchurch and Poole Council shall be entitled to appoint one Governor each in accordance with the process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not preclude the said local authority from appointing its Governor.

2.3 The Trust ~~shall~~ has nominated Bournemouth University and University Hospitals Dorset NHS Foundation Trust Volunteers Group to be designated as Partnership Organisations for the purposes of this Constitution. Bournemouth University and the University Hospitals Dorset NHS Foundation Trust Volunteers Group shall be entitled to appoint one Governor each in accordance with a process agreed by it with the ~~Trust~~Company Secretary. The absence of any process of appointment agreed with the Trust shall not preclude the said Partnership Organisation from appointing its Governor provided that appointment is duly made in accordance with the University's and the volunteer group's own internal processes.

~~2.3~~2.4 The Trust may nominate a Voluntary Organisation to be designated as a Partnership Organisation for the purposes of this Constitution. Such Voluntary Organisation shall be entitled to appoint one Governor in accordance with a process agreed by it with the Company Secretary, with the length of tenure to be agreed by the Trust, not to exceed the duration set out in Clause 13. The absence of any process of appointment agreed with the Trust shall not preclude the said Partnership Organisation from appointing its Governor provided that appointment is duly made in accordance with the Voluntary Organisation's own internal processes.

3 **Policy on Composition of the Council of Governors**

3.1 The Council of Governors, subject to the 2006 Act, shall seek to ensure that through the composition of the Council of Governors:

3.1.1 it has regard to the need for those eligible for membership of the Trust to be representative of those to whom the Trust provides services;

3.1.2 the interest of the community served by the Trust are appropriately represented;

3.1.3 the level of representation of the Public Constituency and the classes of the Staff Constituency and the Partnership Organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs;

3.1.4 the actual membership of the Public Constituency is representative of those eligible for such membership pursuant to section 61 of the 2006 Act;

and to this end, the Council of Governors:

3.1.5 shall at all times maintain a policy for the composition of the Council of Governors which takes into account the membership strategy; and

3.1.6 shall from time to time and not less than every three years review the policy for the composition of the Council of Governors; and

3.1.7 when appropriate shall propose amendments to the Constitution.

	Electing/Appointing Body	Number of Governors	Total
1	**Public Constituencies**		**17**
	1.1 Bournemouth	6	
	1.2 Christchurch, East Dorset and Rest of England	5	
	1.3 Poole and Rest of Dorset	6	
2	**Staff Constituencies**		**~~5~~6**
	2.1 ~~Medical and Dental~~Clinical	~~3~~1	
	2.2 ~~Allied Health Professionals, Scientific and Technical~~Non-Clinical	~~2~~3~~1~~	
	~~2.3 Nursing, Midwifery and Healthcare Assistants~~	~~1~~	
	~~2.4 Administrative, Clerical and Management~~	~~1~~	
	~~2.5 Estates and Ancillary Services~~	~~1~~	
3	**Appointed Governors**		**5**
	3.1 ~~NHS Dorset CCG~~	~~1~~	
	3.2 Dorset Council (Local Authority)	1	
	3.3 Bournemouth, Christchurch and Poole Council (Local Authority)	1	
	3.4 University Hospitals Dorset NHS Foundation Trust Volunteers Group (Partnership Organisation)	1	

	3.5 Bournemouth University (Partnership Organisation)	1	
	3.6 Voluntary Organisation (Partnership Organisation)	1	
	Total number of Governors	~~27~~28	~~27~~28

Annex 4 – Additional Provisions – Council of Governors

~~1 Terms of Office~~

~~1.1 A Governor shall be:~~

~~1.1.1 elected or appointed for a term of three years;~~

~~1.1.2 shall be eligible for re-election or re-appointment at the end of that term but may not serve as a Governor for more than a total of nine consecutive years. Years of office are consecutive unless there is a break of at least one year between them.~~

~~2~~1 **Eligibility to be on the Council of Governors**

~~2.1~~1.1 A person may not become or continue as a governor, and if already holding such office will immediately cease to do so if:

~~2.1.1~~1.1.1 any of the grounds contained in Clause 14 of the Constitution apply to that person;

~~2.1.2~~1.1.2 they cease to be a member of the Trust constituency they were elected to or, in the case of an Appointed Governor, if the body which appointed that person withdraws its appointment at any time;

1.1.3 they are a member of a committee which has, any role on behalf of a local authority to scrutinise and review health matters including a local authority's scrutiny committee covering health matters;

1.1.4 they are a member of a committee of the ~~Integrated Care Board~~ICB relevant to the oversight of the Trust's performance;

~~2.1.3~~

Formatted: No bullets or numbering

~~2.1.4~~1.1.5 they have, within the preceding two years been lawfully dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

~~2.1.5~~1.1.6 they are a person whose term of office as the chair~~man~~ or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the NHS, including non-attendance at meetings or non-disclosure of a pecuniary interest;

~~2.1.6~~1.1.7 they have had their name removed by a direction under Part 7 of the 2006 Act from any list prepared under Chapter 6 of that Act and has not subsequently had their~~his~~ name included in such a list and in addition, for example GMC, GDC, NMC;

~~2.1.7~~1.1.8 they have failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act;

~~2.1.8~~1.1.9 they are subject to a direction made under the Education Act 2011 or the Safeguarding Vulnerable Groups Act 2006;

~~2.1.9~~1.1.10 they are subject to a Sexual Offenders Order under the Sexual Offences Act 2003 or other relevant legislation;

~~2.1.10~~1.1.11 they have been previously removed as a Governor of the Trust, or been removed as a governor of another NHS foundation trust;

~~2.1.11~~1.1.12 they have received a written warning from the Trust for verbal and/or physical abuse towards Trust staff, patients, relatives or visitors;

~~2.1.12~~1.1.13 they have been determined by the Trust as a vexatious or persistent litigant or complainant with regard to the Trust's affairs and nine years have not passed since the date of lifting of such determination;

~~2.1.13~~1.1.14 the person is a member of a Staff Class and any professional registration relevant to his eligibility to be a member of that Staff Class has been suspended for a continuous period of more than six months;

~~2.1.14~~1.1.15 they were at any time eligible to be a member of the Staff Constituency during the period they are or were a member of a Public Constituency;

~~2.1.15~~1.1.16 they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;

~~2.1.16~~1.1.17 they are a Director of the Trust, or a governor or director of another NHS body (unless they are an Appointed Governor, appointed by an organisation which is an NHS body) or of an independent/private sector healthcare provider;~~.~~ ~~(These restrictions do not apply to Appointed Governors);~~

~~2.1.17~~1.1.18 they are a person who is not a fit and proper person as defined by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and/or condition G~~3~~4 of the Trust's provider licence.

~~2.1.18~~1.1.19 their term of office was terminated pursuant to paragraph ~~3~~ 2 of this Annex;

~~3~~2 **Termination of office and removal of a Governor**

~~3.1~~2.1 A person holding office as a Governor shall immediately cease to do so if:

~~3.1.1~~2.1.1 they cease to fulfil the requirements of paragraph 1~~2~~ above;

~~3.1.2~~2.1.2 they resign by notice in writing to the Company Secretary;

~~3.1.3~~2.1.3 they fail to attend two consecutive meetings of the Council of Governors, unless the Council of Governors is satisfied that:

(a) the absences were due to reasonable causes; and

(b) they will be able to start attending meetings of the Council of Governors again within such periods as is considered reasonable by the Council of Governors;

~~3.1.4~~2.1.4 in the case of an Elected Governor, they cease to be a member of the constituency or class of constituency by which they were elected;

~~3.1.5~~2.1.5 in the case of an Appointed Governor, the appointing Local Authority or Partnership Organisation terminates the appointment, the appointing Partnership Organisation ceases to exist or they withdraw themselves as the Appointed Governor representative;

~~3.1.6~~2.1.6 they have refused, without reasonable cause, to undertake training which the Council of Governors requires all Governors to take;

~~3.1.7~~2.1.7 they have failed to sign and deliver to the Company Secretary a statement in the form required by the Company Secretary confirming acceptance of the ~~code~~ Code of ~~conduct~~ Conduct for Governors.

~~3.2~~2.2 A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting at a meeting of the Council of Governors on the grounds that:

~~3.2.1~~2.2.1 they have committed a material breach of any code of conduct applicable to Governors of the Trust; and/or

~~3.2.2~~2.2.2 they have acted in a manner detrimental to the interests of the Trust, and/or

~~3.2.3~~2.2.3 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor. Circumstances where it may not be appropriate for an individual to continue as a Governor include the circumstances set out in paragraph 2.3;

~~3.3~~2.3 The Council of Governors may remove a Governor in accordance with paragraph 2.2 where the Council of Governors finds that their continuing as a Governor would or would be likely to:

~~3.3.1~~2.3.1 prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

~~3.3.2~~2.3.2 prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

~~3.3.3~~2.3.3 adversely affect public confidence in the goods and services provided by the Trust; or

~~3.3.4~~2.3.4 otherwise bring the Trust into disrepute or is detrimental to the interest of the Trust; or

~~3.3.5~~2.3.5 not in the best interests of the Trust for that person to continue in office as a Governor; or

~~3.3.6~~2.3.6 fail to comply in a material way with the values and principles of the NHS or the Trust.

~~3.4~~2.4 Upon a Governor resigning under paragraph 2.1.2 of this Annex or upon the Council of Governors resolving to terminate a Governor's tenure of office in accordance with the above provisions, that Governor shall cease to be a Governor and their name shall be removed from the register of Governors.

~~3.5~~2.5 The decision of the Council of Governors to terminate the tenure of office of the Governor concerned shall not take effect until the later of:

3.5.1 seven days after the date of decision; or

3.5.2 where the Governor applies for the decision to be referred to an independent assessor, the date on which the independent assessor determines the matter.

3.62.6 The Governor in question will be permitted to appeal any decision of the Council of Governors to terminate that Governor's tenure of office made in accordance with Annex 4 paragraph 2.23.4 in writing, within 28 days of the date upon which notice of the decision is received, for that decision to be referred to an independent assessor.

3.72.7 On receipt of an application under paragraph 23.6 above, the Council of Governors and the applicant Governor will co-operate in good faith to agree on the appointment of the independent assessor. If the parties fail to agree on the identity of the independent assessor within twenty-one days of the date upon which the application is received by the Council of Governors, then the Council of Governors shall request the Chartered Institute of Arbitrators to nominate an independent assessor.

3.82.8 The independent assessor will consider the evidence and conclude whether the decision to remove the Governor was reasonable or otherwise.

3.92.9 The independent assessor's decision will be binding on the parties. If the independent assessor finds that the decision of the Council of Governors to remove the Governor was not reasonable, the decision of the Council of Governors will be rescinded.

The Trust shall bear the independent assessor's costs unless the independent assessor determines that such costs shall be shared between the Trust and the Governor.

3.102.10 The Standing Orders adopted by the Council of Governors may contain provisions governing its procedure for termination under these provisions and for a Governor to appeal against the decision terminating their tenure of office.

3.112.11 A Governor:

2.11.1 who resigns or whose tenure of office is terminated under paragraph 2.1 of this Annex shall not be eligible to stand for re-election for a period of six years from the date of their resignation or removal from office, save where: ; or

- They are a Staff Governor and have voluntarily ceased employment with the Trust and no other circumstances in paragraph 2.1 apply;
- They are a Public Governor and have relocated to another public constituency and no other circumstances in paragraph 2.1 apply.

Formatted: Bulleted + Level: 1 + Aligned at: 1.89 cm + Indent at: 2.52 cm

3.11.12.11.2 whose tenure is terminated under paragraph 2.2 2.2 of this Annex shall not be eligible to stand for re-election for a period of nine years from the date of their removal from office or the date upon which any appeal against their removal from office is disposed of whichever is the later.

3.11.22.11.3 not less than twenty percent of the Governors may, where the process leading to the possible removal of a Governor has been initiated, require the appointment of an independent assessor to consider the evidence and advise as to the appropriateness of removal. It will also be available to the Chairman to initiate any such independent assessment at any time.

3.122.12 Where a person has been elected or appointed to be a Governor and that person becomes disqualified from that appointment that individual shall notify the Trust in writing of such disqualification as soon as practicable and in any event within fourteen days of first becoming aware of those matters which rendered the individual disqualified.

3.132.13 If it comes to the notice of the Trust that a Governor is disqualified, the Trust shall immediately declare Governor disqualified and shall give the Governor notice in writing to that effect as soon as practicable.

3.142.14 Upon the giving of notice under paragraphs 23.12 and 23.13 of this Annex, that person's tenure of office as a Governor shall thereupon be terminated and the individual shall cease to be a Governor and the individual's name shall be removed from the Register of Governors.

43 **Vacancies**

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

4.1.13.1.1 in the case of an Appointed Governor, the Company Secretary shall request that the appointing Partnership Organisation appoints a replacement to hold office for the remainder of the term of office; and

4.1.23.1.2 in the case of an Elected Governor, elections for a new governor shall take place as soon as practicable subject to the provisions of paragraphs 3.2 and 34.3 of this Annex.

4.23.2 Where an Elected Governor ceases for whatever reason to hold office within twelve months of that Elected Governor's election:

4.2.13.2.1 the Trust shall offer the candidate who was ranked next highest in the last election for the constituency, class or Staff Class (as the case may be) in which the vacancy has arisen the opportunity to assume the vacant office of Governor for the unexpired balance of the former Governor's term of office; or

4.2.23.2.2 if that candidate does not accept that invitation in a timely manner it shall be offered to that candidate who was next highest ranked in the last said election until the vacancy is filled; but if no other candidate stood for election or there are no remaining candidates who stood for election to that office or no candidate accepts the Trust's invitation in accordance with the above provisions within such time as the Trust may in its absolute discretion decide, the Trust shall hold an election for the vacancy as soon as reasonably practicable thereafter; or.

4.2.33.2.3 carry the vacancy until the next scheduled election takes place.

4.33.3 Notwithstanding the above provisions of this paragraph 4 3 of this Annex, where the termination of a Governor's term of office causes the total number of Public Governors to be equal to or fewer than the other Governors of the Trust then an election for that vacant office shall be held as soon as reasonably practicable.

4.43.4 No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

54 **Roles and Responsibilities of the Council of Governors**

5.14.1 The statutory duties of the Council of Governors are provided in Clause 15 of the Constitution.

~~5.2~~4.2 The Council of Governors and each Governor shall act in the best interests of the Trust at all times and with proper regard to the provisions of the ~~NHS Foundation Trust Code of~~Code of Governance for NHS Provider Trusts and the Trust's code of conduct for Governors.

~~5.3 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.~~

Remuneration of Governors

Formatted: Sch 2 Number, Indent: Left: -9 cm, Don't keep with next, Tab stops: -1.25 cm, Left

~~6.1~~4.3 Governors are not to receive remuneration.

~~6.2~~4.4 The Trust ~~will~~ may pay travelling expenses to Governors in accordance with Clause 19 of the Constitution.

~~7~~5 **Declarations**

~~7.1~~5.1 A member of a Public Constituency standing for election as Governor must make a declaration for the purposes of Section 60 of the 2006 Act in the form specified below stating the particulars of that member's qualification to vote as a member and that they are not prevented from being a member of the Council of Governors by virtue of any provisions of this Constitution. It is an offence to knowingly or recklessly make a statement or declaration which is false in a material particular.

~~7.2~~5.2 The specified form of declaration shall be set out on the nomination form referred to in the Model Election Rules at Annex 9 and shall state as follows:

I, the above named candidate, consent to my nomination and agree to stand for election. I confirm that, to the best of my knowledge, the information provided on (or with) this form is accurate. I also agree to abide by the University Hospitals Dorset NHS Foundation Trust code of conduct for Governors and the NHS core principles.

I declare that I am resident at the address given and that to the best of my knowledge I am eligible to stand for election to the Council of Governors for the area named overleaf. I declare that I am not debarred from standing by any of the provisions detailed in Section 1 of the guidance notes and the Exclusion and Disqualification criteria also detailed in the guidance notes supplied with this nominations paper. I understand if any declaration on this form is later found to be false I will, if elected, lose my seat on the Council of Governors and may have my membership withdrawn.

~~7.3~~5.3 A Governor elected to the Council of Governors by a Public Constituency or a Staff Class within the Staff Constituency may not vote at a meeting of the Council of Governors unless, within the period since that Governor's election, that Governor has made a declaration in the form specified in paragraph 5.4 of this Annex stating of which class of constituency that Governor is a member and that the Governor is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or by virtue of any provisions of this Constitution.

~~7.4~~5.4 The specified form of declaration referred to in paragraph 5.3 of this Annex shall state as follows:

I declare that I am a Member of the Public Constituency or Staff Class of the Staff Constituency and am eligible to vote at a meeting of the Council of Governors. I declare that I am not debarred from voting by any of the provisions detailed in paragraph 8 of Schedule 7 to the 2006 Act or by virtue of any provisions of this Constitution.

~~8~~6 **Appointment of Lead Governor**

6.1 The Council of Governors shall appoint one of the Governors to be Lead Governor of the Council of Governors.

6.2 The term of office for the Lead Governor shall be for a period of three years or the earlier of (a) such Lead Governor ceasing to be a member of the Council of Governors; and (b) resignation by such person of the position of Lead Governor by giving notice to the Chair and Company Secretary in writing.

6.3 The main duties of the Lead Governor are to:

6.3.1 Facilitiate a good working relationship among Governors with the support of the Company Secretary;

6.3.2 Provide additional assurance to Governors gained through meetings with the Chair;

6.3.3 Provide a regular link to the Chair and reflect the views of Governors on issues affecting the Trust and the Governors' role;

6.3.4 Contribute, along with the other members of the Council of Governors, to the process agreed with, and for the annual appraisal of the Chair led by the Senior Independent Director;

6.3.5 Act as a point of contact for NHS England should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate.

6.3.6 Be the conduit for raising with NHS England any Governor concerns that the Foundation Trust is at risk of significantly breaching the conditions of its Provider Licence, having first made every attempt to resolve any such concerns locally;

6.3.7 Be a point of contact when Governors wish to seek advice and/or raise issues;

6.3.8 Chair such parts of meetings of the Council of Governors when required to do so by the Standing Orders at Annex 5;

6.3.9 Prepare and present a report from the Council of Governors at the Annual Members' meeting;

6.3.10 Such other duties consistent with the 2006 Act and this Constitution, as may be approved by the Council of Governors from time to time.

6.4 The Company Secretary shall ensure that NHS England is provided with details of the serving Lead Governor.

~~8.1~~

Formatted: Indent: Left: 0 cm, Hanging: 1 cm

Formatted: Sch 3 Number, Indent: Left: 1 cm

Annex 5 – Standing Orders for the Practice and Procedure of the Council of Governors

FOREWORD

This document provides a regulatory and business framework for the conduct of the Council of Governors.

1 **Interpretation and definitions**

1.1 These Standing Orders are the standing orders referred to in Clause 17 of the Constitution. If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

1.2 In these Standing Orders, the following expressions have the following meanings:

Meeting means a duly convened meeting of the Council of Governors;

Other terms defined in the Constitution shall have the same meaning in these Standing Orders.

2 **Composition of the Council of Governors**

The composition of the Council of Governors shall be as set out in Annex 3 of the Constitution.

3 **Appointment of the Chair~~man~~ and Non-Executive Directors**

The Chair~~man~~ and Non-Executive Directors are appointed by the Council of Governors in accordance with Clause 24 of the Constitution and Standing Order 21 below.~~.~~

4 **Terms of Office of the Chairman and Non-Executive Directors**

The provisions governing the period of tenure of office of the Chair~~man~~ and the Non-Executive Directors are contained in Clause 31 of the Constitution.

5 **Removal of Chair and other Non-Executive Directors**

The removal of the Chair or other Non-Executive Directors shall be in accordance with Clause 24 of the Constitution and subject to the following procedures.

5.1 The Council of Governors should raise issues to the Chair or in the case of the Chair to the Senior Independent Director prior to any formal action to remove a Non-Executive Director or the Chair.

5.2 Any proposal for removal must be proposed by a Governor and seconded by not less than ten Governors.

5.3 Written reasons for the proposal shall be provided to the Chair or Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.

5.4 In making any decision to remove the Chair or a Non-Executive Director, the Council of Governors shall take into account the annual appraisal carried out by the Chair or Senior Independent Director, respectively.

Formatted: Sch 1 Number, Indent: Hanging: 0.5 cm, Keep with next

Formatted: Font: Bold

5.5 A decision to remove the Chair or a Non-Executive Director will only be effective if such decision is approved by not less than three quarters of the total number of the Council of Governors.

Formatted: Sch 2 Number, Indent: Left: 1.27 cm

5.16 Appointment of Vice Chairman of the Board and of the Council of Governors

5.16.1 The Council of Governors shall appoint a Vice Chairman in accordance with Clause 25 of the Constitution.

5.26.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman (in the Chairman's capacity of Chair of the Board of Directors and Chair of the Council of Governors). The Council of Governors may thereupon appoint another Non-Executive Director as Vice Chairman in accordance with Clause 25 of the Constitution.

5.36.3 The Vice-Chairman may preside at meetings of the Council of Governors in the following circumstances:

5.3.16.3.1 when there is a need for someone to have the authority to chair any meeting of the Council of Governors when the Chairman is not present;

5.3.26.3.2 when the remuneration, allowances and other terms and conditions of the Chairman are being considered;

5.3.36.3.3 when the appointment of the Chairman is being considered, should the current Chairman be a candidate for reappointment;

5.3.46.3.4 on occasions when the Chairman declares a pecuniary interest that prevents that person from taking part in the consideration or discussion of a matter before the Council of Governors.

MEETINGS OF THE COUNCIL OF GOVERNORS

6 Admission of the Public

The Meetings of the Council of Governors shall be open to members of the public (which, for the avoidance of doubt, shall include representatives of the press) unless the Council of Governors resolves that the public be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings. The Chairman may also exclude any member of the public from a Meeting of the Council of Governors if that individual is interfering with or preventing the proper conduct of the Meeting.

7 Chairman of Meetings

The Chairman of the Trust, or in that person's absence, the Vice Chairman is to preside at Meetings of the Council of Governors. If the Chairman is absent from a Meeting or temporarily absent on the grounds of a declared conflict of interest the Vice Chairman shall preside. If the Chairman and Vice Chairman are absent from the Meeting or absent temporarily on the grounds of a declared conflict of interest, such Non-Executive Director as the Gg overnors present shall choose shall preside. If the person presiding has a conflict

of interest in relation to the business being discussed the Lead Governor will chair that part of the meeting.

~~8~~9 Calling Meetings

~~8.1~~9.1 The Council of Governors will meet at least four times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least seven days' written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website. Seminars, workshops or similar events involving Governors are not to be treated as Meetings of the Council of Governors.

9.2 Meetings of the Council of Governors are called by the Company Secretary or by the Chair~~man~~ or by ten governors (including at least two Public or Staff Governors and two Appointed Governors) who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Company Secretary shall call a Meeting within at least seven, but not more than 28 days, to discuss the specified business. If the Company Secretary fails to call such a Meeting within seven clear days, then the Chair~~man~~ or ten Governors, whichever is the case, shall call such a Meeting.

~~9.2~~9.3 Meetings may be transacted through virtual media (including, but not limited to, video conferencing).

~~9~~10 Agendas and Papers

~~9.1~~10.1 An agenda, copies of any questions on notice and/or motions on notice to be considered at the relevant Meeting and any supporting papers shall be sent to each Governor so as to arrive with each Governor normally no later than ~~five~~three clear ~~7~~ days in advance of each Meeting. Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item.

~~9.2~~10.2 The Council of Governors may determine that certain matters shall appear on every agenda for a Meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

~~9.3~~10.3 A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included in request in writing to the Chair~~man~~ or Company Secretary at least fourteen days before the Meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than fourteen clear days before the Meeting may be included on the agenda at the discretion of the Chair~~man~~. Receipt of such matters via electronic means is acceptable.

~~10~~11 Notices of Motion

~~10.1~~11.1 A Governor desiring to move or amend a motion shall send a written notice thereof at least ~~fourteen~~ ten clear days before the Meeting to the Chair~~man~~ or Company Secretary, who shall insert in the agenda for the Meeting all notices so received subject to the notice being permissible under the appropriate regulations. For the purposes of this Standing Order 10, receipt of any such motions via electronic means is acceptable. All motions received by the Chair~~man~~ or Company Secretary will be acknowledged by the Company Secretary in writing to the Governors who have signed or transmitted the same. This paragraph shall not prevent any motion being moved during the Meeting, without notice on

any business mentioned on the agenda in accordance with Standing Order 11 of this Annex, subject to the Chair~~man~~'s discretion.

~~10.2~~11.2 Motions must be about matters for which the Council of Governors has a responsibility or which affect the area covered by the Trust.

~~11~~12 **Motions without Notice**

~~11.1~~12.1 The following motions may be moved without notice:

~~11.1.1~~12.1.1 to change the order of business in the agenda for the Meeting;

~~11.1.2~~12.1.2 to refer a matter discussed at a Meeting to an appropriate body or individual;

~~11.1.3~~12.1.3 to appoint a group arising from an item on the agenda for the Meeting;

~~11.1.4~~12.1.4 to receive reports or adopt recommendations made by the Board of Directors;

~~11.1.5~~12.1.5 to withdraw a motion;

~~11.1.6~~12.1.6 to amend a motion;

~~11.1.7~~12.1.7 to proceed to the next business on the agenda;

~~11.1.8~~12.1.8 that the question now be put;

~~11.1.9~~12.1.9 to adjourn a debate;

~~11.1.10~~12.1.10 to adjourn the Meeting;

~~11.1.11~~12.1.11 to suspend a particular Standing Order contained within these Standing Orders in accordance with Standing Order 26.~~(provided that any Standing Orders may only be suspended if at least one half of the aggregate number of Governors are present at the Meeting in question and provided also that the Standing Order in question may only be suspended for the duration of the Meeting in question);~~

~~11.1.12~~12.1.12 to exclude the public and press from the Meeting in question; ~~(the motion shall be "To exclude the press and public from the remainder of the Meeting, owing to the confidential nature of the business to be transacted");~~

~~11.1.13~~12.1.13 to not hear further from a Governor, or to exclude them from the Meeting in question (if a Governor persistently disregards the ruling of the Chair~~man~~ or behaves improperly or offensively or deliberately obstructs business, the Chair~~man~~, in their~~its~~ absolute discretion, may move that the Governor in question be not heard further at the Meeting in question. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chair~~man~~ may move that either the Governor leaves the meeting room or that the Meeting in question is adjourned for a specified period. If seconded, the motion will be voted on without discussion);

~~11.1.14~~12.1.14 to give the consent of the Council of Governors to any matter where its consent is required pursuant to the Constitution.

~~12~~13 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be in writing and shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor to propose a motion to the same effect within six months.

~~13~~14 Questions from Governors

~~13.1~~14.1 A Governor may ask a question through the Chair~~man~~ without notice upon a report from an Executive Director or other Officer of the Trust when that item is being received or under consideration by the Council of Governors.

~~13.2~~14.2 Questions relating to matters other than those under report may be asked with due notice. For the avoidance of doubt, questions on notice must be given in writing (including email) to the Company Secretary at least ~~fourteen~~ ten clear days in advance of the Meeting. If the question is urgent and with the agreement of the person to whom the question is being put, the content of the question may be given to the Company Secretary by 10.00am on the day of the Meeting (if the Meeting is scheduled for the afternoon) or by 2.00pm on the preceding day (if the Meeting is scheduled for the morning). Urgent is defined as a matter that will adversely affect the Trust in the next seven days.

~~14~~15 Chair~~man~~'s Ruling

~~14.1~~15.1 Statements of Governors made at Meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair~~man~~ of the Meeting on questions of order, relevancy, regularity and any other matters shall be observed at the Meeting.

~~14.2~~15.2 Save as permitted by law, at any Meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which that person should be advised by the Chief Executive).

~~15~~16 Voting/Decision-Making

~~15.1~~16.1 Save as otherwise provided in the Constitution and/or the 2006, 2012 or 2022 Act~~s and/or the 2012 Act~~, and these Standing Orders if the Chair~~man~~ so determines or if a Governor requests, questions at a Meeting shall be determined by a majority of the votes of the Governors present and voting on the question.

~~15.2~~16.2 At the Meeting of the Council of Governors a vote shall be decided ~~on a~~by oral expression or a show of hands, the result being declared by the Chair~~man~~ and recorded in the minutes. The entry in the minutes shall confirm the result without recording the number of proportion in favour or against the motion unless a request is made under Standing Order 15.~~4~~8. Every Governor shall have one vote ~~whether voting in person~~.

~~15.3~~16.3 A paper ballot may be used if a majority of the Governors present so request. If a paper ballot is used, it shall be taken at such time and place and in such a manner as the Chair~~man~~ of the Meeting shall direct and the result of the ballot shall be deemed to be the resolution of the Meeting at which the ballot was demanded. The ~~demand~~ request for a

ballot shall not prevent the continuance of a Meeting for the transaction of any business other than the question on which a ballot has been requesteddemanded.

15.416.4 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

15.516.5 No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

16.6 If a Governor so requests, that Governor's vote shall be recorded by name upon any vote (other than by paper ballot).

15.616.7 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

16.8 All decisions taken in good faith at a Meeting of the Council of Governors shall be valid even if it is discovered subsequently that there was a defect in the calling of the Meeting, or the appointment of the Governors attending the Meeting.

17 Written Resolutions

176.1 In exceptional circumstances, and with the agreement of the Chair, a Governor or Director may propose a written resolution to the Council of Governors.

176.2 Notice of the written resolution will be given by the Company Secretary, stipulating the proposed resolution and the long-stop date by which responses must be received. This long-stop date should be no less than seven days from the date the notice is dispatched by the Company Secretary.

176.3 The notice must be given in writing, either by email or post.

176.4 A proposed written resolution shall be adopted when it has been signed and returned to the Company Secretary by email or post by a majority of members of the Council of Governors. Where a member of the Council of Governors returns the proposed written resolution to the Company Secretary by email it shall be deemed to have been duly signed even in the absence of a physical signature.

176.5 The proposed written resolution shall lapse if it has not been signed and returned to the Company Secretary by the required number of members of the Council of Governors by the long-stop date.

176.6 If a written resolution is adopted it shall be reported to the next meeting of the Board of DirectorsCouncil of Governors and treated as if it was a decision taken at a Board Council of Governors meeting in accordance with these Standing Orders.

Formatted: Heading 2, Indent: Hanging: 1.25 cm, Space Before: 0 pt, After: 0 pt

Formatted: No bullets or numbering

1618 Attendance

The names of the Chairman and Governors present at the meeting shall be recorded in the minutes. Governors who are unable to attend a meeting shall notify the Company Secretary in advance of the Meeting so that their apologies may be recorded. For the avoidance of doubt, attendance may include through virtual media.

~~17~~19 **Quorum**

~~17.1~~19.1 No business shall be transacted at a Meeting of the Council of Governors unless at least nine of the Council of Governors are present and that those present include at least one Staff Governor, seven Public Governors and one Appointed Governor. At the start of each meeting, the Chair shall be responsible for determining that the meeting is quorate.

~~17.2~~19.2 A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the Meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the Meeting room, and will not count towards the quorum of the Meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that Meeting. Such a position shall be recorded in the minutes of the Meeting. The Meeting must then proceed to the next business.

~~17.3~~19.3 Subject to Standing Orders in relation to interests, any director or their nominated representatives shall have the right to attend Meetings of the Council of Governors and, subject to the overall control of the Chair~~man~~, to speak to any item under consideration.

~~18~~20 **Minutes**

~~18.1~~20.1 The minutes of the proceedings of a Meeting shall be drawn up and submitted for agreement at the next ensuing Meeting ~~where they will~~ and shall be signed by the person presiding at it. The approved minutes will be conclusive evidence of the events of the Meeting and retained by the Company Secretary.

~~18.2~~20.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair~~man~~ considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next Meeting.

COMMITTEES

~~19~~21 **Committees**

~~19.1~~21.1 The Council of Governors may not delegate any of its functions or powers to a committee or sub-committee, but it may appoint committees to assist the Council of Governors in carrying out its role. The Council of Governors may, through the Company Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

~~19.2~~21.2 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors.

~~19.3~~21.3 Each committee and sub-committee shall have such terms of reference and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with any guidance issued by ~~Monitor~~NHS England and any legislation or applicable guidance issued by the Secretary of State.

~~19.4~~21.4 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

~~19.5~~21.5 A Governor or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the committee shall resolve that it is confidential.

~~19.6~~21.6 The Council of Governors shall establish the Non-Executive Director Nominations, Evaluation and Remuneration Committee to advise the Council of Governors on its functions in relation to the appointment of the Chair~~man~~ and non-executive directors as further described in Standing Orders 21.8 and 21.9 below.

~~19.7~~21.7 The Council of Governors shall resolve in a general meeting to appoint such candidate or candidates (as the case may be) as it considers appropriate and on reaching its decision it shall have regard to the Board of Directors and of the Nominations, Remuneration and Evaluation Committee as to the suitability of the available candidates.

~~19.8~~21.8 The role of the Nominations Evaluation and Remuneration Committee shall be as follows:

~~19.8.1~~21.8.1 to determine the criteria of process for the selection of candidates for office as Chair~~man~~ or other Non-Executive Director of the Trust having first consulted with the Board of Directors as to these matters and having regard to such views as may be expressed by the Board of Directors;

~~19.8.2~~21.8.2 to seek by way of open advertisements and other means candidates for office and to assess, shortlist and select for interview such candidates as are considered appropriate and in doing so the committee shall be at liberty to seek advice and assistance from persons other than members of the committee or of the Council of Governors such as external organisations recognised as experts at appointment to identify the skills and experience required of Chair~~man~~ and Non-Executive Directors;

~~19.8.3~~21.8.3 to make recommendations to the Council of Governors as to potential candidates for appointment as Chair~~man~~ or other Non-Executive Director, as the case may be.

~~19.9~~21.9 The Nominations, Evaluation and Remuneration Committee shall:

~~19.9.1~~21.9.1 on a regular and systematic basis monitor the performance of the Chair~~man~~ and other Non-Executive Directors and make reports thereon to the Council of Governors from time to time when requested to do so or when in the opinion of the committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors; and

~~19.9.2~~21.9.2 consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chair~~man~~ and Non-Executive Directors;

~~19.9.3~~21.9.3 review the structure, size and composition of the Board of Directors from time to time and to make any recommendation to the Council of Governors.

DECLARATIONS OF INTEREST AND REGISTER OF INTERESTS

2022 Declaration of Interests

20.122.1 In accordance with Clause 18 of the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interests (including, but not limited to, financial interests, non-financial professional interests, non-financial personal interests and indirect interests) which is are relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

20.2 A Governor must declare to the Company Secretary:

20.2.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and

nily or loyalty interests) which are relevant and material to the business of the Trust.

Formatted: Sch 2 Number, Indent: Left: 0 cm, First line: 0 cm

20.322.2 Such a declarationDeclarations shall be made by completing and signing a form, as prescribed by the Company Secretary from time to time., This shall setting out any interests required to be declared in accordance with the Constitution or these Standing Orders, or set out that there are no such interests to declare, and delivering it shall be delivered to the Company Secretary within twenty eight days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest.

- Within twenty-eight days of a Governor's election or appointment; and
- On an annual basis; and
- Otherwise within seven days of becoming aware of the existence of a relevant or material interest.

Formatted: Bulleted + Level: 1 + Aligned at: 0.63 cm + Indent at: 1.27 cm

If the Governor is in any doubt whether an interest should be disclosed, they should discuss the position with the Chairman or Company Secretary.

The Company Secretary shall ensure that amend the register of interests is amended within three working days of receipt of notification.

20.422.3 If a Governor is present at a Meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration (irrespective of having previously disclosed), the Governor shall at the Meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if the Governor has declared a pecuniary interest, the Governor shall not take part in the consideration or discussion of the matter. The provisions of this Standing Order are subject to Standing Order 22.7 of this Annex.

20.522.4 A material relevant interest is:

20.5.122.4.1 any directorship of a company including non-executive directorships held in limited companies (with the exception of dormant companies);

20.5.222.4.2 any interest or position in any firm, company, business, which in connection with the matter has or is likely to have a trading or commercial relationship with the Trust; Any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding is less than 2% of the total shares

in issue) held by a Governor in any firm or company or business which, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust.

22.4.3 ~~any interest in a voluntary or other organisation providing health and social care services to the National Health Service;~~ Any interest in an organisation providing health and social care services to the NHS.

~~20.5.3~~22.4.4 any interest in an organisation involved in the regulation or oversight of the Trust;

~~20.5.4~~22.4.5 ~~any interest held by a Governor or a spouse/partner~~their family ~~in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;~~

~~20.5.5~~22.4.6 a position of authority in a charity or voluntary organisation in the field of health and social care;

~~20.5.6~~22.4.7 ~~any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.~~ Any other interest that may conflict or be perceived to conflict with the performance of the Governor's duties.

~~20.5.7 research funding/grants that may be received by an individual or their department;~~

~~interests in pooled funds that are under separate management.~~

22.5 An interest will be deemed relevant if it is held by the Governor, their spouse or partner or immediate relative.

~~20.6~~22.6 For the avoidance of doubt relevant interest includes employment (including self-employment or private work).

~~20.7 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:~~

~~20.7.1 the Governor or a nominee of the Governor, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or~~

~~20.7.2 the Governor is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.~~

~~20.8~~22.7 The exceptions which shall not be treated as material interests are as follows:

~~20.8.1 membership of a company or other body, if the Governor has no beneficial interest in any securities of that company or other body;~~

~~20.8.2 an interest in any company, body or person with which they are~~he is ~~connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter;~~

~~20.8.3 an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body and:~~

~~(a) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and~~

~~(b)~~(a) ~~if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one hundredth of the total issued share capital of that class,~~

~~20.8.4~~22.7.2 an employment contract held by Staff Governors;

~~20.8.5~~22.7.3 an Appointed Governor's employment contract with their appointing organisation; or

~~20.8.6~~22.7.4 any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution.

~~20.9~~22.8 In the case of an interest that falls within paragraph Annex 11.1.1 the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to the Governor's duty to disclose the interest.

Field Code Changed

~~20.10~~22.9 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these Standing Orders to be also an interest of the other.

~~21~~23 **Conflict of Interest**

During the course of a Council of Governors Meeting, if a conflict of interest is disclosed the Governor concerned shall withdraw from the Meeting and take no further part in the matter under discussion.

~~22~~24 **Register of Interests**

~~22.1~~24.1 The Company Secretary shall record any declarations of interest made in a register of interests kept in accordance with Clause 32.3 of the Constitution. Any interest declared at a Meeting shall also be recorded in the minutes of the Meeting.

~~22.2~~24.2 The register will be available for inspection by members of the public free of charge at all reasonable times. A person who requests it is to be provided with a copy or extract from the register.

~~22.3~~24.3 In establishing, maintaining, updating and publicising the register, the Trust shall comply with all guidance issued from time to time by ~~Monitor~~NHS England.

STANDARDS OF BUSINESS CONDUCT

~~23~~25 **Standards of business conduct**

~~23.1~~25.1 In relation to their conduct as a Governor of the Trust, each Governor must comply with the Constitution, the ~~Trust's code of conduct~~Code of Conduct for Governors, the ~~NHS Foundation Trust Code of Governance,~~Code of Governance for NHS Provider Trusts, all applicable Trust policies, the requirements of the law and any guidance issued by NHS England ~~Monito~~r.

~~23.2~~25.2 Governors ~~will~~ must confirm their agreement to adhere to the ~~Trust's c~~Code of ~~conduct~~ Conduct for Governors by signing a copy annually and returning it to the Company Secretary.

~~23.3~~25.3 Canvassing of Directors or Governors or of any members of any committee of the Trust directly or indirectly for any appointment by the Trust shall disqualify the candidate for such appointment.

~~23.4~~25.4 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this Standing Order shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

~~24~~26 **Interest of Governors in Contracts**

If it comes to the knowledge of a Governor that a contract in which the Governor has any pecuniary interest not being a contract to which the Governor is a party, has been, or is proposed to be, entered into by the Trust the Governor shall, at once, give notice in writing to the Company Secretary of the fact that the Governor is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

STANDING ORDERS

~~25~~27 **Suspension of Standing Orders**

27.1 Except where this would contravene any statutory provision or any direction made by NHS England ~~Monitor~~, any one of the Standing Orders may be suspended at any Meeting, provided that at least two-thirds of the Council of Governors are present, including one Public Governor and one Staff Governor, and that a majority of those present vote in favour of suspension.

~~25.1~~27.2 A decision to suspend Standing Orders shall apply only for the duration of the Meeting in question.

~~25.2~~27.3 A decision to suspend Standing Orders shall be recorded in the minutes of the Meeting.

~~25.3~~27.4 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair~~man~~ and the members of the Council of Governors.

~~25.4~~27.5 No formal business may be transacted while Standing Orders are suspended.

~~26~~28 **Variation and Amendment of Standing Orders**

These Standing Orders may only be amended in accordance with Clause 41 of the Constitution.

~~27~~29 **Review of Standing Orders**

These Standing Orders shall be reviewed annually by the Council of Governors. The requirement for review extends to all documents having effect as if incorporated in these Standing Orders.

Annex 6 - Governors and Directors: Communication and Conflict

1 **Summary**

This Annex describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal and formal communications between the Council of Governors and the Board of Directors.

2 **Informal Communications**

2.1 Informal and frequent communication between the Governor and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

2.2 The Chair~~man~~ shall use reasonable endeavours to encourage effective informal methods of communication including:

2.2.1 participation of members of the Board of Directors in the induction, orientation and training of Governors;

2.2.2 development of ~~special interest~~ relationships between Non-Executive Directors and Governors such as through Board and Council of Governors Development Sessions;

2.2.3 discussions between Governors and the Chair~~man~~ and/or the Chief Executive and/or Directors through the office of the Chief Executive or a nominated officer;

2.2.4 involvement in membership recruitment and briefings at public events organised by the Trust.

3 **Formal Communication**

3.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

3.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

3.2.1 specific requests by the Council of Governors will be made through the Chair~~man~~ to the Board of Directors;

3.2.2 any Governor has the right to raise specific issues to be put to the Board of Directors at a Meeting of the Council of Governors through the Chair~~man~~ but if the Chair~~man~~ declines to raise any such issue the said Governor may nonetheless still raise it provided two thirds of the Governors present approve the request to do so. The Chair~~man~~ shall then raise the matter with the Board of Directors and provide the response to the Council of Governors;

3.2.3 joint meetings will take place between the Council of Governors and the Board of Directors as and when appropriate as determined by the Chair~~man~~ (in the capacity as the Chair~~man~~ of both the Board of Directors and the Council of Governors).

3.3 The Board of Directors may request the Chair~~man~~ to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

3.4 Communications between the Council of Governors and the Board of Directors may occur with regard to, but shall not be limited to:

3.4.1 the Board of Directors proposals for the strategic direction and the annual business plan, including information on ICS plans, decisions and delivery that directly affect the organisation and its patients;

3.4.2 the Board of Directors' proposals for developments;

3.4.3 Trust performance;

3.4.4 involvement in service reviews and evaluation relating to the Trust's services; and

3.4.5 proposed changes, plans and developments for the Trust ~~other than may be covered by paragraph Annex 87.6 of this Annex~~not covered by paragraph 3.4 above.

3.5 Some or all of t~~T~~he Board of Directors shall also present to the Council of Governors the Annual Accounts, Annual Report and Auditor's Report in accordance with the terms of this Constitution and of the 2006 Act.

3.6 The following formal methods of communication may also be used as appropriate ~~with the consent of both the Council of Governors and the Board of Directors~~:

3.6.1 attendance by ~~the~~ Directors at a Meeting of the Council of Governors;

3.6.2 provision of formal reports or presentations by Executive Directors to a m~~M~~eeting of the Council of Governors;

3.6.3 inclusion of appropriate minutes for information on the agenda of a m~~M~~eeting of the Council of Governors;

3.6.4 reporting the views of the Council of Governors to the Board of Directors though the Chair~~man~~ or Vice Chair~~man~~ or the Senior Independent Director.

4 Other Communication

4.1 The Governors are welcomed to public meetings of the Board of Directors. There is an item on each Part 1 agenda "Questions from the Governors". These are requested by the Chair~~man~~, enabling individual Governors to put questions to the Board of Directors. Verbal responses will be supplied as far as is reasonable at the time of the meeting ~~and reported in the minutes of the meeting.~~ . The Chair~~man~~ has discretion to manage this item in the light of other Board of Directors business. It is also a matter for Governors as to whether the question is for a formal Board of Directors' Meeting or can be raised through the informal route. ~~Board time is set aside for informal discussion between individual Governors and Board Members prior to commencement of the public meetings.~~ Shortly following a Board of Directors' meeting a briefing meeting takes place with the Chair~~man~~ and Governors with the purpose of informing the Governors as far as reasonable about the discussions conducted under the private session of the Board of Directors meetings. Executive and Non-Executive Directors may exceptionally attend these briefings to support the Chair~~man~~ and impart further information if required. The Chairs~~chairmen~~ of the committees of the Board of Directors ~~may~~ are also to periodically attend meetings or briefings ~~annually~~ to discuss the work of the ~~sub~~-committees to assist the Council of Governors in their duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

~~4.1~~

5 Senior Independent Director

5.1 The Senior Independent Director (SID) can act as an alternative source of advice to Governors from the Chair.

5.2 The SID shall be available to Governors if they have concerns that contact through normal channels has failed to resolve any issues which been raised or for which such contact is inappropriate.

Formatted: Indent: Hanging: 1.25 cm

Formatted: Heading 2, Indent: Hanging: 1.5 cm, Don't keep with next

Formatted: Font: Not Bold

~~5~~6 Dispute Resolution Procedure

~~5.1~~6.1 The Council of Governors adopts a policy to proactively engage with the Board of Directors in those circumstances where they have concerns. The Council of Governors is encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective. Governors can raise concerns with the Company Secretary who may in the first instance be able to resolve the matter informally.

~~5.2~~6.2 Where the Company Secretary has been unable to resolve the matter, t~~T~~he Lead Governor shall be the first point of contact when Governors wish to seek advice and/or raise issues and who acts as the Council of Governors lead representative to the Chair~~man~~ on Governor matters.

~~5.3~~6.3 In the event of a dispute arising between the Council of Governors and the Board of Directors, the Chair~~man~~ (or Vice-Chair~~man~~ if the dispute involves the Chair~~man~~) will endeavour to resolve the dispute informally, through discussions within the Council of Governors.

~~5.4~~6.4 Within twenty-eight days of the Council of Governors or the Board of Directors resolving that a dispute exists with the other, the Company Secretary shall call a joint meeting to be held as soon as reasonably practicable within three months of the resolution. The joint meeting shall be held under the Trust's Board of Directors' Standing Orders, but the provisions of the Standing Orders of the Council of Governors in relation to interests shall apply to Governors attending the joint meeting as they apply to a Council of Governors meeting.

~~5.5~~6.5 The joint meeting shall be chaired by the Chair~~man~~ and the agenda shall be agreed with the Chief Executive. The joint meeting shall either recommend to each of the constituents a formula for resolving the dispute which each shall receive and consider formally as soon as practicable, or, if possible, shall agree the relevant issues and the possible ways forward.

~~5.6~~6.6 If either constituent resolves to refer the issue to mediation, the Lead Governor and a second nominated Governor on behalf of the Council of Governors and the Chief Executive and the Vice-Chair~~man~~ of the Board of Directors shall meet within twenty eight days of such resolution to agree a mediator. In default of agreement, either constituent may resolve to refer the dispute for resolution by ~~Monitor~~NHS England.

~~5.7~~6.7 On the satisfactory completion of this disputes process the Board of Directors or Council of Governors, as appropriate, shall implement any agreed actions.

~~5.8~~6.8 The existence of the dispute shall not prejudice the duty of the Board of Directors in the exercise of the Trust's powers on its behalf.

~~5.9~~6.9 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing ~~Monitor~~ NHS England that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors and that the Trust is not meeting the conditions of its provider licence. The Lead Governor will act as the conduit between the Council of Governors and ~~Monitor~~NHS England.

Annex 7– Standing Orders for the Practice and Procedure of the Board of Directors

FOREWORD

This document, together with the Standing Financial Instructions provides a regulatory framework for the business conduct of the Trust.

All Executive and Non-Executive Directors should be aware of the existence of this document and, where necessary, be familiar with the detailed provisions.

SECTION A: INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

1 **Interpretation and definitions**

1.1 Save as otherwise permitted by law, at any Board of Directors' meeting the Chair~~man~~ of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Company Secretary).

1.2 Wherever the title Chief Executive, Director or other Nominated Officer is used in these Standing Orders, it should be deemed to include such other officers who have been duly authorised to represent them in their absence.

1.3 Any expression to which a meaning is given in the 2006 Act, as amended by the 2012 Act, and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders.

1.4 Other items defined in the Constitution shall have the same meaning in these Standing Orders.

Commissioning	means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
Committee	means a committee or sub-committee created and appointed by the Board of Directors.
Committee Members	means persons formally appointed by the Board to sit on or to chair specific committees.
Contracting and procuring	means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Funds held on trust	shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under section 51 of the 2006 Act. Such funds may or may not be charitable.

Nominated Officer	means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Officer	means employee of the Trust or any other person holding a paid appointment or office with the Trust.
SFIs	means Standing Financial Instructions.
SOs	means Standing Orders.

SECTION B:STANDING ORDERS

2 Introduction

2.1 Statutory Framework

2.1.1 University Hospitals Dorset NHS Foundation Trust (the Trust) is a public benefit corporation which came into existence on 1 October 2020 following the grant of an application by Monitor pursuant to section 56 of the 2006 Act and the Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (Dissolution and Transfer of Property and Liabilities) Order 2020 made on 18 September 2020 and effective from 1 October 2020~~—~~.

2.1.2 The functions of the Trust are conferred by 2006 Act and the Trust will exercise its functions in accordance with the terms of its provider licence (No. 130167) and all relevant legislation and guidance.

2.1.3 The principal places of business of the Trust are:

(a) Poole Hospital

(b) Royal Bournemouth Hospital, and

(c) Christchurch Hospital

2.1.4 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property on behalf of patients.

2.2 NHS Framework

2.2.1 The Constitution requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. This document, together with Standing Financial Instructions (SFIs) and Scheme of Delegation set out the responsibilities of individuals.

2.3 Delegation of Powers

2.3.1 All business shall be conducted in the name of the Trust. ~~The business of the Trust is to be managed by the Board of Directors, who shall exercise all~~

~~the powers of the Trust, subject to any contrary provisions of the 2006 Act given effect by the Constitution.~~

2.3.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Scheme of Reservation and Delegation of Powers'. Those powers which it has delegated to Directors are also contained in the Scheme of Reservation and Delegation of Powers.

2.4 **Funds held on Trust**

2.4.1 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to Funds Held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.4.2 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable Funds Held on Trust is to the Charity Commission. Accountability for non-charitable Funds Held on Trust is only to ~~Monitor~~NHS England.

3 **The Board of Directors**

3.1 **Composition of the Membership of the Board**

3.1.1 In accordance with Clause 21 of the Constitution, the composition of the Board shall be:

(a) a non-executive Chair~~man~~;

(b) no more than eight other Non-Executive Directors (one of which may be nominated as the Senior Independent Director);

(c) ~~a minimum of~~ no more than eight Executive Directors including:

(i) the Chief Executive (Accounting Officer).

(ii) the ~~Director of Finance~~Chief Finance Officer.

(iii) a registered medical practitioner, or, a registered dental practitioner.

(iv) a registered nurse or registered midwife.

Provided that at least half of the Board of Directors excluding the non-executive Chair, shall at all times comprise Non-Executive Directors.

Formatted: Indent: Left: 3.5 cm, No bullets or numbering

~~(iv)~~

Formatted: Indent: Left: 1.27 cm, No bullets or numbering

3.2 **Terms of Office of the Directors**

3.2.1 The Chair~~man~~ and Non-Executive Directors shall be appointed for a term of office of up to three years.

3.2.2 The Chair~~man~~ and Non-Executive Directors may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director.

3.2.3 The Chair~~man~~ and Non-Executive Directors may in exceptional circumstances serve longer than 6 years subject to annual re-appointment and subject to external competition if recommended by the Board of Directors and approved by the Council of Governors.

3.2.4 The provisions governing the remuneration, allowances, term of office and other terms and conditions of office for the Chair~~man~~ and Non-Executive Directors are set out in Clause 31.1 of the Constitution.

3.2.5 The provisions governing the remuneration, allowances, term of office and other terms and conditions of office for the Chief Executive and other Executive Directors is set out in Clause 31.2 of the Constitution.

3.3 **Appointment and Powers of Vice-Chair~~man~~**

3.3.1 Subject to Standing Order 3.3.2, the Council of Governors may appoint a Non-Executive Director to be Vice-Chair~~man~~, for such period, not exceeding the remainder of that individual's term as a Non-Executive Director of the Trust, as they may specify on appointment.

3.3.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair~~man~~ by giving notice in writing to the Chair~~man~~ (in the Chair~~man~~'s capacity as Chair of the Board of Directors and the Council of Governors). The Council of Governors may thereupon appoint another Non-Executive Director as Vice-Chair~~man~~ as provided for in Annex 5 ~~in accordance with the provisions of Standing Order 3.3.1~~.

3.3.3 Where the Chair~~man~~ of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair~~man~~ owing to illness or any other cause, the Vice-Chair~~man~~ shall act as Chair~~man~~ until a new Chair~~man~~ is appointed or the existing Chair~~man~~ resumes their duties, as the case may be; and references to the Chair~~man~~ in these Standing Orders shall, so long as there is no Chair~~man~~ able to perform those duties, be taken to include references to the Vice-Chair~~man~~.

3.4 **Appointment and Role of the Senior Independent Director**

3.4.1 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 Chair~~man~~ or Chief Executive, or in circumstances in which such contact would be inappropriate.

3.4.2 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.

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

3.4.4 In accordance with a process to be agreed between the Chair~~man~~ and Council of Governors, the SID will lead in the process for evaluating the performance of the Chair~~man~~.

3.4.5 The SID shall lead a meeting of the Non-Executive Directors at least annually without the Chair~~man~~ to evaluate the Chair~~man~~'s performance, as part of the process agreed with the Council of Governors for appraising the Chair~~man~~ and in line with guidance issued for time to time by NHS England.

3.5 **Joint Directors**

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed jointly, those persons shall count for the purpose of these Standing Orders as one person (save that the Executive Director positions of registered medical practitioner or registered dentist and registered nurse or registered midwife cannot be shared between the two professions). Where such an arrangement is in force, both individuals may attend or take part in meetings of the Board of Directors provided that they may only count as one individual for the purposes of the quorum and may only exercise one vote between them. Where two individuals disagree as to how to vote at a Board of Directors meeting, then no vote shall be cast. If only one individual attends the meeting they can cast the vote on behalf of both. The presence of either or both persons shall count as the presence of one person for the purposes of quorum.

3.6 **Roles and responsibilities**

3.6.1 ~~All the powers of the Trust are exercisable by the Board of Directors, a committee of the Board of Directors or an Executive Director.~~

~~3.6.1~~3.6.2

~~3.6.2~~3.6.3 The Board of Directors will function as a unitary Board. The Board is collectively responsible for discharging the powers and for the performance of the Trust. Executive and Non-Executive Directors will have joint responsibility for every decision of the Board regardless of their individual skills or status.

~~3.6.3~~3.6.4 The Board will function as a corporate decision-making body and Non-Executive Directors and Executive Directors will be full and equal Board members. ~~Their role as members of the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. In exercising these functions the Board will consider guidance from the NHS Foundation Trust Code of Governance Code of Governance for NHS Provider Trusts as amended or replaced from time to time.~~

~~3.6.4 **Executive Directors**~~

~~Executive Directors shall exercise their authority within the terms of the Constitution these Standing Orders, the Standing Financial Instructions and the Scheme of Delegation.~~

3.6.5 **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the Trust. The individual is the **Accounting Officer** and shall be responsible for ensuring the discharge of obligations under any financial directions and in guidance issued by Monitor NHS England or any other relevant body.

3.6.6 **Chief Finance Officer**

The Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its Directors and for the supervision of financial control and accounting systems. The individual shall be responsible along with the Chief Executive for ensuring the discharge of obligations under any relevant financial directions.

3.6.7 **Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as Directors of or when chairing a Committee of the Trust which has delegated powers.

3.6.8 **Chairman**

(a) The Chairman shall be responsible for the leadership and operation of the Board (and Council of Governors) and chair all Board (and Council of Governors) meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment, the Constitution and with these Standing Orders.

(b) The Chairman shall take responsibility either directly or indirectly for the Non-Executive Director's induction, their portfolios of interests and assignments, and their performance.

(c) The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

3.7 **Lead Roles for Directors**

The Chairman will ensure that the designation of lead roles or appointments of Board Directors to such lead roles as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement. (e.g. appointing a lead Board member with responsibilities for Infection Control or Child Protection Services etc.).

4 **Board of Directors: Disqualification**

4.1 In addition to the grounds of disqualification set out in Clause 27 of the Constitution, a person may also not be or continue as a Director or Chair~~man~~ of the Trust if:

4.1.1 they are a member of the Council of Governors, or a governor of another NHS Foundation Trust;

4.1.2 they are a director, or hold an equivalent role, of another NHS body except with the approval of the Board of Directors and in the case of a Non-Executive Director, with the approval of the Council of Governors;

4.1.3 they are a member of a committee which has, any role on behalf of a local authority to scrutinise and review health matters including a local authority's scrutiny committee covering health matters;

4.1.4 they are the spouse, partner, parent or child of a member of the Board of Directors;

4.1.5 in the case of a Non-Executive Director, they no longer satisfy relevant appointment requirements;

4.1.6 they are a person whose tenure of office as a chair~~man~~ or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

4.1.7 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a health service body;

4.1.8 information revealed by a Disclosure and Barring Service check is such that it would be inappropriate for them to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

4.1.9 they are subject to an unexpired disqualification order made under the Company Directors Disqualification Act 1986;

4.1.10 in the case of a Non-Executive Director they have refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or

4.1.11 they have refused to sign and deliver to the Company Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors;

4.1.12 in the case of an Executive Director, they are no longer employed by the Trust.

5 **Meetings of the Board of Directors**

5.1 **Admission of the Public and the Press**

5.1.1 Meetings of the Board of Directors shall be open to members of the public and representatives of the press unless the Board of Directors decides

otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds. The Chair~~man~~ may exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

5.1.2 In the event that the public and press are admitted to all or part of a Board meeting pursuant to Standing Order 5.1.1 above, the Chair~~man~~ (or Vice-Chair~~man~~ if one has been appointed) or the person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption, and the public will be required to withdraw upon the Trust Board resolving that in the interests of public order the meeting adjourn for the period to be specified to enable the Board of Directors to complete its business without the presence of the public.

5.1.3 Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided in Standing Order 5.1.1 above shall be confidential to the Directors of the Board.

5.1.4 The Chair~~man~~, Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board of Directors meeting which may take place on such reports or papers.

5.2 **Calling Meetings**

5.2.1 Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may determine. Meetings may be transacted through virtual media (including, but not limited to, video conferencing).

5.2.2 Meetings of the Board of Directors are called by the Company Secretary, or by the Chair~~man~~, or by four Directors who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Company Secretary shall call a meeting within at least 14 but not more than 28 days to discuss the specific business. If the Company Secretary fails to call such a meeting within seven clear days, the Chair~~man~~ or four Directors, whichever is the case, shall call such a meeting. The Chair~~man~~ of the Trust may call a meeting of the Board at any time.

5.3 **Notice of Meetings and the Business to be Transacted**

5.3.1 Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every Director, or sent by post to the usual place of residence of each Director, so as to be available to Directors at least three clear days before the meeting. Want of service of such a notice on any Director shall not affect the validity of a meeting.

5.3.2 In the case of a meeting called by Directors in default of the Chair~~man~~ calling the meeting, the notice shall be signed by those Directors.

5.3.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 6.1

5.3.4 A Director desiring a matter to be included on an agenda shall make a request in writing to the Chair~~man~~ at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair~~man~~.

5.3.5 In the event that a meeting of the Board of Directors is to be held in public pursuant to Standing Order 5.1 a public notice of the time and place of the meeting~~, and the public part of the agenda~~, shall be displayed at the Trust's principal offices and on~~at~~ the Trust's ~~principal offices~~website at least three clear days before the meeting.

Formatted: Not Highlight

5.4 **Agenda and Supporting Papers**

5.4.1 The agenda will be sent to Directors six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency.

5.4.2 Before holding a meeting, the Board of Directors will send a copy of the agenda (but not supporting papers) to the Council of Governors.

5.5 **Petitions**

5.5.1 Where a petition has been received by the Trust the Chair~~man~~ of the Board of Directors shall include the petition as an item for the agenda of the next Board of Directors meeting.

5.6 **Notices of Motion**

5.6.1 Subject to the provision of Standing Orders 5.6.3 and 5.6.4, a Director of the Board of Directors wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair~~man~~.

5.6.2 The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

5.6.3 A motion or amendment once moved and seconded can be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair~~man~~.

5.6.4 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it also

the signature of four other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any Director other than the Chair~~man~~ to propose a motion to the same effect within six months; however, the Chair~~man~~ may do so if they consider it appropriate.

5.6.5 The mover of a Motion shall have a right of reply at the close of any discussion on the Motion or any amendment thereto.

5.6.6 When a Motion is under discussion, or immediately prior to discussion, it shall be open to a Director to move:

(a) an amendment to the Motion;

(b) the adjournment of the discussion or meeting;

(c) that the meeting proceed to the next business;

(d) the appointment of an ad-hoc committee to deal with a specific item of business;

(e) that the Motion now be put.

5.6.7 No amendment to the Motion shall be admitted if, in the opinion of the Chair~~man~~ of the meeting, the amendment negates the substance of the Motion.

5.7 **Chair~~man~~ of Meeting**

5.7.1 At any meeting of the Board of Directors the Chair~~man~~, if present, shall preside. If the Chair~~man~~ is absent from the meeting, the Vice-Chair~~man~~ (if one is appointed), if present, shall preside.

5.7.2 If the Chair~~man~~ and Vice-Chair~~man~~ are absent, such Non-Executive Director as the Directors present shall choose shall preside.

5.8 **Chair~~man~~'s Ruling**

Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair~~man~~ of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

5.9 **Voting**

5.9.1 Every question/decision put to a vote at a meeting shall be determined by a majority of the votes of Chair~~man~~ and Directors present and voting on the question and, in the case of an equality of votes, the person presiding shall have a second or casting vote. However, no resolution shall be passed if it is opposed by all the Non-Executive Directors or by all of the Executive Directors present.

5.9.2 At the discretion of the Chair~~man~~ all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair~~man~~

directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

5.9.3 If at least one-third of the Directors present so request, the voting on any question may be recorded so as to show how each Director present voted or did not vote (except when conducted by paper ballot).

5.9.4 If a Director so requests, that Director's vote shall be recorded by name upon any vote (other than by paper ballot).

5.9.5 In no circumstances may an absent Director vote by proxy. This does not prohibit an absent Director recording their vote with the Company Secretary in the election of the Senior Independent Director. Absence is defined as being absent at the time of the vote.

5.9.6 An Officer who has been formally appointed by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director.

5.9.7 An Officer attending the Board of Directors meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

5.9.8 For the voting rules relating to joint Directors see Standing Order 3.5.

Formatted: Sch 2 Number, Indent: Left: -7.73 cm, First line: 0 cm, Tab stops: Not at 2.5 cm

5.10 Written Resolutions

5.10.1 In exceptional circumstances, and with the agreement of the Chair, a Director may propose a written resolution to the Board of Directors.

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Sch 3 Number, Indent: Left: 0 cm

5.10.2 Notice of the written resolution will be given by the Company Secretary, stipulating the proposed resolution and the long-stop date by which responses must be received. This long-stop date should be no less than seven days from the date the notice is dispatched by the Company Secretary.

5.10.3 The notice must be given in writing, either by email or post.

5.10.4 A proposed written resolution shall be adopted when it has been signed and returned to the Company Secretary by email or post by a majority of members of the Board. Where a member of the Board returns the proposed written resolution to the Company Secretary by email it shall be deemed to have been duly signed even in the absence of a physical signature.

5.10.5 The proposed written resolution shall lapse if it has not been signed and returned to the Company Secretary by the required number of members of the Board by the long-stop date.

5.10.6 If a written resolution is adopted it shall be reported to the next meeting of the Board of Directors and treated as if it was a decision taken at a Board meeting in accordance with these Standing Orders.

Formatted: Sch 3 Number, Indent: Left: 0 cm, First line: 0 cm

Formatted: Font: Not Bold

~~5.10~~5.11 **Record of Attendance**

The names of the Chair~~man~~ and Directors present at the meeting shall be recorded. For the avoidance of doubt, attendance may include through virtual media.

~~5.11~~5.12 **Quorum**

~~5.11.1~~5.12.1 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of voting Directors are present, including at least one Non-Executive Director and one Executive Director. At the start of each meeting, the Chair shall be responsible for determining that the meeting is quorate.

~~5.11.2~~5.12.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum. If the Chair~~man~~ or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 8.1) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

~~5.12~~5.13 **Minutes**

~~5.12.1~~5.13.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting ~~where they~~and shall be signed by the person presiding at it. The approved minutes will be conclusive evidence of the events of the meeting.

~~5.12.2~~5.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair~~man~~ considers discussion appropriate.

~~5.12.3 As soon as practicable after holding a meeting, the Board of Directors shall send a copy of the minutes of the meeting to the Council of Governors. Where providing a record of a public meeting the minutes shall be made available to the public.~~

6 Arrangements for the exercise of functions

6.1 Emergency Powers and Urgent Decisions

The powers which the Board has retained to itself within these Standing Orders (see Standing Order 2.3.2) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair~~man~~ after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair~~man~~ shall be reported to the next formal meeting of the Board of Directors for ratification.

6.2 **Delegation to Officers**

6.2.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Executive Directors / Officers to undertake the remaining functions for which the Chief Executive will still retain accountability to the Board of Directors.

6.2.2 The Chief Executive shall prepare a Scheme of Delegation identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors as indicated above.

6.2.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the ~~Director of Finance~~Chief Finance Officer or other Executive Directors to provide information and advise the Board of Directors in accordance with the Constitution, the Trust's provider licence or any statutory or Department of Health and Social Care requirements or provisions required by ~~Monitor~~ NHS England. Outside of these requirements, the role of the ~~Director of Finance~~Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

6.2.4 The Trust shall have a Trust ~~Executive~~ Management Group (or equivalent, with supporting sub-groups as deemed necessary by the Chief Executive) ~~with delegated responsibility of the~~accountable to the Chief Executive, who may choose to review the structure at any stage.

6.3 **Appointment of Committees**

6.3.1 The Board of Directors may appoint Committees of the Board of Directors, consisting wholly of the Chair~~man~~ and Directors of the Trust.

6.3.2 The Trust shall determine the membership and terms of reference of Committees and shall if it requires to, receive and consider reports of such Committees.

6.4 **Applicability of Standing Orders and Standing Financial Instructions to Committees**

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings of~~and~~ any Committees established by the Board. In which case the term "Chair~~man~~" is to be read as a reference to the Chair~~man~~ of other committee as the context permits, and the term "member" is to be read as a reference to a member of other Committee also as the context permits. (There is no requirement to hold meetings of Committees established by the Board in public).

6.5 **Terms of Reference**

Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board shall decide and shall be in accordance with any legislation and regulation, or any guidance issued by NHS England~~Monitor~~.

6.6 **Delegation of Powers by Committees to Sub-Committees**

Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

6.7 **Approval of Appointments to Committees**

The Board shall approve the appointments to each of the Committees which it has formally constituted.

6.8 **Appointments for Statutory Functions**

Where the Board is required to appoint persons to a Committee and/or to undertake statutory functions and where such appointments are to operate independently of the Board such appointment shall be made in accordance with any applicable regulations and directions.

6.9 **Committees Established by the Board**

6.9.1 The Committees established by the Board are:

(a) Audit Committee

As laid down in the Constitution and the 2006 Act, a committee of Non-Executive Directors will be established and constituted to provide the Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Audit ~~and Governance~~ Committee Terms of Reference will be approved by the Board and reviewed on a periodic basis.

~~(b) Finance and Performance Committee~~

~~The Committee is responsible for scrutinising the detailed financial reports and making recommendations to ensure the robust use of financial resources. The Committee will review the substance of the Annual Plan and revenue and capital budgets.~~

~~(c)~~(b) Appointment and Remuneration Committee

As laid down in the Constitution and the 2006 Act, it is for a committee consisting of the Chair~~man~~, Chief Executive and the Non-Executive Directors to appoint or remove the other Executive Directors. As laid down in the Constitution and the 2006 Act a committee of Non-Executive Directors will be established to decide the remuneration and allowances of, and other terms and conditions of the Executive Directors. The Appointment and Remuneration Committee Terms of

Reference will be approved by the Board and reviewed on a periodic basis.

Formatted: Indent: Left: 3.5 cm

~~(d)~~(c) Other Committees

The Board of Directors may also establish such other Committees as required to discharge the Board of Director's responsibilities in relation to quality, finance ~~and~~, performance and culture.~~.~~

6.9.2 The Board of Directors may elect to change the Committees of the Board of Directors, as necessary, without requirement to amend these Standing Orders.

7 Confidentiality

7.1 A Director or appointee of a working group shall not disclose a matter dealt with, by, or brought before, the relevant committee or working group without its permission until the committee or working group has reported to the Board of Directors or shall otherwise have concluded on that matter.

7.2 A Director or appointee of a working group shall not disclose any matter reported to the Board of Directors otherwise dealt with by the relevant committee or working group, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee or working group shall resolve that it is confidential.

8 Declaration of Interests and Register of Interests

8.1 Declaration of Interests

8.1.1 In accordance with Clause 30 of the Constitution the Chair~~man~~ and Directors shall declare interests which are relevant and material to the Board of Directors, whether that interest is direct or indirect. All existing Directors and the Chair~~man~~ should declare such interests. Any Directors or Chair~~man~~ appointed subsequently should do so on appointment.

8.1.2 Any Director who fails to disclose any interest required to be disclosed under this section must permanently vacate their office if required to do so by the majority of the remaining Directors and (in the case of a Non-Executive Director) by the requisite majority of the Council of Governors.

8.1.3 Interests which should be regarded as "relevant" ~~and material" are~~:

(a) ~~outside employment and other engagements, outside of formal employment arrangements, including any directorships or non-executive director roles;~~ Any directorship of a company.

Formatted: Default Paragraph Font

(b) ~~any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust;~~ Any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding is less than 2% of the total shares in issue) held by a member of staff in

any firm or company or business which, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust.

(c) any interest in an organisation providing health and social care services to the National Health Service;

~~(c)~~(d) any interest in an organisation involved in the regulation or oversight of the Trust;

~~(d)~~(e) ~~a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other organisation in the field of health and social care;~~ A position of authority in a charity or voluntary organisation in the field of health and social care.

~~(e)~~(f) ~~any patents and other intellectual property rights held, which are, or might be reasonably expected to be related to items to be procured or used by the Trust;~~ Any other interest that may conflict or be perceived to conflict with the performance of the Director's duties.

~~(f) research funding/grants that may be received by an individual or their department;~~

~~(g) any clinical private practice.~~

8.1.4 An interest will be deemed relevant if it is held by the Director, their spouse/partner or immediate relative.

8.1.5 For the avoidance of doubt relevant interest includes employment (including self-employment or private work).

~~8.1.4~~8.1.6 If Directors have any doubt about the relevance of an interest, this should be discussed with the Chair~~man~~ or with the Company Secretary.

~~8.1.5~~8.1.7 At the time a Director's interests are declared, they should be reported in the minutes. Any changes in interest should be declared at the next Board of Directors' meeting following the change occurring.

~~8.1.6~~8.1.8 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. This information should be kept up to date for inclusion in succeeding Annual Reports.

~~8.1.7~~8.1.9 Interests to be declared include those of close family members and relatives, close friends and associates and business partners where Directors know (or could be reasonably expected to know) about these.

8.2 **Conflicts of Interest**

8.2.1 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision and shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

8.2.2 A conflict of interest is defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply

Formatted: Default Paragraph Font

Formatted: Default Paragraph Font

Formatted: Default Paragraph Font

judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by the interest they hold.

8.3 **Register of Interests**

8.3.1 The Chief Executive will ensure that a register of interests is established to record formally declarations of interests of Directors and Committee and sub-committee members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors.

8.3.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

8.3.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

8.4 **Disability of Directors in Proceedings on account of Pecuniary Interest**

8.4.1 Subject to the following provisions of this Standing Order, if the Chair~~man~~ or a Director of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.4.2 The Board of Directors may exclude the Chair~~man~~ or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which that member has a pecuniary interest is under consideration.

8.4.3 The Board of Directors, as it may think fit, may remove any disability imposed by this Standing Order in any case in which it appears to the Board of Directors that, in the interests of the Trust, the disability shall be removed. Such action shall have the support of more than half of the Directors present at the meeting (including two Executive and two Non-Executive Directors).

8.4.4 Any remuneration, compensation or allowance payable to the Chair~~man~~ or a Director shall not be treated as a pecuniary interest for the purpose of this Standing Order.

9 **Standard of Business Conduct**

9.1 **Policy**

All staff should comply with the Trust's Constitution and NHS England's guidance "Managing Conflicts of Interest in the NHS" (1 June 2017) as updated or replaced from time to time.

9.2 **Interest of officers in contracts**

9.2.1 If it comes to the knowledge of a Director or~~f~~ Officer (the term officer in this instance includes all staff, consultants, contractors and Governors) of the Trust that a contract in which they have any pecuniary interest, direct or indirect, the officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or the Company Secretary as soon as practicable. In the case of married persons, civil partners or persons living together as partners, the interests of one partner shall, if known to the other, be deemed to be also the interest of that partner.

9.2.2 A Director or Officer should also declare to the Chief Executive any other employment or business or other relationship of that Director or Officer, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

9.3 **Canvassing of and recommendations by Directors in relation to appointments**

Canvassing of Directors of the Trust or of members of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates. Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

9.4 **Relatives of members or officers**

9.4.1 Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render that individual liable to instant dismissal.

9.4.2 The Chair~~man~~ and every Director and Officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

9.4.3 On appointment, a Director or the Chair~~man~~ (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

9.4.4 Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair~~man~~ and members in proceedings on account of pecuniary interest' (Standing Order 8.4) shall apply.

10 Custody of Seal and Sealing of Documents

10.1 Custody of Seal

The common seal of the Trust shall be kept by the Company Secretary in a secure place.

10.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Executive Directors, not also from the originating department, and shall be attested by them.

10.3 Register of Sealing

10.3.1 An entry of every sealing shall be made and numbered consecutively by the Company Secretary. A report of all sealing shall be made to the Board of Directors annually.

10.3.2 The seal should be used to execute deeds (e.g. conveyances of land) or where otherwise required by law.

10.4 Signature of Documents

10.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

10.4.2 The Chief Executive, or the ~~Director of Finance~~Chief Finance Officer or other Executive Directors shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or any Committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11 Standing Orders

11.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of the Standing Orders and Standing Financial Instructions.

11.2 Suspension of Standing Orders

11.2.1 Except where this would contravene any provision of the Constitution or authorisation of any statutory provision or any direction made by NHS England~~Monitor~~, or the rules relating to the quorum (Standing Order 5.12), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the Directors of the

Board are present (including at least one Executive Director and one Non-Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Board minutes.

~~11.2.1~~11.2.2 A decision to suspend Standing Orders shall apply only for the duration of the meeting in question.

~~11.2.2~~11.2.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair~~man~~ and Directors of the Trust.

~~11.2.3~~11.2.4 No formal business may be transacted while Standing Orders are suspended.

~~11.2.4~~11.2.5 The Audit Committee shall review every decision to suspend Standing Orders.

11.3 **Amendment of Standing Orders**

These Standing Orders shall not be varied except in accordance with Clause 41 of the Constitution.

11.4 **Review of Standing Orders**

The Standing Orders shall be reviewed annually by the Board of Directors.

Annex 8 – Further Provisions

1 **Eligibility for Membership**

1.1 The Trust shall take steps to ~~at all times~~ ensure that taken as a whole its actual membership of any public constituency is representative of those eligible for such membership. The Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time.

1.2 An individual shall be eligible for Membership of the Trust provided:

1.2.1 the individual is sixteen years of age at the date of application or invitation to become a Member (as the case may be); and

1.2.2 the individual is otherwise eligible for Membership pursuant of the terms of this Constitution.

1.3 For the purposes of determining whether an individual lives in an area specified as an area for Public Constituency, an individual shall be deemed to do so if:

1.3.1 That person's name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

1.3.2 the Trust is otherwise satisfied that the individual lives ~~in the~~at said area.

1.4 An individual who is a Member of a Public Constituency shall cease to be eligible to continue as a Member if that individual ceases to live in the area of the Public Constituency of which the individual is a Member save as may otherwise be provided in paragraph 1 of this Annex.

1.5 Where a Member of a Public Constituency ceases to live permanently in an area for a Public Constituency of which that individual is a Member that individual shall forthwith advise the Trust that ~~that individual is~~they are no longer eligible to continue as a Member and the Trust shall forthwith remove the individual's name from the Register of Members unless the Trust is satisfied that the individual concerned lives in some other Area for a Public Constituency of the Trust. Where the Trust is satisfied that such an individual continues to live in an Area for a Public Constituency of the Trust it shall, if the individual so requests, thereafter treat that individual as a Member of that other Public Constituency and amend the Register of Members accordingly provided the Trust has given that individual not less than fourteen days' notice of its intention to do so.

1.6 Where a Member ceases to live temporarily in an Area for a Public Constituency of which the individual is a Member, the Trust may permit that individual nonetheless to remain on the Register of Members for that Area for a Public Constituency if it is for good cause satisfied that the absence is of a temporary duration only and that the Member will either return to live in an Area for a Public Constituency of which ~~that Member is~~they are a Member or will live in some other part of the Area of the Trust in which case the provisions of paragraph 1.5 of this Annex shall apply as appropriate.

1.7 A Member of a Staff Class will cease to be eligible to be a Member of that Staff Class if they no longer meet the eligibility requirements of Clause 8 of the Constitution and of Annex 2.

1.8 Where an individual is a Member by virtue of their eligibility to be a Member of a Staff Class and they cease to be eligible for membership of that Staff Class but are eligible for membership of some other Staff Class then the individual's membership will be automatically transferred to that Staff Class. ~~Trust may give notice to that Member of its intention to transfer the individual to that other Staff Class. on the expiration of a period of time or upon a date specified in the said notice and shall after the expiration of that notice or date amend the Register of Members accordingly.~~

2 **Application for Membership**

2.1 An individual may become a Member by application to the Trust in accordance with this Constitution or, where so provided for in this Constitution, by being invited by the Trust to become a Member of a Staff Class of the Staff Constituency in accordance with Clause 8 of the Constitution.

2.2 Where an individual wishes to apply to become a Member of the Trust, the following procedure shall apply:

2.2.1 the Trust shall upon request supply the individual with a form of application for Membership in a form determined by the Trust;

2.2.2 upon receipt of the said form of application duly completed and signed by the applicant (or at~~in~~ the Trust's discretion signed on behalf of the applicant) the Trust shall as soon as is reasonably practicable and in any event within ten working days of receipt of the duly completed form consider the same;

2.2.3 unless the applicant is ineligible for Membership or is disqualified from Membership, the Trust shall cause the individual's name to be entered forthwith on the Trust's Register of Members and shall give notice in writing to the applicant of that fact;

2.2.4 upon the applicant's name being entered on the Trust's Register of Members the individual shall thereupon become a Member;

2.2.5 the information to be included in the Trust's Register of Members shall include the following details relating to that Member:

(a) full name and title;

(b) date of birth;

(c) full postal address;

(d) home telephone number (if any);

(e) email address (if any);

(f) the constituency of which the individual is a Member;

(g) the date upon which the individual became a Member;

(h) gender and ethnicity (if disclosed).

2.3 Where an individual is to be invited by the Trust to become a Member, the following procedure shall apply:

2.3.1 it is the responsibility of each Member to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. A Member who becomes aware of their ineligibility shall inform the Trust as soon as practicable and that person shall thereupon be removed forthwith from the Register of Members and shall cease to be a Member.

2.3.2 in the case of the Staff Constituency:

~~2.3.1~~ (a) the Trust shall take ~~all~~ reasonable steps to satisfy itself that the individual is eligible to become a Member of the ~~Staff Class of the~~ Staff Constituency ~~relevant to the individual~~ before inviting the individual to become a Member of the Trust and that it has all the information needed to complete the Register of Members in accordance with paragraph 2.2.5 of this Annex;

~~2.3.2~~ (b) the Trust having so satisfied itself, it shall thereupon invite that individual to become a Member pursuant to Clause 6 of the Constitution and if necessary shall request the individual to provide such further information, if any, as it may need to complete the necessary entry in the Register of Members;

2.3.3 unless the individual has within fourteen days of the date upon which the Trust dispatches its invitation to the individual to become a Member advised the Trust that ~~the individual does~~they do not wish to become a Member, the Trust shall thereupon enter that individual's name on the Register of Members and the individual shall thereupon become a Member provided that the Trust has been provided with the information, if any, requested pursuant to paragraph 2.2.5 of this Annex to enable it to complete the relevant entry in the Register of Members;

2.3.4 if the individual has failed to provide the information requested by the Trust within fourteen days of being invited by the Trust to provide it in accordance with paragraph 2.2.5 of this Annex, the Trust shall give notice in writing to the applicant that the information has not been provided and that unless and until the information is provided that individual's name shall not be entered on the Register of Members.

2.4 No individual who is ineligible or disqualified from Membership shall be entered or remain on the Register of Members.

2.5 For the avoidance of doubt, an individual shall become a Member on the date upon which the individual's name is entered on the Trust's Register of Members and shall cease to be a Member upon the date on which the individual's name is removed from the Register of Members as provided for in this Constitution.

2.6 The Trust shall procure that the Register of Members and all other Registers to be maintained in accordance with this Constitution or in accordance with the 2006 Act are regularly reviewed and updated and that the Register of Members in particular is reviewed and updated as appropriate and no less often than every twenty-eight days.

Formatted: Sch 3 Number, Indent: Left: 0 cm, First line: 0 cm

Formatted: Indent: Left: 2.5 cm, No bullets or numbering

3 **Disqualification from Membership**

3.1 A person may not become or continue ~~to~~ as a member of the Trust if:

3.1.1 within the last five years they have shown aggressive or violent behaviour towards Trust staff which has resulted in a warning letter being sent in accordance with the Trust's Policy for the Management of Violence and Aggression;

3.1.2 they have been confirmed as an unreasonable or persistent complainant in accordance with the relevant Trust policy for handling complaints; or

3.1.3 they have been removed as a member from another NHS Foundation Trust.

4 **Termination of Membership**

4.1 A Member shall cease to be a Member if:

4.1.1 they resign by notice to the Company Secretary;

4.1.2 they die;

4.1.3 they are expelled from Membership under this Constitution;

4.1.4 they are disqualified from Membership under this Constitution;

4.1.5 if it appears to the Company Secretary they no longer wish to be a Member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a Member of the Trust;

4.1.6 they cease to be entitled under this Constitution to be a member of ~~the~~ a Public Constituency or of any of the classes of the Staff Constituency.

5 **Expulsion from Membership**

5.1 An individual shall not become or continue as a Member if the Council of Governors resolves for reasonable cause that their so doing would or would be likely to:

5.1.1 Harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provision of goods and services; or

5.1.2 Adversely affect public confidence in the goods or services provided by the Trust; or

5.1.3 Otherwise bring the Trust into disrepute.

Formatted: Sch 3 Number, Indent: Left: 0 cm, First line: 0 cm

~~5.1~~5.2 A Member may be expelled by a resolution approved by not less than two-thirds of the Council of Governors present and voting at a general meeting of the Council of Governors. The following procedure is to be adopted:

~~5.1.1~~5.2.1 any Member may complain to the Company Secretary that another Member of the Trust has acted in a way detrimental to the interests of the Trust.

~~5.1.2~~5.2.2 if a complaint is made, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that each Member's point of view is heard and may either:

(a) dismiss the complaint and take no further action; or

(b) for a period not exceeding twelve months suspend~~et~~ the rights of the member of the Trust complained of to attend Members' Meetings and vote under the Constitution; or

(c) arrange for a resolution to expel the Member of the Trust complained of to be considered at the next General Meeting of the Council of Governors.

~~5.1.3~~5.2.3 if a resolution to expel a Member of the Trust is to be considered at a General Meeting of the Council of Governor, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

~~5.1.4~~5.2.4 at the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

~~5.1.5~~5.2.5 if the Member complained of fails to attend the meeting without reasonable cause the meeting may proceed in that Member's absence.

~~5.2~~5.3 A person expelled from Membership will cease to be a Member upon the declaration by the Chair~~man~~ of the meeting that the resolution to expel them is carried.

~~5.3~~5.4 No person who has been expelled from Membership is to be re-admitted except by a resolution carried by not less than two-thirds of the members of the Council of Governors present and voting at a general meeting of the Council of Governors.

6 Disputes

6.1 Where an individual is held by the Trust to be ineligible and/or disqualified from Membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Chief Executive (or such other officer of the Trust as the Chief Executive may nominate) as soon as reasonably practicable thereafter.

6.2 The Chief Executive (or a nominated representative) shall:

6.2.1 review the original decision having regard to any representations made by the individual concerned and such other material, if any, as the Chief Executive considers appropriate;

6.2.2 then either confirm the original decision or make some other decision as appropriate based on the evidence which the Chief Executive has considered; and

6.2.3 communicate his decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

6.3 Notwithstanding paragraphs 5.1 and 6.2 an independent assessor may be appointed (as if it had been a possible removal pursuant to and using the process set out in paragraph 6.2) to consider the evidence and advise on whether this justified disqualification under the terms of the Constitution.

6.4 In the event that the independent assessor appointed pursuant to paragraph 6.3 advises that the evidence justifies the disqualification, the original decision to disqualify shall stand. If however the independent assessor advises that there is at least reasonable doubt that the evidence justified disqualification, the matter shall be put to the Council of Governors to decide whether to uphold the disqualification or not (such decision requiring support of not less than three quarters of the Governors present and voting at a meeting of the Council of Governors convened for that purpose). If the Council of Governors does not uphold the disqualification, then such disqualification shall not stand and the individual subject to the proposed disqualification shall remain a Member of the Trust.

6.5 Pending a decision of the independent assessor or the Council of Governors as referred to in paragraph 6.4, the individual shall (without prejudice to the outcome of such review process) not be able to exercise any right or powers of Member.

7 **Annual Members' Meeting**

7.1 The Trust shall hold an Annual Members' Meeting within eight months of the end of each Financial Year of the Trust.

7.2 Any Members' meetings other than the Annual Members' Meeting shall be called a "**Special Members' Meetings**". Annual Members' Meetings and Special Members' Meetings are referred to in this paragraph 7 as "~~**Annual**~~ **Members' Meetings**".

7.3 ~~Annual~~ Members' Meetings shall be open to all Members of the Trust, members of the Council of Governors and the Board of Directors, representatives of the Trust's financial auditors and to members of the public. The Trust may invite representatives of the media, and any experts or advisors, whose attendance they consider to be in the best interests of the Trust to attend any such meeting~~ Annual Meeting~~. ~~–~~ The Chair~~man~~ may also exclude any member of the public from a ~~n Annual~~Members' Meeting if they are interfering with or preventing the proper conduct of the meeting.

7.4 The Board of Directors may convene a Special Members' Meeting when it thinks fit. All Annual Members' Meetings are to be convened by the Company Secretary by order of the Council of Governors.

7.5 The Trust shall make provision for the Annual Members' Meeting to be held at a Hospital of the Trust or a venue close to a Hospital of the Trust.

7.6 The Board of Directors (or at least one member of the Board of Directors) shall present at the Annual Members' Meeting:

7.6.1 the annual accounts;

7.6.2 any report of the external Auditor on them;

7.6.3 the annual report; and

7.6.4 forward planning information for the next Financial Year.

7.7 The Council of Governors shall present to the Annual Members' Meeting:

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

7.7.2 the progress of the Membership strategy;

7.7.3 any proposed changes to the policy for the composition of the Council of Governors and of the Non-Executive Directors;

7.7.4 the results of the election and appointment of Governors any other reports or documentation it considers necessary or otherwise required by ~~Monitor~~ NHS England or the 2006 Act (to be commenced by the Company Secretary).

7.8 The Trust shall give notice of all Annual Members' Meetings:

7.8.1 by notice in writing to all Members;

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

7.8.3 by notice on the Trust's website at least seven clear days before the date of the meeting;

7.8.4 to the Council of Governors and the Board of Directors, and to the Trust's auditors ~~stating whether the meeting is an Annual or Special Meeting giving the time, date and place of the meeting and indicating the business to be dealt with at the meeting~~.

7.9 The Chair~~man~~ or in their absence the Vice Chair~~man~~ shall preside at all ~~Annual~~ Members' Meetings of the Trust. If neither the Chair~~man~~ nor the Vice Chair~~man~~ is present, the Lead Governor shall act as Chair~~man~~ at all Annual Members' Meetings of the Trust. If neither is present, the members of the Council of Governors present shall elect a Governor from the elected Constituencies (public and staff) to be Chair~~man~~ and if there is only one such Governor present and willing to act they shall be Chair~~man~~.

7.10 Before a ~~n Annual~~ Members' Meeting can do business there must be a quorum present. Except where this Constitution says otherwise, a quorum is 20 Members present. If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Board of Directors ~~Council of Governors~~ determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Members present during the meeting is to be a quorum.

7.11 If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a Members' meeting at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date and/or place.

~~7.11~~7.12 A resolution put to the vote at a~~n Annual~~ Members' Meeting shall be decided upon by ~~a poll~~oral expression or a show of hands.

~~7.12~~7.13 Every Member present ~~and every Member who has voted by post or using electronic communications~~ is to have one vote. In the case of an equality of votes the Chair~~man~~ of the meeting is to have the second or casting vote.

~~7.13~~7.14 The result of any vote will be declared by the Chair~~man~~ and recorded in the minutes. The minutes will be conclusive evidence of the result of the vote.

7.15 Minutes of the proceedings of an Annual Members' Meeting shall be prepared and submitted ~~to be read and~~ for agreement at the next Annual Members' Meeting ~~where they will be considered to have been~~and shall be signed by the person presiding at it. The approved minutes will be conclusive evidence of the events of the meeting.

~~7.14~~7.16 An accidental omission to give notice of a Members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

Annex 9– Model Election Rules

Part 1 - Interpretation

1. Interpretation

Part 2 – Timetable for election

2. Timetable
3. Computation of time

Part 3 – Returning officer

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

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

Part 5 – Contested elections

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

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

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32-1. ID declaration form for replacement ballot papers (public and patient constituencies)
33. Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text messages

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

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

Part 6 – Counting the votes

41. Arrangements for counting of the votes
42 The count
43. Rejected ballot papers and rejected text voting records
44. Equality of votes

Part 1 - Interpretation

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

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

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

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

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

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

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

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

"*ID declaration form*" has the meaning set out in rule 21.1;

"internet voting record" has the meaning set out in rule 26.4(d);

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

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

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

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

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act, which operates with the National Health Service Trust Development Authority as NHS ~~Improvement~~England.";

"*numerical voting code*" has the meaning set out in rule 55.2(b)

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

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

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

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

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

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

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

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

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

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

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

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

Part 2 – Timetable for election

2. Timetable

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

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

3. Computation of time

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

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

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

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

Part 3 – Returning officer

4. Returning officer

4.1 Subject to rule 60, the returning officer for an election is to be appointed by the corporation.

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

5. Staff

5.1 Subject to rule 60, the returning officer may appoint and pay such staff, including such technical advisers, as ~~he or she~~they consider~~s~~ necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

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

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

7. Duty of co-operation

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

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

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

(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination forms may be obtained;
(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address or such return) and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer,
(g) the contact details of the returning officer, and
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

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

9.2 The returning officer:

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

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

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name

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

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

11. Declaration of interests

11.1 The nomination paper must state:

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

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

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

12. Declaration of eligibility

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

(a) that they~~he~~ are~~is~~ not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and

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

13. Signature of candidate

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

(a) they wish to stand as a candidate,

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

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

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

14. Decisions as to the validity of nomination

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

(a) decides that the candidate is not eligible to stand,
(b) decides that the nomination paper is invalid,
(c) receives satisfactory proof that the candidate has died, or
(d) receives a written request by the candidate of their withdrawal from candidacy.

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

(a) that the form is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
(b) that the form does not contain the candidate's particulars, as required by rule 10;
(c) that the form does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the form does not include a declaration of eligibility as required by rule 12, or
(e) that the form is not signed and dated by the candidate, as required by rule 13.

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

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

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

15. Publication of statement of candidates

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

15.2 The statement must show:

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

as given in their nomination form

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

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

16. Inspection of statement of nominated candidates and nomination papers

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

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

17. Withdrawal of candidates

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

18. Method of election

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

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

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

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

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

Part 5 – Contested elections

19. Poll to be taken by ballot

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

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

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

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

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

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

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

20.2 Every ballot paper must specify:

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

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

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

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

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or
(ii) to whom the voter ID number contained within the e-voting information was allocated,

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

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

("declaration of identity")

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

21.2 The voter must be required to return their~~his~~ declaration of identity with their~~his~~ ballot.

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

Action to be taken before the poll

22. List of eligible voters

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

22.2 The list is to include, for each member:

(a) a postal address; and,
(b) the members email address, if this has been provided

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

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

23. Notice of poll

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

(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,
(l) the address and final dates for applications for replacement voting information, and
(m) the contact details of the returning officer.

24. Issue of voting documents by returning officer

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

(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required)

(c) information about each candidate standing for election, pursuant to rule 52 of these rules, and

(d) a covering envelope.

("postal voting information")

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

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

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 55 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

(d) contact details of the returning officer.

("e-voting information")

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

(a) only be sent postal voting information; or

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

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

for the purposes of the poll.

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

24.5 The voting information is to be sent to the postal address and/ or e-mail address for

each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

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

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

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

(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

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

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

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

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

(a) require a voter to:

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

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

in order to be able to cast their~~his~~ vote;

(b) specify:

(i) the name of the corporation,

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

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

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

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

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

(vii) the contact details of the returning officer;

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

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

(i) the voter's voter ID number;

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

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

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

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

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

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

(a) require a voter to
  (i) enter his voter ID number in order to be able to cast ~~his or her~~ their vote; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:
  (i) the name of the corporation,
  (ii) the constituency, or class within a constituency, for which the election is being held,
  (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
  (iv) instructions on how to vote and how to make a declaration of identity,
  (v) the date and time of the close of the poll, and
  (vi) the contact details of the returning officer;

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

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
  (i) the voter's voter ID number;
  (ii) the voter's declaration of identity (where required);
  (iii) the candidate or candidates for whom the voter has voted; and
  (iv) the date and time of the voter's vote

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

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

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

(a) require a voter to:
(i) provide theirhis or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or hertheir vote;

(b) prevent a voter from voting for more candidates than they arehe is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(ii) the candidate or candidates for whom the voter has voted; and
(iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

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

28. Voting by persons who require assistance

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

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

29. Spoilt ballot papers and spoilt text message votes

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

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

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless they:

(a) is satisfied as to the voter's identity, and
(b) has ensured that the completed ID declaration form , if required, has not been returned.

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

(a) the name of the voter, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement ballot paper.

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

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

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

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

(a) the name of the voter, and

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

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

30. Lost voting information

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

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

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

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

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

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

(a) the name of the voter

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

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless,

in addition to the requirements imposed rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

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

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

(c) the voter ID number of the voter

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

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

33. Procedure for remote voting by internet

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

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

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

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

33.5 The voter will not be able to access the internet voting system for an election once

~~his or her~~their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

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

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

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

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

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

35. Voting procedure for remote voting by text message

35.1 To cast ~~his or he~~their~~r~~ vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

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

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

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

36. Receipt of voting documents

36.1 Where the returning officer receives a:

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

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

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

(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

37. Validity of votes

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

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

(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

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

(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form, accompanying the ballot paper, mark it as "disqualified" and attach it the ballot paper,

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

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

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

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

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

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

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

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

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

38.1 Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the ID declaration form, in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election ~~he or she~~they shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,
(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the ID declarations forms if required,
(c) the list of spoilt ballot papers,
(d) the list of lost ballot papers,
(e) the list of eligible voters, and
(f) the list of tendered ballot papers.

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

Formatted: Indent: Left: 1.25 cm, First line: 0 cm

Part 6 - Counting the votes

41. Arrangements for counting of the votes

41.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

41.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and
(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such

software will produce an accurate result.

42. The count

42.1 The returning officer is to:

(a) count and record the number of :
  (i) ballot papers that have been returned, and
  (ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 41.2(ii) where vote counting software is being used

42.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

42.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

43. Rejected ballot papers and rejected text voting records

43.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules 43.2 and 43.3, be rejected and not counted.

43.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

43.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark,
(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

43.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules 43.2 and 43.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

43.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

43.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules 43.7 and 43.8, be rejected and not counted.

43.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

43.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

43.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules 43.7 and 43.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

43.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

44 Equality of votes

44.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

45 Declaration of result for contested elections

45.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the Council of Governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who ~~he or she has~~they have declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the ~~Aintree Hospital~~University Hospitals Dorset NHS Foundation Trust by section 33(4) of the 2006~~3~~ Act, to the chair~~man~~ of the NHS Trust, or

(ii) in any other case, to the chair~~man~~ of the corporation; and

(c) give public notice of the name of each candidate whom ~~he or she has~~they have declared elected.

45.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule 43.5,
(c) the number of rejected text voting records under each of the headings in rule 43.10

available on request.

46. Declaration of result for uncontested elections

46.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who ~~he or she ha~~they haves~~s~~ declared elected to the chairman of the corporation, and
(c) give public notice of the name of each candidate who ~~he or she has~~they have declared elected.

Part 8 – Disposal of documents

47. Sealing up of documents relating to the poll

47.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting papers endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records.

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage

47.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

47.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

48. Delivery of documents

48.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49 , the returning officer is to forward them to the chair of the corporation.

49. Forwarding of documents received after close of the poll

Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new ballot papers to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair~~man~~ of the corporation.

50. Retention and public inspection of documents

50.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

50.2 With the exception of the documents listed in rule 51.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

50.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

51. Application for inspection of certain documents relating to an election

51.1 The corporation may not allow

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iiv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters

(b) Access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage

by any person without the consent of the regulator.

51.2 A person may apply to the regulator to inspect any of the documents listed in rule 51.1 and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

51.3 The board of directors of the corporations consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

51.4 On an application to inspect any of the documents listed rule 51.1 the board of directors of the corporation must:

(a) in giving its consent, , and
(b) in making the documents available for inspection,

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that ~~his or her~~ their vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

52. Countermand or abandonment of poll on death of candidate

52.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to

(a) countermand notice of the poll, or, if ballot papers have been issued, direct that the poll be abandoned within that constituency or class, and
(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

52.2 Where a new election is ordered under rule 52.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

52.3 Where a poll is abandoned under paragraph (52.1)(a), paragraphs (52.4) to (52.7) are to apply.

52.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

52.5 The returning officer is to:

(a) count and record the number of ballot papers that have been received, and

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complex electronic copies of the internet voting records telephone voting records and text voting records crated in accordance with rule 26 are held in a device suitable or the purpose of storage,

52.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

52.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to paragraphs (52.4) to (57.6), the returning officer is to deliver them to the chairman of the corporation, and rules 50 and 51 are to apply.

Part 10 – Election expenses and publicity

Election expenses

53. Election Expenses

53.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

52. Expenses and payments by candidates

52.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

53. Election expenses incurred by other persons

53.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or ~~his or her~~their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

53.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 56 and 57.

Publicity

54. Publicity about election by the corporation

54.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

54.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 57, must be:

(a) objective, balanced and fair,

(b) (as far as the information provided by the candidates so allows) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

54.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

55. Information about candidates for inclusion with voting information

55.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

55.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words, and

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate

if supplied by the candidate.

56. Meaning of "for the purposes of an election"

56.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

56.2 The provision by any individual of ~~his or her~~their own services voluntarily, on ~~his or her~~their own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

57. Application to question an election

57.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor or the purpose of seeking a referral to the independent election arbitration panel (IEAP).

57.2 An application may only be made once the outcome of the election has been declared by the returning officer.

57.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

57.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the regulator may require.

57.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

57.6 If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

57.7 Monitor shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.

57.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

57.9 The IEAP may prescribe rules of procedure for the determination of an application, including costs.

Part 12 – Miscellaneous

58. Secrecy

58.1 The following persons:

(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given a ballot paper or who has or has not voted,
(ii) the unique identifier on any ballot paper,
(iii) the voter ID number allocated to any voter
(iv) the candidate(s) for whom any member has voted.

58.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

58.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

59. Prohibition of disclosure of vote

59.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

60. Disqualification

60.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

61. Delay in postal service through industrial action or unforeseen event

61.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll as ~~he or she~~they considers appropriate.~~, with the agreement of the Regulator~~.

Annex 10 - Transitional Provisions

1 ~~Interim Directors~~Governors

1.1 ~~The Interim Directors shall exercise the functions of the Trust on its behalf until such time as the Board of Directors is appointed in accordance with this Constitution.~~Notwithstanding anything to the contrary in this Constitiution from the date of adoption of this revised Constitution all Governors shall be appointed or elected (as the case may be) in accordance with its provisions.

1.2 Each Staff Governor serving at the date of adoption of this revised Constitution shall continue to serve for the remainder of the term of office in respect of the Staff Class for which they were originally elected (as if there had been no change to the Staff Classes within the Staff Constituencies). For the avoidance of doubt, this paragraph shall cease to apply in relation to any re-election of such Staff Governor.

1.3 For the purposes of calculating any vacancies in the number of Staff Governors, this shall be determined by:

1.3.1 The number of Staff Governors for the applicable Staff Class set out in Annex 2; minus

1.3.2 The number of Staff Governors holding office in respect of the former Staff Class comprised within the successor Staff Class set out in Annex 2.

~~1.1~~

~~1.2 The Interim Directors shall comply with this Constitution in exercising the functions of the Trust as if they were the Directors.~~

~~1.3 This Constitution shall apply to the Interim Directors as if they were the Directors.~~

~~2 Initial Governors~~

~~2.1 The term of office for the Initial Governors will commence on the date notified to them by the Trust in writing and shall be for the terms set out below. Any Initial Governor who is elected to serve a further term of office thereafter will serve a term of office of three years.~~

~~2.2 For the Poole and Rest of Dorset Public Constituency, the three Governors that poll the highest number of votes will serve a term of office of three years. The three Governors polling the next highest number of votes will serve a term of two years.~~

~~2.3 For the Bournemouth Public Constituency, the three Governors that poll the highest number of votes will serve a term of office of three years. The three Governors polling the next highest number of votes will serve a term of two years.~~

~~2.4 For the Christchurch, East Dorset and Rest of England Public Constituency, the three Governors that poll the highest number of votes will serve a term of office of three years. The two Governors polling the next highest number of votes will serve a term of two years.~~

~~2.5 The Governors elected to represent the Staff Constituency shall draw lots to determine their term of office. Three of these Staff Governors shall serve a term of three years and two shall serve a term of two years.~~

Formatted: Sch 3 Number, Indent: Left: 2.91 cm, First line: 0 cm

2.6 Where a Governor has been elected unopposed, the length of their term of office will be determined by a lot so as to secure that there is an appropriate balance of Governors serving two and three year terms.

2.7 All Appointed Governors shall have an initial term of three years.

2.7.1 Until such time as the Initial Governors are elected, the Appointed Governors shall be responsible for holding the Non-Executive Directors individually and collectively to account for their performance as a Board.

2.7.2 Before holding a meeting, the Interim Directors must send a copy of the agenda of the meeting to the Appointed Governors. As soon as practicable after holding a meeting, the Interim Directors must send a copy of the minutes of the meeting to the Appointed Governors.

2.7.3 The Appointed Governors may hold a meeting for the purpose of exercising their general duty to hold the Interim Non-Executive Directors individually and collectively to account for their performance. The Company Secretary shall, at the request of at least two Appointed Governors, call a meeting of the Appointed Governors and shall provide at least ten (10) days' written notice of any such meeting. The meeting shall be quorate provided that at least three Appointed Governors are in attendance. One of the Interim Non-Executive Directors shall preside at any meeting of the Appointed Governors.

2.7.4 Meetings of the Appointed Governors shall be held in accordance with Clause 16 of the Constitution and paragraphs 7-18 of the Standing Orders for the Council of Governors.

2.7.5 The Appointed Governors shall declare any interests that they may have in accordance with Clause 18 of the Constitution and the Standing Orders for the Council of Governors.

NHS
University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 6.2

Subject:	Annual Audit Committee Report to Board of Directors and consultation on Audit Committee Terms of Reference
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance (Terms of Reference) Ewan Gauvin, Corporate Governance Manager (Report on Committee's adherence to its Terms of Reference)
Presented by:	Judy Gillow, Non-Executive Director, Senior Independent Director and Chair of Audit Committee

Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☐ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Review and Discussion
Executive Summary:	The purpose of these reports is to: • Present to the Council of Governors the report by the Audit Committee to the Board following a review of the Committee's adherence to its Terms of Reference for 2023/24; • Consult with the Council of Governors on proposed amendments to the Audit Committee's Terms of Reference (ToR). •
Background:	<u>Review of Audit Committee's adherence to its Terms of Reference</u> Under the Code of Governance for NHS Foundation Trusts, section C: Composition, succession and evaluation, paragraph 4.5: *There should be a formal and rigorous annual evaluation of the performance of the board of directors and its committees.* The Audit Committee presented the attached report to the Board of Directors following a review of the Committee's adherence to its terms of reference.

	Proposed amendments to ToR The Audit Committee ToR have been reviewed and updated to align with the Healthcare Financial Management Association (HFMA) Audit Committee Handbook (March 2024) example ToR. Proposed amendments are tracked.
Key Recommendations:	To note the Audit Committee annual review of its effectiveness and the proposed amendments to the Committee's terms of reference.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee report on adherence to Terms of Reference		
Board of Directors	03/07/2024	The Board of Directors approved the annual report.
Audit Committee	23/05/2024	The annual report was approved by the Committee.
Terms of Reference		
Audit Committee	18/07/2024	The Committee endorsed the amendments to its Terms of Reference, with a recommendation to the Board to approve them. This was subject to a change being made to reflect that one member of the Committee should be both a qualified accountant and have recent and relevant financial experience.

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality Patient confidentiality Staff confidentiality Other exceptional reason	☐ ☐ ☐ ☐

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AUDIT COMMITTEE ANNUAL REPORT 2023/24

1 PURPOSE OF THE REPORT

1.1 The Audit Committee (the "Committee") is presenting this report to the Board of Directors following a review of the Committee's adherence to its terms of reference. The report sets out how the Committee satisfied its terms of reference between 1 April 2023 and 31 March 2024 (the "review period"), particularly to provide the Board with evidence relevant to its responsibilities for the Annual Governance Statement. The Committee's terms of reference are next due to be reviewed in July 2024.

1.2 The existence of an independent audit committee is a central means by which the Board of Directors ensures that there are effective internal control arrangements in place. The Committee independently reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

1.3 The Committee receives and considers reports from both internal and external auditors, counter fraud specialists and scrutinises the Trust's annual report and financial statements.

1.4 The Committee has a governance cycle detailing which papers are expected to be presented at each meeting of the Audit Committee. This is reviewed annually and updated as necessary during the year.

2 MEETINGS

2.1 Five formal meetings were held during the year, all of which were quorate:

- Thursday 18 May 2023
- Thursday 13 July 2023
- Monday 9 October 2023
- Thursday 18 January 2024

In addition to the Joint Audit and Finance & Performance Committee meeting held on Wednesday 28 June 2023.

2.2 Meeting attendance is detailed in **Appendix 1.**

2.3 It is usual for the External and Internal Auditors and the Counter Fraud Specialist to attend all formal meetings of the Committee. During the period, a representative from external audit, internal audit and the counter fraud specialists was present at each meeting.

2.4 The Trust Chair is not a member of the Committee but may attend meetings at the invitation of the Audit Committee Chair.

2.5 Although the Senior Independant Director should ideally not chair the Audit Committee *(Code of Governance for NHS Provider Trusts B2.5),* this is provided for in the Committee's terms of reference and was approved by the Board.

3 MEMBERSHIP

3.1 Membership of the Committee comprises of four independent Non-Executive Directors (other than the Trust Chair), one of whom will be a qualified accountant and one of whom will also be a member of the Quality Committee.

Membership of the Committee in 2023-24 comprised of:

- Stephen Mount, Non-Executive Director and Chair *(until 30 September 2023)*
- Judy Gillow, Non-Executive Director and Chair *(from 1 October 2023)*
- John Lelliott, Non-Executive Director
- Cliff Shearman, Non-Executive Director
- Claire Whitaker, Non-Executive Director *(from 1 October 2023)*

During his tenure, Stephen Mount was - and John Lelliott is - a qualified accountant. Cliff Shearman and Judy Gillow were members of the Quality Committee during the period.

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team, for review and consideration, by and to support the Committee) in May 2024 by scrutinising the agendas and minutes of the Committee meetings which took place between 1 April 2023 and 31 March 2024. This evidences how the Committee has discharged each of its responsibilities:

4.2 **Governance, risk management and internal control**

To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisations' objectives.[1] In particular, the Committee will review the adequacy and effectiveness of:

4.2.1 **All risk and control related disclosure statements (in particular the annual governance statement, annual report, quality accounts, annual financial statements, annual draft licence compliance, annual draft code of governance compliance, assurance process for licence condition compliance, assurance process for corporate governance statement together with any accompanying internal audit statement, external audit opinion or other appropriate independent assurances), prior to submission to the Board.**

The Committee (or joint Audit and Finance & Performance Committee) reviewed these items prior to submission to the Board:

[1] The Quality Committee has primary responsibility for the oversight of clinical risk management.

- Annual governance statement – May 2023 *(for 2022-23)* and March 2024 *(for 2023-24)*;
- Annual report – June 2023;
- Annual financial statements, including external audit opinion – June 2023;
- Annual draft licence compliance, including assurance – March 2024;
- Annual draft code of governance compliance – March 2024;

In 2023-24, the Quality Account was reviewed by the Quality Committee prior to submission to the Board.

4.2.2 **The underlying assurance processes that indicate the degree of the achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.**

The Committee reviewed the risk register at each meeting, in addition to the Board Assurance Framework (BAF) on a quarterly basis.

Progress reports were received from internal audit in relation to audits undertaken aligned to the BAF and provided an assessment of design effectiveness, areas of strength and improvement including recommendations.

In 2023-24, the Committee commissioned a risk management action plan aimed at strengthening the Trust's approach to risk management, particularly risk appetite and tolerance. It reviewed the action plan in January 2024 and will continue to monitor progress throughout 2024-25.

4.2.3 **The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.**

During 2023-24 the Committee reviewed and recommended to the Board the Anti-Fraud, Bribery and Corruption Policy and the Managing Conflicts of Interest Policy.

As a consultation group, it also received an update on the development of a new Fit & Proper Persons Policy.

The Committee received an update on ongoing quality improvement work for the Trust's policies and procedures; it received a formal report at the meeting held in April 2024 (outside the scope of this report).

In March 2024, the Committee reviewed the Trust's compliance with the Code of Governance for NHS Provider Trusts and the Provider Licence.

It also recommended approval of the annual certificates (Continuity of Services 7 and Training of Governors) in March 2024.

4.2.4 **The wording in the annual governance statement and other disclosures relevant to the Terms of Reference of the Committee.**

The Committee reviewed and recommended approval of the draft annual governance statement in May 2023 (for 2022-23) and March 2024 (for 2023-24).

4.2.5 **The clinical audit system plan to ensure that it is robust, reflecting both national and local priorities, comprehensive and embedded across all clinical**

teams with the outcomes used to drive improvement and enhance the overall quality of clinical care[2].

The clinical audit plan for 2023-24 was presented to the Committee in May 2023, with a subsequent progress report received in January 2024.

4.3 **Counter Fraud**

4.3.1 **To review the adequacy and effectiveness of policies and procedures for all work related to counter-fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service;**

The Committee received the counter fraud progress report at each meeting, including updates on investigations.

It also reviewed and recommended approval to the Board of the Anti-Fraud, Bribery and Corruption Policy and Managing Conflicts of Interest Policy in July 2023 and January 2024 respectively.

4.3.2 **To ensure that the counter fraud function has appropriate standing within the organisation.**

The annual review of the effectiveness of the Local Counter Fraud Specialist was presented to and approved by the Committee in October 2023.

The regular reports from the LCFS included updates on their activities within the Trust, including engagement with staff.

4.3.3 **To review the counter fraud programme, consider major findings of investigations (and management's response), and ensure co-ordination between the internal auditors and counter fraud.**

The Committee reviewed and approved the counter fraud programme for 2024-25 in January 2024.

The LCFS' reports to the Committee contained findings from investigations and management responses.

4.4 **Internal Audit**

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

4.4.1 **Considering the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.**

The Committee received progress reports from internal audit at each meeting.

[2] In conjunction with the Quality Committee

The annual review of the effectiveness of the internal audit service was presented to and approved by the Committee in October 2023.

4.4.2 **Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework.**

The annual internal audit plan was considered at the meeting held in April 2024 (outside the scope of this report).

4.4.3 **Considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;**

The Committee reviewed the major findings and management action plans as part of the internal audit progress report presented to each meeting.

Representatives of both internal and external audit received each other's progress reports and plans as part of the Committee's meeting materials (consequently supporting coordination).

4.4.4 **Ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust.**

The annual review of the effectiveness of the internal audit service was presented to and approved by the Committee in October 2023.

4.4.5 **Monitoring the effectiveness of internal audit and carrying out an annual review.**

As above.

4.5 **External Audit**

To review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process, more particularly, reviewing the work and findings of the external auditors and considering the implications and management's response to their work. This will be achieved by:

4.5.1 **Considering the appointment and performance of the external auditors, including providing information and recommendations to the Council of Governors in connection with the appointment, reappointment and removal of the external auditors in line with criteria agreed by the Council of Governors and the Committee.**

The annual review of the effectiveness of the external audit service was presented to the Committee in October 2023 and recommended for approval by the Council of Governors.

4.5.2 **Discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan.**

The annual external audit plan was considered at the meeting held in April 2024 (outside the scope of this report).

4.5.3 **Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.**

The Committee received an external progress report at each meeting and technical update.

4.5.4 **Reviewing all external audit reports, including reports to the Board and the Council of Governors, and any work undertaken outside the annual external audit plan together with any significant findings and the appropriateness and implementation of management responses.**

The Committee reviewed external audit reports at each meeting.

4.5.5 **Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.**

A policy is in place on the use of external auditors for non-audit work in place which is due for review by the Committee in October 2024.

4.6 **Financial Reporting**

4.6.1 **To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.**

The integrity of the financial statements is monitored through regular external audit reports.

4.6.2 **To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.**

As above.
In addition, the Committee received an internal audit report on Key Financial Systems (Cash Office).

4.6.3 **To review the annual report, annual governance statement and annual financial statements before these are presented to the Board to determine their completeness, objectivity, integrity and accuracy and the letter of representation addressed to the external auditors from the Board.**

The Committee reviewed the draft annual governance statement in May 2023 (for 2022-23) and March 2024 (for 2023-24). The annual report and accounts, alongside the external audit report on the financial statements was reviewed by the Joint Audit and Finance & Performance Committee in June 2023.

4.7 **To review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in matters of financial reporting and control, fraud, bribery and corruption, clinical quality, patient safety or other matters.**

The effectiveness of the LCFS was reviewed in October 2023.

During 2023-24, regular reporting on Freedom to Speak Up was presented to the People & Culture Committee. Reporting on this has since been included in the Committee's governance cycle for 2024-25.

4.8 **To receive assurance that the Trust is complying with EPRR legal and policy requirements, including sufficient experience and qualified resource having been allocated prior to this being presented to the Board.**

The Committee reviewed reports on Emergency Preparedness, Resilience and Response in May 2023 and October 2023.

5 CONCLUSION

5.1 The Committee considers that it has discharged its responsibilities as noted above.

Judy Gillow
Chair, Audit Committee
May 2024

Appendix 1 – Attendance at Audit Committee 2023/24

Attendance at Audit Committee

Audit Committee		18 May 2023	13 July 2023	09 October 2023	18 January 2024
Present	Stephen Mount				
	Judy Gillow				
	John Lelliott				
	Cliff Shearman			A	A
	Claire Whitaker			A	
In attendance	Melanie Alflatt				
	Mandi Barron				
	Jonathan Brown				
	Yasmin Dossabhoy				
	Ewan Gauvin				
	Judy Gillow				
	Tony Hall				
	Kim Hampson				
	Siobhan Harrington				
	Matt Hodson				
	Duncan Laird				
	Mark Mould				
	Pete Papworth				
	Richard Renaut				
	Paula Shobbrook				
	Joanne Sims				
	Adam Spires				
	Mark Stabb				
	Carrie Stone				
	Kani Trehorn				
	Peter Wilson				
Was the meeting quorate?		Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 6.3

Subject:	Review of the terms of reference of the Nominations, Remuneration and Evaluations Committee
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance Klaudia Zwolinska, Corporate Governance Assistant
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☐ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of this paper is to approve the Nominations, Remuneration and Evaluation Committee's Terms of Reference. Under the Committee's Terms of Reference, they are to be reviewed annually or sooner if appropriate.
Background:	The Nominations, Remuneration and Evaluation Committee (NREC) is a committee constituted by the Council of Governors as provided for within the Trust's Constitution. Its Terms of Reference are now due for annual review by the Council of Governors. An update on the Terms of Reference was carried out with largely non-material amendments made, with changes tracked in the attached. The change to reflect the Committee making a recommendation of the Non-Executive Director candidate for the position of Vice Chair is to align to the draft updates to the Trust's Constitution.
Key Recommendations:	To consider and if thought fit to approve the updated terms of reference of the Nominations, Remuneration and Evaluation Committee.

Implications associated with this item:	Council of Governors Equality, Equity, Diversity & Inclusion Financial Health Inequalities Operational Performance People (inc Staff, Patients) Public Consultation Quality Regulatory Strategy/Transformation System (Explained above).	☒ ☐ ☐ ☐ ☐ ☒ ☐ ☐ ☒ ☐ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☐ ☐ ☐ ☐ ☒ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
N/A	N/A	N/A

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality Patient confidentiality Staff confidentiality Other exceptional reason	☐ ☐ ☐ ☐

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Council of Governors' Nominations, Remuneration and Evaluation Committee

July 2024~~3~~

We are caring one team listening to understand open and honest always improving inclusive

DOCUMENT DETAILS

Author:	~~Sarah Locke~~Yasmin Dossabhoy, Associate Director of Corporate Governance and Klaudia Zwolinska, Corporate Governance Officer
Job Title:	~~Deputy Company Secretary~~Associate Director of Corporate Governance; Corporate Governance Officer
Signed:	
Date:	July 2024~~3~~
Version No: (Author Allocated)	32.0
Next Review Date:	July 2025~~4~~

Approving Body/Committee:	Council of Governors
Body/Committee Chair:	Rob Whiteman
Signed:	
Date Approved:	
Target Audience:	Council of Governors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
July 2022	1.0	July 2023	July 2022	Company Secretary	Full review and revision of terms of reference
July 2023	2.0	July 2024	27 July 2023	Company Secretary	Full review and revision of terms of reference
July 2024	3.0	July 2025	29 July 2024	Company Secretary	Full review of terms of reference

TABLE OF CONTENTS

INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
COUNCIL OF GOVERNORS APPROVAL			
If the Council of Governors has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Council of Governors	Date	297 July 20243
Print Name	Rob Whiteman	Signature of Body/Committee Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

NOMINATIONS, REMUNERATION AND EVALUATION COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 Under the Trust's Constitution, the Nominations, Remuneration and Evaluation Committee (the Committee) is:

- To determine the criteria or process for the selection of candidates for office as Trust Chair or other Non-Executive Director of the Trust, having regard to such views as may be expressed by the Board of Directors.
- To seek by way of open advertisements and other means candidates for office and to assess, shortlist and select for interview such candidates as are considered appropriate.
- To make recommendations to the Council of Governors as to potential candidates for appointment as Trust Chair or other Non-Executive Director, as the case may be.
- To monitor the performance of the Trust Chair and other Non-Executive Directors and make reports to the Council of Governors from time to time on such performance.
- To consider and make recommendations to the Council of Governors about the remuneration and allowances and other terms and conditions of office of the Trust Chair and Non-Executive Directors.
- To review the structure, size and composition of the Board of Directors from time to time and make recommendations to the Council of Governors.

1.3 The Committee is a committee of the Council of Governors and has no delegated authority but will assist the Council of Governors in carrying out its role.

2. RESPONSIBILITIES

To advise and/or make recommendations to the Council of Governors relating to:

2.1 The evaluation of the performance of the Trust Chair and Non-Executive Directors. The Committee will on an annual basis monitor the performance of the Trust Chair and other Non-Executive Directors and make reports on the same to the Council of Governors ~~when requested to do so by the Lead Governor or~~ when in the opinion of the Committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors.

2.2 The remuneration, allowances and other terms and conditions of office for the Trust Chair and Non-Executive Directors.

2.3 The composition of the Board of Directors and the skill mix of the Non-Executive Directors.

2.4 The recruitment criteria and/oror process for the selection of candidates for the office of Trust Chair or other Non-Executive Directors. In this context:

- The Committee shall determine the processes for the selection of candidates for office as Trust Chair or other Non-Executive Director of the Trust having first consulted with the Board of Directors as to these matters and having regard to such views as may be expressed by the Board of Directors.

- The Committee shall, using the Trust's HR Services, seek candidates for office and to assess, shortlist and select for interview such candidates as are considered appropriate and in doing so the Committee shall be at liberty to seek advice and assistance from persons other than members of the Committee or of the Council of Governors such as external organisations recognised as experts in recruitment and remuneration.

- The Committee shall make recommendations to the Council of Governors of the candidate for appointment as the Trust Chair or other Non-Executive Directors, as the case may be.

2.5 The Non-Executive Director candidate for the position of Vice Chair.

2.56 The consideration of the continuing tenure of absentee Governors.

3. MEMBERSHIP AND ATTENDANCE

3.1 The Trust Chair, or in their absence, the Vice Chair is to preside at meetings of the Committee. If the Trust Chair is absent from a meeting or temporarily absent on grounds of a declared interest the Vice-Chair shall preside. If the Trust Chair and Vice Chair are absent, such Non-Executive Director as the Ggovernors present shall choose shall preside.

3.2 The Committee will comprise of one Ggovernor from each of the public constituencies, one appointed Ggovernor and one Ggovernor from a staff constituency.

3.3 Governors comprising the Committee will be nominated by constituency. Where there is more than one nomination a ballot of that constituency will take place. The term of office will be for a three-year term with a permitted maximum of two three-year terms.

3.4 If the Lead Governor is not one of the Governors nominated by constituency, then the Lead Governor will automatically be co-opted to the Committee as a member. The term of office will coincide with such person holding the role of Lead Governor.

3.5 In discharging its responsibilities, the Chief Executive of the Trust will be entitled to attend meetings of the Committee unless the Committee decides otherwise, and the Committee will be required to take account of the Chief Executive's views.

3.6 In addition, the Chief People Officer may from time to time attend the Committee to provide information, advice and/or to present to the Committee:

3.7 Committee members should aim to attend all scheduled meetings.

3.8 Subject to paragraphs 3.5 and 3.6 above, only members of the Committee have the right to attend Committee meetings.

4. AUTHORITY

4.1 The Committee is authorised by the Council of Governors to carry out any activity within its Terms of Reference.

4.2 For the appointment of the Trust Chair, the Committee will seek the services of an independent assessor.

4.3 For all appointments and matters relating to remuneration, the Committee will seek advice from the professional human resource services of the Trust who may in turn seek professional external support.

5. CONDUCT OF BUSINESS

5.1 The Trust's Constitution shall apply to the Committee, to the extent applicable, and any its meetings.

5.2 The Committee will meet as a minimum, twice per year and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee will be quorate if at least three members are present, one of whom must be a publicly elected Governor.

5.4 Meetings of the Committee shall be called by the Company Secretary (or nominee on their behalf) at the request of the Committee Chair.

5.5 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members.

5.6 Unless otherwise agreed by the Committee Chair, agenda and papers should be circulated no less than five working days before the meeting.

5.7 Proceedings and decisions made will be formally recorded by the Company Secretary Team in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

5.8 The Committee Chair should draw attention to the Council of Governors any matters relevant to the Committee's duties.

5.9 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Committee Chair shall be responsible for determining that the meeting is quorate.

5.10 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: the Committee Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee and/or the Council of Governors at the next meeting.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Council of Governors.

6.2 The Committee Chair will report back to the next formal meeting of the Council of Governors.

7. MONITORING

7.1 Attendance will be monitored at each Committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 On an annual basis, the Committee will provide a report of its own work.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

APPENDIX A

ATTENDANCE AT NOMINATIONS, REMUNERATION AND EVALUATION COMMITTEE MEETINGS

NAME OF COMMITTEE:	Nominations, Remuneration and Evaluation Committee			
Present *(including names of members present at the meeting)*	**Meeting Dates**			
Was the meeting quorate? Y/N *(Please refer to Terms of Reference)*				

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 6.4

Subject:	Code of Conduct update
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Yasmin Dossabhoy, Associate Director of Corporate Governance

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of this paper is to present to the Council of Governors an updated draft of the Code of Conduct for Governors.
Background:	Governors are required to provide a declaration to confirm that they will comply with the Trust's Code of Conduct for Governors in all respects. The Associate Director of Corporate Governance periodically leads a review of the Code. The proposed amendments to the Code include taking account of thematic feedback from the Constitution Review Group and the Effectiveness Group, respectively, relating to: • The importance of those in public office demonstrating integrity; and • The need for existing and prospective Governors to be clear on the expectations of the role and to fulfil such expectations when carrying out such role. Additionally, the Constitution Review Group discussed a supplemental procedure in relation to alleged breaches of the Code of Conduct, with this currently being reviewed.
Key Recommendations:	To consider and if thought fit to endorse the updated Code of Conduct.

Implications associated with this item:	Council of Governors	☒
	Equality, Equity, Diversity & Inclusion	☐
	Financial	☐
	Health Inequalities	☐
	Operational Performance	☐
	People (inc Staff, Patients)	☒
	Public Consultation	☐
	Quality	☐
	Regulatory	☒
	Strategy/Transformation	☐
	System	☐
	(Explained above).	
CQC Reference:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
N/A	N/A	N/A

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality	☐
	Patient confidentiality	☐
	Staff confidentiality	☐
	Other exceptional reason	☐

University Hospitals Dorset
NHS Foundation Trust

CODE OF CONDUCT FOR COUNCIL OF GOVERNORS

1. INTRODUCTION

1.1 University Hospitals Dorset NHS Foundation Trust prides itself on being open and in providing friendly, professional patient care with dignity and respect. As a Governor, sometimes dealing with difficult and confidential issues, Governors are required to act with discretion and care in the performance of their role without compromising patient and/or staff confidentiality.

1.2 The purpose of this ~~code~~ Code is to provide clear guidance on the standards of conduct and behaviour expected of all Governors. ~~The~~ This ~~code~~Code~~, with the Code of Conduct for Directors and the NHS Constitution,~~ forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the ~~Foundation~~ Trust. The ~~code~~ Code ~~is intended to operate~~ should be read in conjunction with:

1.2.1 the Trust's Constitution and ~~Standing Orders~~licence;
1.2.2 The Trust's policy and procedures covering conflicts of interest and counter-fraud;
1.2.3 The Trust's Standing Orders;
1.2.4 *NHS England's Code of Governance for NHS Provider Trusts*, and *Your statutory duties: A reference guide for NHS Foundation Trust Governors*; and
1.2.5 The NHS Constitution.

~~1.2 . The code applies at all times when Governors are carrying out the business of the Foundation Trust or representing the Foundation Trust.~~

Formatted: List Paragraph, No bullets or numbering, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers
Formatted: Font: 11 pt
Formatted: Indent: Hanging: 0.65 cm
Formatted: Font: Italic
Formatted: Font: Italic
Formatted: Indent: Left: 1.9 cm, No bullets or numbering

2. WHY WE HAVE A CODE OF CONDUCT

~~1.3~~2.1 Adherence to this Code helps to ensure that our Trust inspires confidence and trust amongst its patients, members, staff, partners and suppliers by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in the decision-making of the Trust.

2.2 The Council of Governors has an integral role in supporting the Board of Directors in promoting the Trust's values and visions to members, patients and the public.

2.3 The Trust's Constitution makes provision for Governor elections, the appointment of Governors, practice and procedure of Governors and ultimately the removal of Governors. This Code of Conduct complements the Trust's Constitution.

2.4 This Code seeks to outline appropriate conduct for Governors and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied; however, a ~~code~~ Code is considered ~~an~~ essential ~~guide~~ for Governors, ~~particularly~~ including to provide a source of guidance and advice ~~to those who are newly elected~~.

~~1.4~~2.5 ~~Governors are required to maintain confidentiality with regard to information gained via their involvement with the Trust. This may cover patients, staff or commercial confidentiality. If in any doubt seek guidance from the Company Secretary.~~

~~1.5 The Code seeks to expand on and complement our Constitution.~~

~~1.6~~ All Governors are ~~expected~~ required to sign the declaration at paragraph ~~14~~ 19 to confirm that they will comply with the Code in all respects and that, in particular, they support the Trust's objectives.

~~2.~~3. THE PRINCIPLES OF PUBLIC LIFE

The principles underpinning this code of conduct are drawn from the 'Seven Principles of Public Life' (Nolan Principles) and are as follows:

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability

Holders of public office are accountable for to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty

Holders of public office should be truthful.

Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

~~34~~. QUALIFICATIONS FOR OFFICE

~~34~~.1 Governors must continue to comply with the qualifications required to hold public office throughout their period of tenure. The Company Secretary must be advised of any changes in circumstance which may disqualify a Governor from continuing in office. ~~For example, a Governor moving out of the constituency they were elected by or (other than the elected staff members) becoming an employee of the Trust.~~

~~34~~.2 One of the key objectives of the Council of Governors is to promote social inclusion throughout its work. As such, the development and delivery of initiatives should not prejudice any part of the community on the grounds of age, race, disability, ~~marital status~~marriage or civil partnership, gender reassignment, sex, sexual orientation, pregnancy and maternity, or ~~religious~~ religion or belief.

~~34~~.3 Elected Governors (i.e. not Appointed Governors) who are members of any trade~~'s~~ union, political party or other organisation should recognise that they will not be representing those organisations (or the views of those organisations) but will be representing the constituency (public or staff) that elected them.

~~34~~.4 Governors are expected to uphold the seven principles of public life as detailed by the Nolan Committee (please see ~~Section~~ section ~~2~~3).

~~45~~. ROLE AND ~~FUNCTION~~ RESPONSIBLITIES OF THE COUNCIL OF GOVERNORS

~~45~~.1 The general duties of the Council of Governors are:

5.1.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and

5.1.2 To represent the interests of the members of the Trust as a whole and the interests of the public.

The role is set out in further detail in the Trust's Constitution and NHS England's Code of Governance for Provider Trusts.

5.2 The Council of Governors represents the interest of all the Trust's members, not just the constituency that elected, or the external body that appointed, individual Governors.

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

5.4 In fulfilling their roles and responsibilities, Governors must:

5.4.1 adhere to the Trust's rules, ~~and~~ policies and procedures, including the Constitution, Standing Orders and Standing Financial Instructions, and Managing Conflicts of Interests Policy;

5.4.2 support its objectives, in particular those relating to NHS Foundation Trust status and developing a successful Trust;

~~i)~~

Formatted: Indent: Left: 0 cm, Hanging: 1.25 cm

Formatted: Outline numbered + Level: 2 + Numbering Style: 1, 2, 3, … + Start at: 4 + Alignment: Left + Aligned at: 0 cm + Indent at: 0.63 cm

Formatted: Indent: Left: 1.25 cm, Hanging: 1.25 cm, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Indent at: 1.27 cm

Formatted: Indent: Left: 1.25 cm, Hanging: 1.25 cm, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Indent at: 1.27 cm, Tab stops: Not at 3.79 cm

5.4.3 act in the best interests of the Trust at all times;

ii)

5.4.4 contribute to the working of the Council of Governors in order for it to fulfil its role and functions as defined in the Trust's Constitution;

iii)

5.4.5 recognise that their role is a collective one. Collective decision making is exercised at Council of Governors meetings and Governors support decisions made by the Council of Governors even if against their own wishes. The outcome of collective decision making is recorded in the minutes;

5.4.6 recognise that the Council of Governors has no managerial role within the Trust;

iv)5.4.7 support and assist the Chief Executive, as the Accounting Officer of the Trust in their responsibility to answer to NHS England, commissioners and the public..

v) outside Council meetings a Governor has no more rights and privileges than any other member.

56. CONFIDENTIALITY

56.1 All Governors are required tomust respect respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors. This may cover relating to individual patients, members of staff or commercial confidentiality. If in doubt, Governors should seek guidance from the Company Secretary.

5.2

6.2 Governors must comply with the Foundation Trust's confidentiality policies and procedures. Governors must not disclose any confidential information, except in specified lawful circumstances, and must not seek to prevent a person from gaining access to information to which they are legally entitled.

6.3 Without limiting the above, Governors from time to time may be given the opportunity to observe meetings of Board Committees to support their role of holding Non-Executive Directors to account and/or receive information related to meetings of the Board held in private. Governors must respect the confidentiality of information (which shall include but not be limited to, discussions and papers) to which they are made privy as a result of or in connection with the same.

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

67. REGISTER OF INTERESTS

67.1 Governors are required to register all relevant interests on the Foundation Trust's register of interests in accordance with the provisions of the Constitution. It is the

Formatted: Indent: Left: 1.25 cm, Hanging: 1.25 cm, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Indent at: 1.27 cm, Tab stops: Not at 3.79 cm

Formatted: Indent: Left: 1.25 cm, Hanging: 1.25 cm, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Indent at: 1.27 cm, Tab stops: Not at 3.79 cm

Formatted: Indent: Left: 1.25 cm, Hanging: 1.25 cm, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0 cm + Indent at: 1.27 cm, Tab stops: Not at 3.79 cm

responsibility of each Governor to update their register entry if their interests change. A pro forma is available from the Company Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this ~~code~~Code.

~~6~~7.2 There will be a register of Interests in which Governors must enter any ~~pecuniary and non-pecuniary~~relevant interests. Failure to do so may result in dismissal from the Council of Governors. The Register of Council of Governors Interests is a public document that will be available on the Trust's website and by request to the Company Secretary.

~~7~~8. CONFLICTS OF INTEREST

~~7~~8.1 Governors should be honest and act with the utmost integrity, probity, and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment.

~~7~~8.2 Governors have a duty to avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the ~~Foundation~~ Trust. Governors have a further duty not to accept a benefit from a third party by reason of being a Governor or for doing (or not doing) anything in that capacity.

~~7~~8.3 Governors must declare the nature and extent of any interest at the earliest opportunity. If in any doubt they should seek advice from the Company Secretary. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Trust Chair to advise whether it is necessary for the Governor to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this ~~code~~Code. It is important that conflicts of interest, actual or potential, are addressed and are seen to be actioned in the interests of the Trust and all the individuals concerned.

~~7.5~~8.4 Without limiting the generality of paragraph 8.3 and the Constitution, Governors must, for example, declare any involvement they may have in any organisation with which the Trust may be considering entering a contract.

~~8~~9. MEETINGS OF THE COUNCIL OF GOVERNORS

~~8~~9.1 Governors have a responsibility to attend meetings of the Council of Governors and the Annual Members' Meeting. When this is not possible, they should submit an apology to the Company Secretary in advance of the meeting.

~~8~~9.2 Absence from the Council of Governors meetings without good reason established to the satisfaction of the Council of Governors is grounds for dismissal. Absence from two consecutive meetings will result in the Governor being deemed to have resigned their position unless the grounds for absence are deemed to be satisfactory by the Council of Governors.

~~8.3~~ 9.3 Governors are expected to attend for the duration of each meeting.

Formatted: No bullets or numbering

~~9~~10. PERSONAL CONDUCT

~~9~~10.1 Governors are required to adhere to the highest standards of conduct in the performance of their duties and abide by the philosophy and values set out in the Trust's Vision and Values. In respect of their interaction with others they are required to:

i) 10.1.1 ensure that fellow Council Members are valued as colleagues and that judgements statements about colleagues are consistent, fair and unbiased and are properly founded;

ii) 10.1.2 adhere to good practice in respect of conduct of meetings and respect the views of their fellow Governors;

iii) 10.1.3 be mindful of conduct which could be deemed to beviewed unfair or discriminatory. Specifically, Governors must treat others with respect; not breach the equality enactments and not bully any person.

10.1.4 treat the Trust's Directors, other employees and fellow Governors with respect and in accordance with the Trust policies and its vision and values.

iv)

v) 10.1.5 recognise that the Council of Governors and management have a common purpose, i.e. the success of the Trust, and so demonstrate their commitment to working as a team member by working with all their colleagues in the NHS and the wider community;

vi) 10.1.6 conduct themselves in a manner which reflects positively on the Trust and not conduct themselves in a way which could reasonably be regarded as bringing their role the Council of Governors or the Trust into disrepute. When attending external meetings or any other events it is important for Governors to be ambassadors for the Trust;

vii) 10.1.7 seek to ensure that the membership of the constituency, or partner organisation, they represent are properly informed and that their views are fed back to the Trust.

10. 11. FIT AND PROPER PERSON TEST

110.1 It is a condition of the Trust's licence that each Governor serving on the Council of Governors is a "fit and proper person" as defined in the Trust's licence and set out in the Trust's Constitution. Governors must certify on appointment, and each year that they are/remain a fit and proper person. If circumstances change so that a Governor can no longer be regarded as a fit and proper person or if it comes to light that a Governor is not a fit and proper person, they are suspended from being a Governor with immediate effect pending confirmation and any appeal. Where it is confirmed that a Governor is no longer a fit and proper person, their membership of the Council of Governors is terminated.Governors must comply with the Fit and Proper person test contained in the NHS Provider Licence issued by Monitor (now NHS England). According to the Licence 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

Formatted: Indent: Left: 1.25 cm, Hanging: 1.25 cm, No bullets or numbering, Tab stops: Not at 3.79 cm

Formatted: No bullets or numbering, Tab stops: Not at 3.79 cm

Formatted: Indent: Left: 0 cm, Hanging: 2.5 cm, No bullets or numbering, Tab stops: Not at 3.79 cm

Formatted: No bullets or numbering

Formatted: Indent: Left: 0 cm, Hanging: 1.25 cm, No bullets or numbering, No widow/orphan control

~~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.~~

~~b. a body corporate, or a body corporate with a parent body corporate:~~

~~i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or~~

~~ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or~~

~~iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or~~

~~iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or~~

~~v) which passes any resolution for winding up, or~~

~~vi) which becomes subject to an order of a Court for winding up.~~

~~11~~12. COMMUNICATION

~~11~~12.1 With regard to liaison with the media, Governors should seek the advice of the Associate Director of Communications before making comment to or responding to the media and must follow relevant Trust's policies in relation to media comments and more broadly in relation to communications, including, but not limited to, social media.

~~11~~12.2 Issues of a key or strategic nature should be submitted to the Trust Chair or Company Secretary in writing.

1~~3~~2. ~~ACCOUNTABILITY~~STAKEHOLDER ENGAGEMENT

~~12~~13.1 Governors are accountable to the membership and should demonstrate this. They should attend events and provide opportunities to ~~interface with~~meet, talk and listen to the members or partner organisations they represent in order to best understand their views.

13.2 Governors should be fully aware of their representative functions and should not become personally involved in patient or public matters that ought to rightly be handled by the appropriate member of Trust staff. Governors are advised to act as a conduit for forwarding public comments and concerns to the appropriate staff member, when presented with a complaint from a member, patient or the general public.

~~13~~14. TRAINING AND DEVELOPMENT

~~13~~14.1 Training and development are essential for Governors, as for all staff, in ensuring effective performance of their role. Governors will be expected to participate in training and development as provided by the Trust, including induction events.

~~13~~14.2 The ~~Foundation~~ Trust is committed to providing appropriate training and development opportunities for Governors to enable them to carry out their role effectively. Governors are expected to undertake ~~to~~ and participate, given reasonable notice, in training and development opportunities that have been identified as appropriate for them. To that end Governors will participate in the ~~appraisal~~ annual review of the effectiveness of the Council of Governors process and any skills audit carried out by the ~~Foundation~~ Trust.

~~14~~15. ~~VISITS~~ ATTENDANCE BY GOVERNORS ~~TO~~ AT TRUST PREMISES

~~14~~15.1 In fulfilling their core duties and responsibilities, Governors will be expected to attend at Trust premises. For activities other than attending Council of Governors' meetings, development meetings arranged by the Trust as referred to in paragraph 14.1 above, Council of Governors' Committee meetings and any Council of Governors' Group meetings established by the Trust, Governors may wish, as part of their role, to visit Trust premises. However, Governors will recognise that, as the Trust buildings are busy facilities, ~~it~~ It is important for visits to be planned to coincide with operational requirements and may need to be conducted in groups to maximise staff availability.

~~14~~15.2 When ~~the~~ Governors wish to visit the premises of the Trust in a formal capacity as opposed to individuals in a personal capacity, they should liaise with the Company Secretary's office to make the necessary arrangements. Efforts will be made to accommodate such requests but it may not always be possible to agree specific dates, times or site visits.

Formatted: Indent: Left: 0 cm, First line: 0 cm

~~15~~16. NON-COMPLIANCE WITH THE CODE OF CONDUCT

~~15~~16.1 An allegation of non-compliance with the Code may be made by a fellow Governor, a member of staff, a member of the Trust or a member of the public.

16.2 Non-compliance with this Code ~~of Conduct~~ may result in action being taken as follows:

~~i)~~ 16.2.1 where alleged misconduct takes place the Trust Chair following consultation with the ~~Deputy Chair of Governors~~Vice Chair and/or the Lead Governor is authorised to take, without prejudice to any decision by the Council of Governors to initiate a process pursuant to paragraph ~~15~~16.~~1~~(ii)2.2, such action as may be immediately required, including the exclusion of the person concerned from Trust premises and meetings~~;~~

Formatted: Indent: Left: 1.25 cm, Hanging: 1.25 cm, No bullets or numbering

~~ii)~~ 16.2.2 where such misconduct is alleged, it shall be open to the Council of Governors to decide, by simple majority of those in attendance, to initiate formal processes. In such instances it will be the responsibility of the Council of Governors (subject to paragraph ~~15~~16.2.~~1~~(iv)4) to:

- notify the Governor in writing of the allegations, detailing the specific behaviour which is considered to be detrimental to the Trust, and inviting and considering their response within a defined timescale;
- inviting the Governor to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence;
- deciding, by simple majority of those present and voting, whether to uphold the allegation of conduct detrimental to the Trust;
- impose such sanctions as shall be deemed appropriate. Sanctions will range from the issuing of a verbal or written warning to the removal of the Governor from office;

~~iii)~~ 16.2.3 in order to aid participation of all parties, it is imperative that all Governors observe the points of view of others and conduct likely to give offence will not be permitted. The Trust Chair will reserve the right to ask any member of the Council of Governors who (in his / her opinion), fails to observe the ~~code~~ Code to leave the meeting.

Formatted: Indent: Left: 2.75 cm, Hanging: 1.25 cm, No bullets or numbering

~~iv)~~ 16.2.4 Where misconduct is alleged as set out in paragraph 1~~3.1~~6.2.2 ~~(ii)~~ an independent assessor may be appointed pursuant to the provision of Annex 4 ~~paragraphs 3.6 to 3.9~~ of the Constitution at any stage in the process and no decision of the Council of Governors shall be made until such time as the Council of Governors has had an opportunity to consider the advice of the independent assessor.

~~15~~16.~~2~~3 This Code of Conduct does not limit or invalidate the right of the Governor or the Trust to act under the Constitution.

~~16~~17. INTERPRETATION AND CONCERNS

~~16~~17.1 Questions and concerns about the application of the ~~code~~ Code should be raised with the Company Secretary. At meetings, the Trust Chair will be the final arbiter of interpretation of the ~~code~~Code.

~~17~~18. REVIEW AND REVISION OF THE CODE

~~17~~18.1 This ~~code~~ Code has been agreed by the Council of Governors. The Company Secretary will lead periodically a review of the ~~code~~Code. ~~It is for Governors to agree to any amendments or revisions to the code.~~

~~18~~19. UNDERTAKING AND COMPLIANCE:

~~18~~19.1 Governors are required to give an undertaking that they will comply with the provisions of this ~~code~~Code. Failure to comply with the ~~code~~ Code may result in disciplinary action in accordance with agreed procedure.

I …… (*print name*) agree to abide by the Code of Conduct of the Council of Governors of The University Hospitals Dorset NHS Foundation Trust.

Signature ……..…….

Date ……..……..

10

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 7.1

Subject:	Freedom to Speak up Annual Report (2023/4)
Prepared by:	Helen Martin, Freedom to Speak Up Guardian (FTSUG)
Presented by:	Helen Martin, FTSUG

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☐ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	BAF not applicable
Purpose of paper:	Information
Executive Summary:	The purpose of exception report is to: • Review our speaking up culture over 2023/4 and • Understand why our staff are raising concerns and what we have learnt.
Background:	Every Trust is mandated to have a named FTSUG in post and an expectation as part of the well led domain, to see FTSUG reports submitted at least 6monthly to enable the board to maintain a good oversight of FTSU matters and issues. Reports are to be presented by the FTSUG in person. Reports must include both quantitative and qualitative information and case studies or other information that will enable the senior team to understand the issues being identified, areas for improvement, and take informed decisions about action.
Key Recommendations:	• Speaking up benefits everyone; it creates learning and improvement, leads to safer care and improved patient experience. • Case headlines; 412 FTSU referrals 2023/4, an increase of 48% on previous 12month. 185 cases from Poole site and 227 cases from RBCH (45:55% respectively). • Staff approach the FTSU team for a number of reasons. The greatest theme had an element of behaviours (188 staff; 46%). This is followed by process and procedures (131 staff; 32%) and then

	worker safety and wellbeing (76 staff; 18%). Worker safety continues to grow as a theme year on year.
	• Staff use the FTSU channel more for workplace and relational issues than patient safety.
	• 47% of staff who use the FTSU route is because either their line manager is the issue or not addressing the issue. 14% felt insecure.
	• 22% of staff (89 staff) from our global majorities ethnic minority raised FTSU concern. 57% of cases (51 staff) had elements of attitudes and behaviours.
	• Thirty-seven staff reported cases anonymously (9% , similar to National 9.3%).
	• Other points to note:
	  ○ FTSU month (Oct) - #breakingboundaries increase in referrals 75% from previous month.
	  ○ Poor uptake of Speak Up, Listen Up, Follow Up', e-learning modules. Total 2023/4 – 263staff. Just over 600 staff since 2021.
	• Learning;
	  ○ The importance of a respectful and civil culture/programme of work
	  ○ We leave roles because of the people we work with.
	  ○ Merger stresses and differences across sites continue.
	  ○ Our global majorities speak up more about poor behaviours and not belonging.
	  ○ Cost of living struggles.
	  ○ Decision makers involving those who will be impacted by decisions.
	  ○ Busy line managers, not visible. Teams feeling unable to escalate issues. Line managers frustrated as unable to be present and be with teams. Issues often escalate.
	  ○ The importance of leaders creating psychologically safe workspaces and part of this is to encourage speaking up
	  ○ Listening takes time and is at the core of good leadership.
	  ○ Speaking up is everyone's business

Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☒ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☐ Caring ☐

	Responsive	☒
	Well Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
PCC TMG Board of Directors	10 April 24 23 April 24 1 May 24	TMG for assurance and discussion. PCC for approval. For noting

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality	☐
	Patient confidentiality	☐
	Staff confidentiality	☐
	Other exceptional reason	☐

Freedom to Speak Up (FTSU)

Annual Report 2023/24

1.0 Introduction

Reflecting back on 2023/4 I am reminded of a quote from Megan Reitz, who spoke at last year's Freedom to Speak Up Guardian Conference:

"The silence of missing voices costs careers, relationships and lives".

Megan Reitz, 2023

Indeed, we saw this very sharply following the trial and verdict of Lucy Letby last Summer. It is tragic consequences of not listening and taking appropriate timely action like this which must lead us all to redouble our efforts to make speaking up, listening up and following up, business as usual.

Staff tell us that the main barriers to speaking up are fear and futility. Fear of what might happen if you speak up; or a belief that nothing will be done if you do. As leaders we must demonstrate that we welcome and encourage speaking up, through actions, not just words. That means listening to understand and challenging our own biases; remaining impartial and investigating the matter raised, not the person raising it.

At UHD, we have many routes that our people can use to speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route which is both well used and evaluated by staff who use it.

Speaking up is entrenched within our objectives, strategy and improvement programme and we are seeing some early signs of green buds. This year, over 5600 staff shared their voice through the staff survey: 59% of UHD. This rich data tells us that over 50.63% staff feel our speaking up culture has improved from 2021 when only 46.31% felt the same. This is nearly a 10% increase from the previous 12months and will contribute to our safety culture breakthrough objective for quality outcomes and safety. Clearly there is more to do as 49.4% of staff this year do not feel the same.

This work is however more than the FTSU team. The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. Our leaders, need to play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture at UHD. Indeed, it is the experience of how our managers listen and act to concerns that we are often judged. Consequently, we need to be curious as to why staff choose not to go to their line manager. Over the last 12months, 47% of staff who come to the FTSU team say that they cannot go to their line manager because either they are the issue or that they are not addressing it. We need to better at this for us to be an embedded speaking up organisation.

Twenty-twenty-three has also been a year to celebrate. The FTSU team has expanded, with an additional FTSU guardian in post, Tara Vachell. The investment in this role has seen improvements in capacity, access and being able to deliver proactive projects such as hearing more from those seldom heard voices. A recent survey of those staff who have used the FTSU service also told us that the FTSU service reduced their absence but also resulted in them staying in the Trust; contributing to our people breakthrough objective for attracting and retaining the best talent (see section 2.1).

We also had another FTSU month in October and was a month to be proud. The team celebrated #breakingboundaries and visited departments, clinical areas, flying flags, a supportive communications plan, launched a communications development training programme for our IEN workforce and led a Schwartz round on “a time when I spoke up”. Over 60 staff that month (an increase of 75% on the previous month) decided to speak up because of this work (see section 3.3).

The purpose of this paper is to review our speaking up culture for 2023/4 and understand why our staff are raising concerns and what we have learnt.

ACTION: Note approved amendments to FTSU Strategy which now reflects our Patient First Improvement Programme (section 3.8).

2.0 Vision of Speaking up and Commitment from the FTSU team

Supporting you to raise concerns
Freedom to speak up

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

2.1 Speaking up at UHD – Our FTSU team

Our deputy FTSUG commenced in post end of August. This decision was made in line with guidance set out by the National Guardian Office (NGO) on developing FTSU internal networks. This development will allow the service at UHD be both sustainable and resilient, meeting the demands of our staff using the FTSU route, but also allow us to contribute to the organisation overcoming the barriers that result in workers feeling that they must come to a guardian in the first place. This is an exciting opportunity which will build on our FTSU network of Ambassadors set up since 2018. Our FTSU network raises awareness and promotes the value of speaking up, listening up and following up and helps address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

We are now looking to sustain our new model and so have reviewed a number of data to evaluate it.

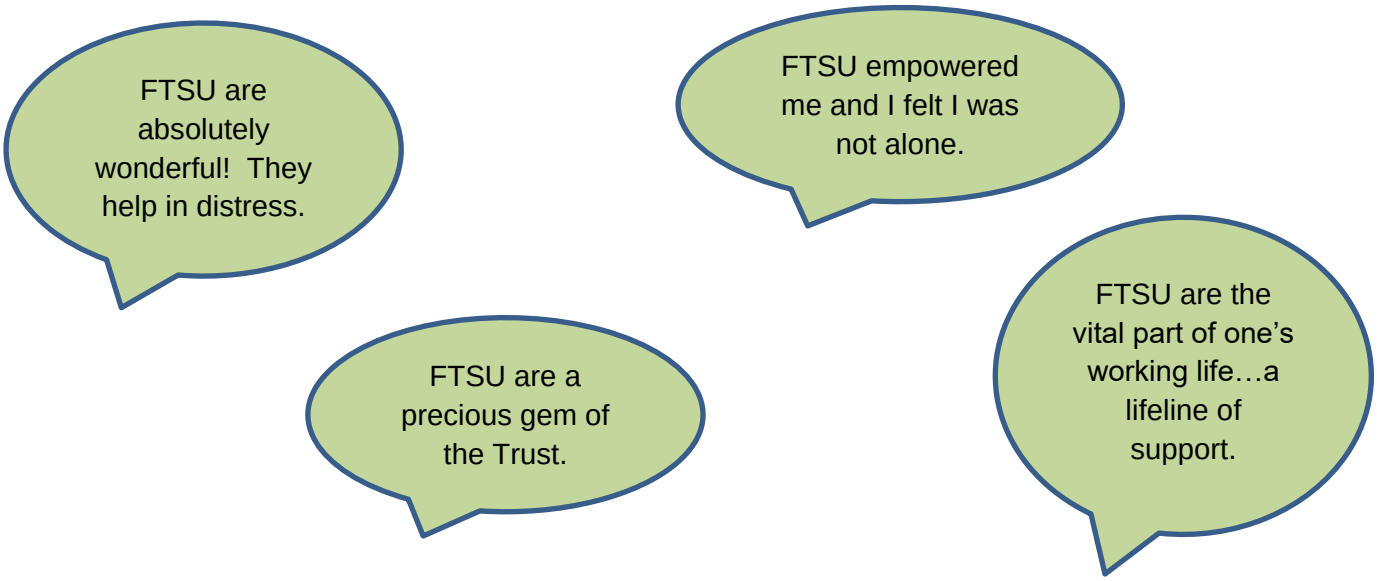
- **Increased Capacity:** The investment of this post has allowed us to meet the year-on-year increase of demand to FTSU service. In quarter 3, 2023, the number of conversations increased by 53% as compared to Q3, 2022 (142 vs 93 referrals, respectively).
- **Improved Access Times to FTSU team:** The investment of this post has allowed us to make contact following a referral within 48hrs working days in 100% of cases and of those, 99.3% within 24hrs.
- **Overcoming barriers and being more proactive:** The NGO warn leaders against FTSUG spending all their time acting as an additional channel rather than undertaking proactive work to overcome the barriers that result in workers feeling that they must come to a guardian in the first place. The investment of this post has allowed the FTSU team to proactively speak to over 400 staff (Qtr 3, 2023) as compared to less than 50 staff (Qtr 3, 2022) through presentations/team meetings/inductions. The team are now accessing groups never previously reached such as international workforce, medical, healthcare support workers and preceptees.
- **Hearing more seldom heard voices:** The function of the FTSU team is well established and continues to increase its reach to those voices seldom heard. In 2022/3 19% of referrals were from our global majority staff which has increased in 2023/4 to 21% of total referrals. Particular focus has been with our international workforce, not only at induction but also now within their development programme by leading a communication and speaking up workshop.
- **Increased team resilience:** The investment of this post has allowed 365day access to the FTSU team thereby improving team resilience but moreover removing a service with a single point of failure.

Another source of data was taken from a survey to staff who have used the FTSU service in quarter 3. Key observations were made:

- **Improved Added Value:** A service user survey was sent to all staff whom used the service in Qtr 3; 2023 to assess the value of staff using the service and supporting the breakthrough objectives for UHD (n=30):

    - **Service Value:** 44% felt stressed and worried before raising their concern
      "the situation felt like it was snowballing out of control and no one was listening", "the incident that I escalated to FTSU made me physically sick and I was off > 1 week."
    - **Support Health and Wellbeing**: 64% of staff felt speaking with the FTSU team supported their Health and Wellbeing
      "gave me the opportunity to start to learn to trust some NHS staff as I feel I have been let down in the past" and "felt listened to and the FTSU team helped me put in a plan to help deal with the situation"
    - **Reduction in Staff sickness:** 7 members of staff (25%) reported that they remained in work as a direct consequence of speaking with the FTSU team
      "The FTSU team helped me return to work more quickly" and "if it was not for the FTSU team, I would have become more physical unwell".
    - **Staff Retention:** 3 members of staff stated that the FTSU team stopped them looking for alternative employment outside of UHD
      "The FTSU team helped me remain in my department and work through the issues" and "I would have handed in my notice if it were not for the FTSU team"
    - **Staff satisfaction:** Given the experience of the FTSU team, 90% of staff service say they will speak up again (October-Dec 2023).

Finally, we asked to describe the FTSU service in one sentence. The responses included:



3.0 Key Progress over 2023/4

3.1 Speaking up at UHD – Our Senior Leaders

Every year our board take time to reflect and publicly commit to the Sir Robert Francis Principles of Speaking Up, alongside a declaration of behaviours. This commitment is made in September as a visual statement, reminding us that the board commit to speaking up and to developing a culture of safety. The declaration of behaviours sets out how the board will role model this and sets the tone of the culture for UHD.

3.2 UHD staff awards – 2023 "Open and Honest"

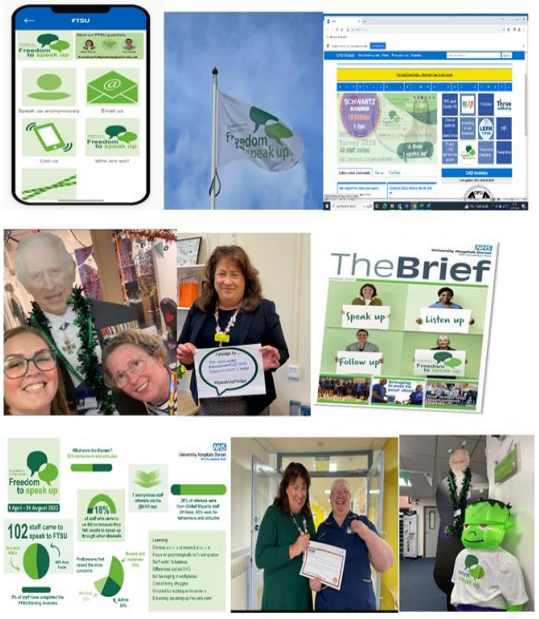
The UHD Awards is an important way to recognise each-other. In 2023, over 800 nominations were received.

One of the awards was the "Open and Honest" category, recognising an individual or team that works hard to promote an open and safe culture.

This year's worthy recipient was Catherine Bishop, one of our FTSU Ambassadors. The award celebrated the work that Catherine does to help others speak up, support their wellbeing and at times speaking truth to power. She is relentless in this work and a credit to our FTSU team.

3.3. Speaking up Month – October 2023 Breaking Barriers

Speak Up Month is the highlight of our calendar and is a chance to raise awareness of speaking up and the work which is going on to make speaking up business as usual. This year we celebrated the sixth Speak Up Month "Breaking Barriers". This topic recognised that there are many barriers which can silence people and that there are some groups which can face more barriers than others. Throughout the month we promoted the importance of speaking up through different ways. Wear Green Wednesdays also returned and visibly support this work by wearing green every Wednesday of October.



We had 63 referrals in October, an increase by 75% from the previous months. Issues raised continued to predominantly be relating to attitudes and behaviours.

3.4 FTSU Networks – "Looking in and out"

Our networks are key to our success in sharing the speaking up message but also as a support for each-other. We have several networks which continue to grow and mature.

3.4.1 UHD FTSU Network: Our FTSU network at UHD meets monthly and discusses our observations and recent guidance. It allows us to quality assure the work and critically appraise what we do. We also completed some team and personal development in September.

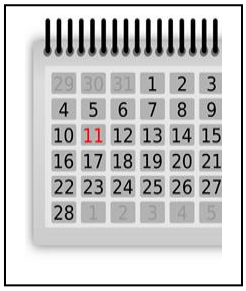
3.4.2 South-west regional Network: UHD stepped down as co-chair for the south west region in June after 3 $^{1}/_{2}$years. The National Guardian, Jayne Chidgey-Clark was present at the step-down meeting to show her appreciation of the work by the co-chairs. UHD will continue to maintain strong links and share good practice.

3.4.3 Dorset and Somerset FTSU Network: UHD set up this network in 2018 and chairs it. The vision of this group was agreed to share best practice and act as mentors for difficult cases. The membership has expanded over time, and now has representation across healthcare system.

3.5 National Guardian Office (NGO)

The NGO was created in response to recommendations made from Sir Robert Francis review in 2015 and leads, trains and supports a network of FTSUG in England. There are now over 1000 FTSUG in NHS, independent and third sector organisations and national bodies (June 2023). The office provides challenge and learning to the healthcare system as a whole, and conducts speaking up reviews to identify learning and support improvement.

A number of key documents have been published over 2023/4; all papers are critically evaluated and appraised with the board and FTSU team.



Mth	Published document	Discussed at UHD
April		
May		
June	Integrated Care Boards and FTSU guidance NGO – fear and futility; what does the staff survey tell us?	Bi-annual report
July	NGO Annual Report NGO FTSUG Survey 2023	Bi-annual report
Aug		
Sept	NHSE response to Lucy Letby case	Bi-annual report
Oct	NGO FTSU month	Annual report
Nov	NGO FTSU Champion and Ambassador Guidance NGO Annual Report laid down in Parliament	Annual report Bi-annual report
Dec		
Jan	NHSE/NGO; guide for leaders submission Publication of Good Medical Practice – including Speak Up	Annual/bi-annual
Feb		
Mar		

3.6 NGO data

UHD continues to be an active contributor to the work from the NGO. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, census information and other surveys.

Quarterly information about speaking up cases are submitted to the NGO, outlining the themes, and reporting the feedback received from those cases closed. Whilst number of referrals does not fully reflect the speaking up culture it does illustrate whether the FTSU is an established route for staff to use. Table 1 below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 1: Quarterly NGO data submissions 2023/24 (x = no data submitted to NGO)

2023/4	Size	Qtr1	Qtr2	Qtr3	Qtr 4	TOTAL (qtr 1-3)
Dorset County	Small	x	56	85		**141**
Dorset Healthcare	Medium	43	29	33		**105**
Salisbury	Small	48	33	37		**118**
Solent	Medium	29	24	43		**96**
University Hospitals Dorset	Medium	57	81	142	132	**412**
University Hospitals Southampton	Large	18	X	X		**18**

Table 1 does create some questions. Why do our staff use the FTSU route when raising concerns more than neighbouring trusts? An initial hypothesis was a result of the significant staff changes in merger and re-organisational processes, resulting in staff being unaware of whom to escalate issues to. This hypothesis continues not to be the case and instead our data over 2023/4 shows us;

- 47% of staff reported that they come to the FTSU team because their line manager is the issue or that they are not addressing it.
- Fourteen per-cent staff reported that the reason they came to the FTSU team was because they felt insecure in raising concerns with line managers. This data is lower than that during 2022/23 (18%).
- A continuing increasing trend is staff are using the FTSU route for advice prior to escalating themselves via the correct route. Thirty-four percent of staff knew what they needed to do but wanted a confidential, impartial viewpoint to draft their thoughts.

These points all suggest that we need to continue to train our line managers to create working environments which are psychologically safe to speak up, and when staff do, that we listen and act.

3.7 NGO: Freedom to Speak Up training programme.

'Speak Up, Listen Up, Follow Up', is an e-learning package, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

Over the last 12 months, 263 people have accessed the training, approximately 2% of the Trust. Since April 2021 when the programme was integrated into the BEAT platform, just over 600 staff have been through one of the modules (6% of UHD).

Focused communications campaigns over the year have happened alongside being implemented into core induction programmes such as Trust induction, preceptorship, medical and international educated programmes and conversations. It is also within our leadership training programmes. Other Trusts have mandated this training and more recently it has been recommended to be mandatory in NGO Freedom to Speak up Guardian Survey 2023. We also need to be mindful that following recent NGO Speak Up review with the Ambulance Trusts these packages were mandated for all staff.

3.8 Freedom to Speak Up Strategy at UHD

In January 2023, our board approved our robust and ambitious FTSU improvement strategy. It is brought again to you today to note amendments in the strategy which now reference our improvement programme Patient First work and new Trust vision, strategic goals and breakthrough objectives. The strategy has been built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy and its progress continues to be updated.

ACTION: Note approved amendments to FTSU Strategy which now reflects our Patient First Improvement Programme.

3.9 NHS Staff Survey

The NHS Staff Survey is aligned to the People Promise which sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

1. We are Compassionate and inclusive
2. We are recognised and rewarded
3. **We each have a voice that counts**
4. We are safe and healthy
5. We are always learning
6. We work flexibly
7. We are a team

The results of the NHS Staff Survey are now therefore measured against these seven People Promise elements and sub-scores, which feed into the People Promise elements. Over 5600 staff at UHD took part in 2023 NHS staff survey, giving us a response rate of 59%. Whilst this response is a significant improvement to previous years, there remains a silence at UHD. We need challenge ourselves on how we will listen to this silence and how we respond?

Speaking up is measured within the People Promise Element “We each have a voice that counts”. There are 2 sub-scores within this element of which raising concerns is one of these. All of the scores are on a 0-10 scale, where a higher score is more positive than a lower score. With this in mind, Graph 1 and Table 2 show us that more staff at UHD feel that they have a voice that counts as compared to 2022 but not yet back to that in 2021. Our bank staff also feel like they have a greater voice than they did in 2022 but overall, they feel they have less of a voice than our substantive staff.

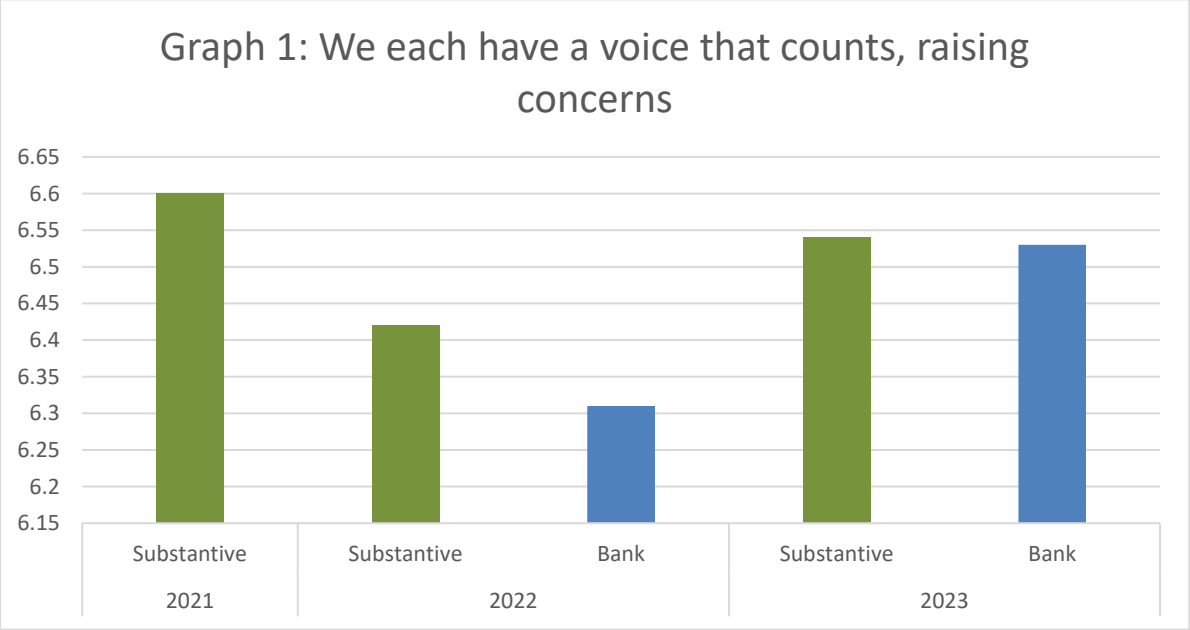
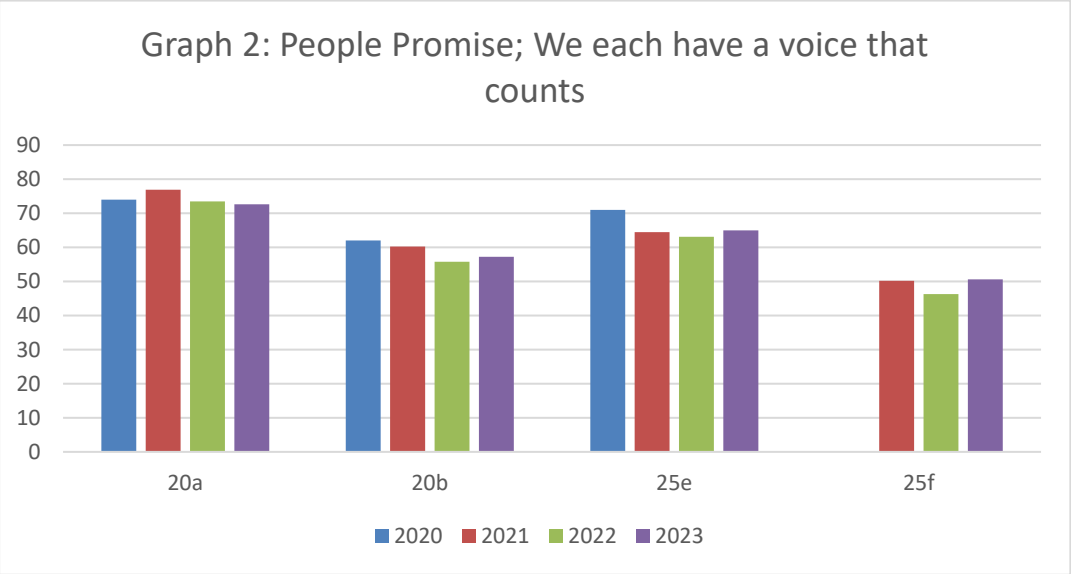


Table 2:					
SUBSTANTIVE n = 5619 (59%) Bank n = 424 (31.5%)	2021	2022		2023	
We each have a voice that counts; Raising concerns	Substantive	Substantive	Bank	Substantive	Bank
	6.60	6.42	6.31	6.54	6.53

To understand exactly which factors are driving the raising concerns sub-score, a number of questions feed into it and are represented in Graph 2. You will notice that in 3 of the 4 questions there is an improvement from 2022 (Q20a is the same as that in 2022). Moreover, for those questions relating to speaking up; raising concerns (25e and 25f) results are the same as that in 2021.

Question 25f, which is highly regarded to reflect a speaking up culture, shows that 50.63% of staff who completed the staff survey felt UHD nurtured a speaking up culture as compared to 46.31% in 2021. This is nearly a 10% increase from the previous 12months and will contribute to our safety culture breakthrough objective for quality outcomes and safety.



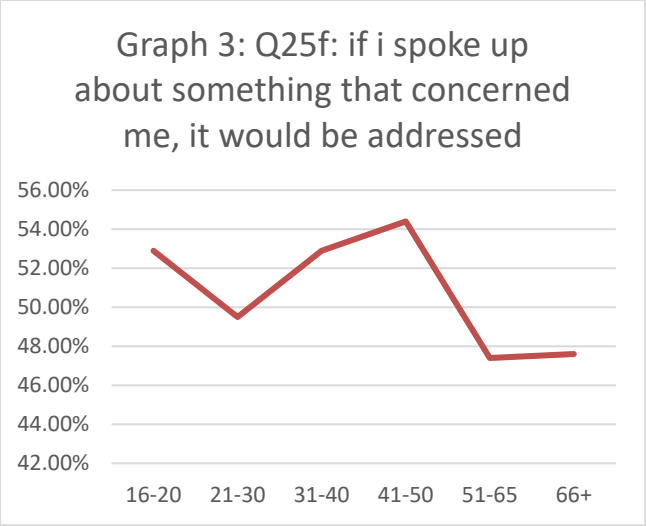
Q	Speaking up - clinical safety
20a	I would feel secure raising concerns about clinical practice
20b	I am confident that my organisation would address my concern
	Speaking up -raising concerns
25e	I feel safe to speak up about anything that concerns me in this organisation
25f	If I spoke up about something that concerned me, I am confident my organisation would address my Concern

This data can also be broken down into Care Group showing us how staff feel about our speaking up culture in different parts of the organisation. Table 3 shows us that there are differences with medical and speciality care groups reporting a better speaking up culture.

TABLE 3: If I spoke up about something that concerned me, I am confident my organisation would address my concern		UHD	Corporate	Medical	Operations	Specialities	Surgical	Non directorate
	25f	50.63	48.3	51.8	46.6	53.3	48.4	45.6

Whilst this high level of data is helpful, there will be some differences within it them and table 4 shows how staff describe the speaking up culture at a directorate level and you will also notice how this has changed from the year before in 2022. You will notice that only 3 areas show a deterioration from 2022; trauma and orthopaedics, Acute and Ambulatory and facilities.

TABLE 4: Question 25f : If I spoke up about something that concerned me, I am confident my organisation would address my concern.					
UHD 50.63%					
Green	Change from 2022/3	**Amber**	Change from 2022/3	**Red**	Change from 2022/3
Cancer Care (57%)	↑	Women's Health (53.7%)	↑	Trauma & Orthopaedics (46.9%)	↓
Child Health (60.7%)	↑	Anaesthetics (48.8%)	↑	Urgent & ED (45.8%)	↑
Radiology & Pharmacy (53.9%)	↑	Head & Neck (51.7%)	↑	Acute & Ambulatory (45.7%)	↓
Finance (58.7%)	↑	Medical Specialities (53.2%)	↑	Facilities (39.6%)	↓
Cardiology (57.4%)	↑	OPM (53.1%)	↑	Pathology (44.1%)	↑
Surgery (58.1%)	↑	People Directorate (53.2%)	↑		
		Clinical Support (50.5%)	↔		



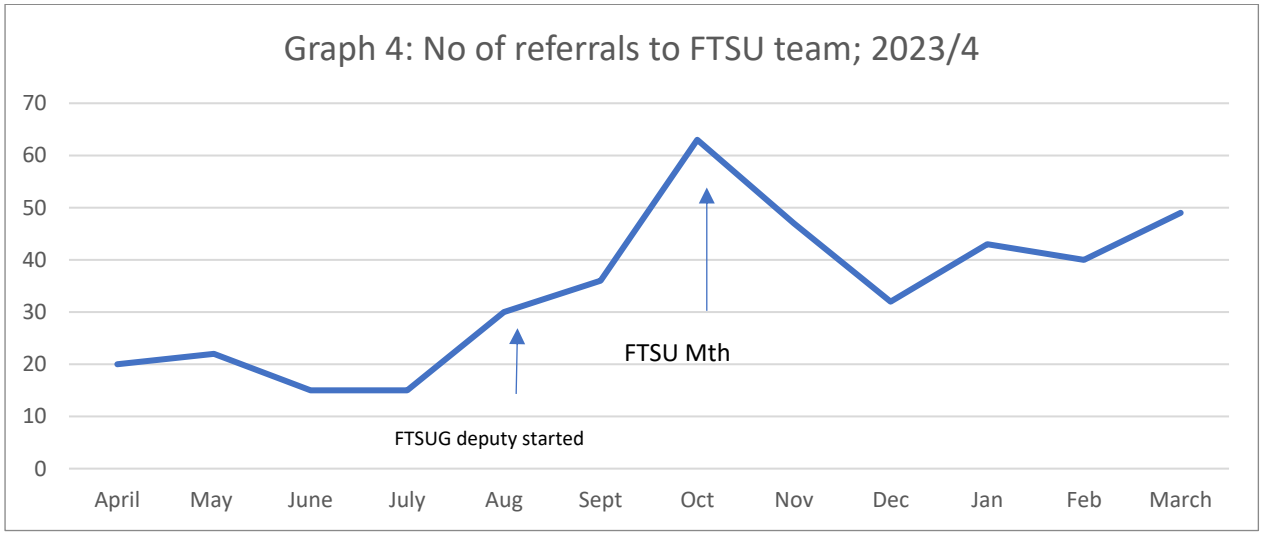
Another interesting observation can be illustrated in graph 3; the older you are in age the less confident you are those concerns addressed thereby reflecting a poorer speaking up culture.

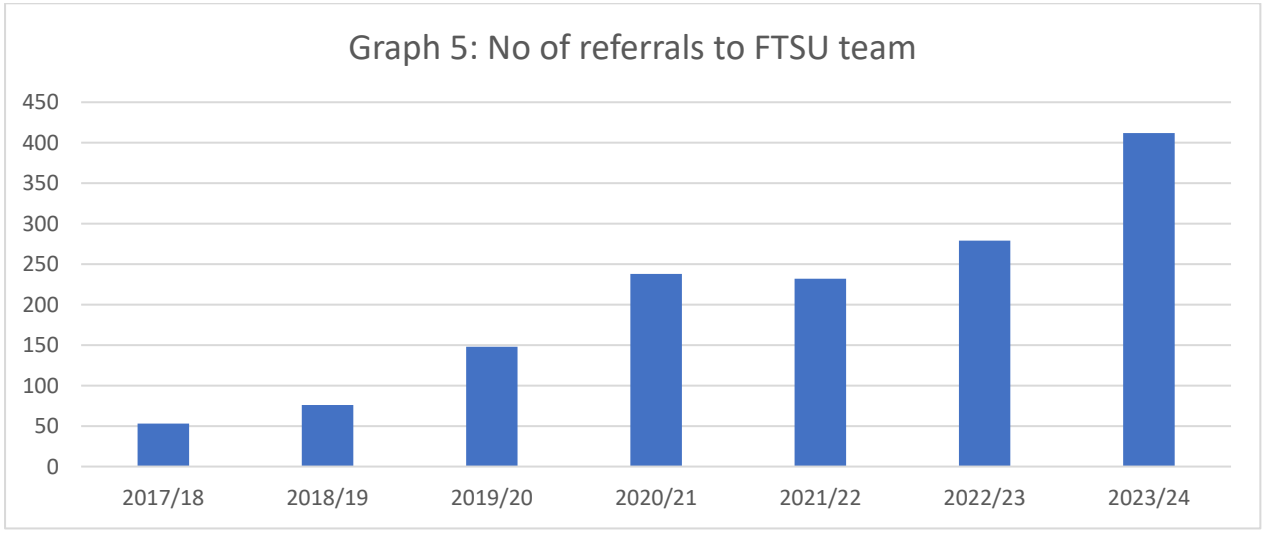
Our staff survey is one tool to understand how our staff are feeling. We are clearly seeing some emerging buds but like gardens, if we do not tend to our culture continuously, be curious and understand our silences more, they will soon become overgrown and harder to cultivate.

4.0 Case Referrals – the Headlines

A range of data is collected by the FTSUG. This report will review the data including the key themes of concerns raised, where concerns have been raised and by whom. Referrals come from a number of routes including trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs, the UHD app and personal recommendation.

Graph 4 highlights the number of referrals received on a monthly basis to the FTSU team over 2023/4. Four hundred and twelve (412) cases were received by the FTSU team of which 185 referrals came from Poole site and 227 from Bournemouth and Christchurch (45:55% respectively). This is an increase of 48% on the previous 12 months (Graph 5).

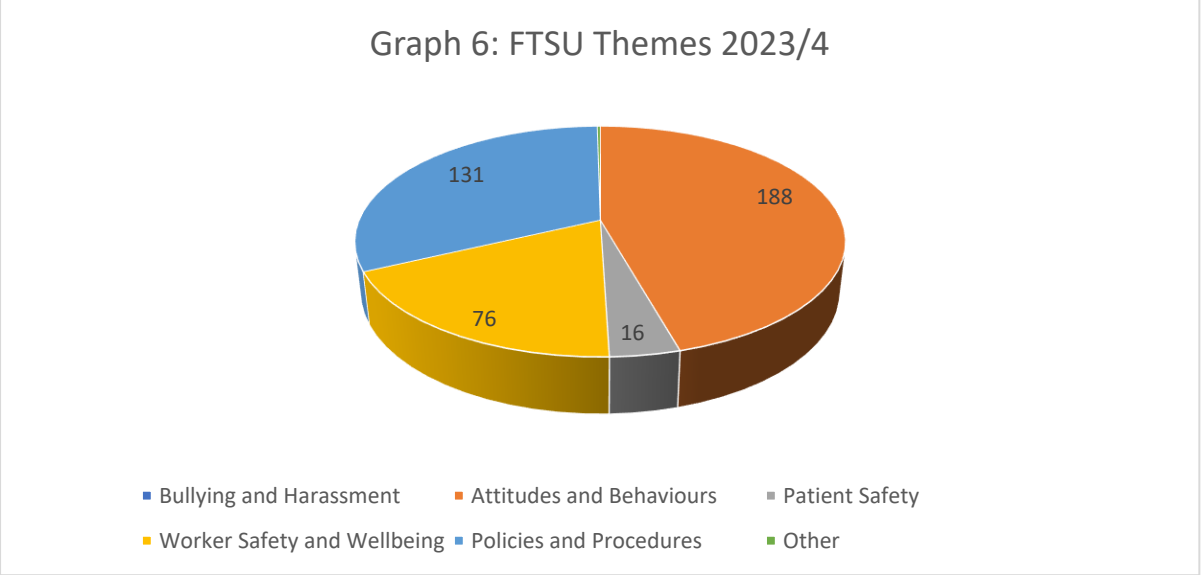




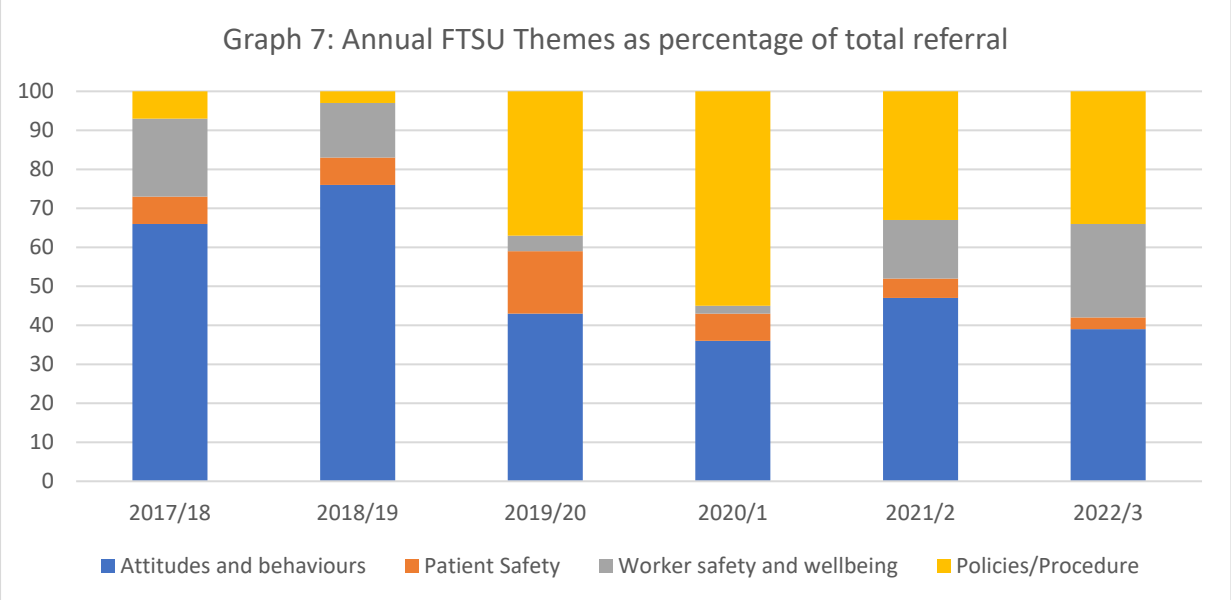
4.1 Key Themes of concerns

Staff approach the FTSU team for a number of reasons. Graph 6 illustrates the greatest theme had an element of behaviours (188 staff; 46%). This is followed by process and procedures (131 staff; 32%) and then worker safety and wellbeing (76 staff; 18%). Speaking up via the FTSU team

continues to be used predominantly for concerns relating to our working environment or relationships rather than patient safety issues and may be a product of our strong LERN culture in capturing our patient safety issues. This needs monitoring and assurance that issues or concerns are not being lost or not reported.



The themes have varied since setting up the FTSU service. Graph 7 looks at the percentage of each theme as compared to the total number of referrals. What is interesting is growth of referrals to the FTSU service relating to worker safety and wellbeing such as burnout over the last 2 years which mirrors the national picture (see section 4.1.3). The number of referrals relating to attitudes has decreased from 2017 when the service was set up, however remains the greatest theme year on year.

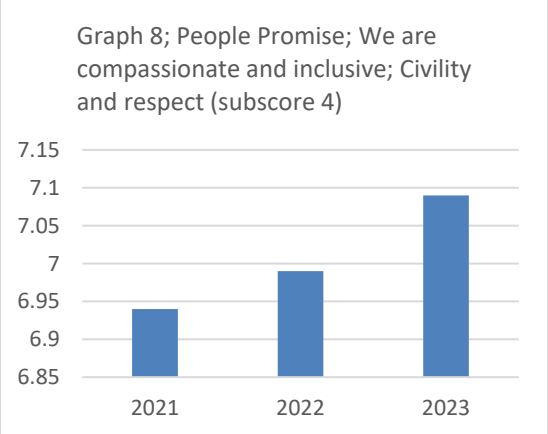


4.1.1 Behaviours and Attitudes (incivility)

"I have not stopped crying following an incident with my line manager. I was shouted at in front of the whole team leaving me mortified but also without a voice to explain. I feel I have no option but to leave UHD"

Attitudes and behaviours are a recurring theme that the FTSU team hear. Behaviours such as disrespectful attitudes, lack of compassion, gossiping, micro-aggressions, micromanagement, aggressive communication styles, rudeness and unprofessional behaviour are frequently cited. Sometimes this behaviour is well known within a team, and in other cases, it is a one off, out of character incident. Whilst both clearly need to be addressed and evidence suggests in different ways, staff feel our interventions are often inconsistent, slow, and unsatisfactory for the recipient but also to those doing the behaviour. The end result is deep, long-lasting, and far reaching causing many staff to choose to leave their role or go absent.

Work is underway with the development of behavioural frameworks, leadership behaviours, information/ tools on our intranet and our patient first improvement programme but until we have a clearer and consistent infrastructure and programme it will remain unsatisfactory for many staff. The FTSU team feel this is the most important piece of work for UHD. The way an organisation handles issues like these says a lot about the culture. We were reminded of the work from Dr Chris Turner, who spoke at our team month in November, about the impact civility and how incivility and being rude directly impacts on the safety of our patients.



With all of this said, it is always important to triangulate the FTSU work to other data. Results from our staff survey are re-assuringly showing some signs of green shoots. Graph 8 shows us improvements in the questions relating to civility and respect as compared to 2021.

People Promise; We are compassionate and inclusive; Civility and (sub-score 4)	
8b	% of staff reported that the people they work with are understanding and kind to one another (q8b)
8c	% of staff reported that the people they work with are polite and treat each other with respect (q8c)

The FTSU team call for focussed work in addressing poor behaviours so by creating psychologically safe workplaces and contributing to our breakthrough objectives to being a great place to work, attracting and retaining best talent.

4.1.2 Process and policy – compassionate and inclusive leadership

It is well documented that at times of significant change such as merger, operational re-structuring, healthcare structural changes or building work will increase workloads for FTSU teams. Part of this is due to issues relating to process or procedure. (NHSE, 2022).

Thirty-two per cent of referrals at UHD had an element of process and procedure. These issues range from requests for agile working, support of staff going through organisational change, assurances that recruitment is both fair with equal access, support through probation and access to study leave.

Since October 2022, these issues have been broken down further into sub themes and represented in Table 5. Sixty-nine per cent of referrals with an element of policy and procedure, are relating to HR issues and how to navigate employment issues. All concerns are signposted to our experts such as HR and our union colleagues. Nationally, this is also seen, and it has been postulated whether a clarity of HR policies and processes may help to reduce the volume of HR issues being raised with Freedom to Speak Up team.

Table 5	Poole	RBCH	UHD TOTAL
Organisation Change	5	1	**6**
Guideline/pathway (clinical)	1	1	**2**
HR related issues (regrading, re-deployment, HR policy	35	55	**90**
Recruitment and selection	4	1	**5**
Parking	3	0	**3**
Education/training	1	1	**2**
Non-clinical guideline/pathway	10	11	**21**
Health and Safety	0	1	**1**
Pension	0	1	**1**
TOTAL	**59**	**79**	**131**

Other issues relating to process and procedure often arises from a conversation or miscommunication often with a line manager/supervisor. When asking staff as to why they are choosing to raise concerns to the FTSU team rather than their line manager, 47% stated that their line manager was the issue of the concern or knew about the issue but not addressing it. A further 14% said it was that they felt insecure in raising this issue. The gift of change lies predominantly

with our line managers and clearly in most cases a resolution needs to happen with them. Is it therefore that our relationship with our line manager is challenged due to lack of visibility, time limitations or manager skill? In many cases, if the relationship/understanding and communication was improved between line manager and team, the need to escalate to the FTSU team would be less.

It is well documented about the importance of delivering compassionate and inclusive leadership. It is encouraged that our leaders, listen to our teams (with fascination), acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change (Michael West). Delivering compassionate leadership and care requires investment in time, in skill and an appreciation of the benefits for our people and ultimately the care we give to our patients. Compassion needs to meet people's needs for belonging and develop and sustain trust for psychological safety.

4.1.3 Worker safety and wellbeing

In response to concerns being raised during the pandemic, the NGO introduced worker safety and wellbeing as a new reporting category. This theme relates to cases with a risk on worker safety or wellbeing and can include issues such as lone working arrangements, insufficient access to equipment and stress at work.

"The change in x, has made us feel dis-empowered and undervalued. It has been a kick in the teeth resulting in my hands never feeling so tied as they do today. If only the decision makers talked to us before changing x…I thought we were on the same team"

At UHD, eighteen per cent who accessed the FTSU team described this theme and predominantly as a result of excessive workload and staffing levels. Moreover, it is also well documented that there are considerable system pressures across the healthcare sector alongside the cost-of-living crisis; both having an impact on worker wellbeing.

Research tells us that until triggers are addressed such as staffing/working environment, the symptoms of feeling overwhelmed will not improve. This is particularly difficult in a financially challenged healthcare system.

4.2 Outcome of referrals

Table 6 illustrates the outcome of referrals once they were made to the FTSU team. Of those referrals, 34% of cases were escalated to the line manager to investigate and action. In 40% of cases, the member of staff was signposted to experts in the field of the concern such as HR, OH,

or other including infection control, risk and governance or our networks. Five percent were escalated to director/executive level.

Table 6: Outcome of referrals received by FTSU team

		Poole	RBCH	Total UHD
Line manager		66	74	**140**
FTSU advice		43	41	**84**
Escalate to Chief/Director		7	15	**22**
Signpost	HR	31	46	**77**
	Other	38	51	**89**
TOTAL		**185**	**227**	**412**

Following the Lucy Letby case there were a number of questions raised about how concerns were not listening to or that appropriate and timely action was not taken when concerns were raised. All 180 cases raised to the FTSU team in quarter 1-3 (2023/4) were all closed with no outstanding action.

4.3 Who are raising concerns?

Table 7: Staff who are raising concerns to the FTSU team.

2023/4	Total UHD	No of staff (as of May 23)
Additional Clinical services*	36	2129
Additional Professional#	8	350
Admin and clerical	93	2147
AHP	38	809
Estates and Ancillary	23	710
Healthcare scientists	10	189
Medical and Dental	28	1519
Nursing/Midwife	131	3044
Students	7	101
Other	1	
Anon	37	
TOTAL	**412**	**10 998**
BAME	89	

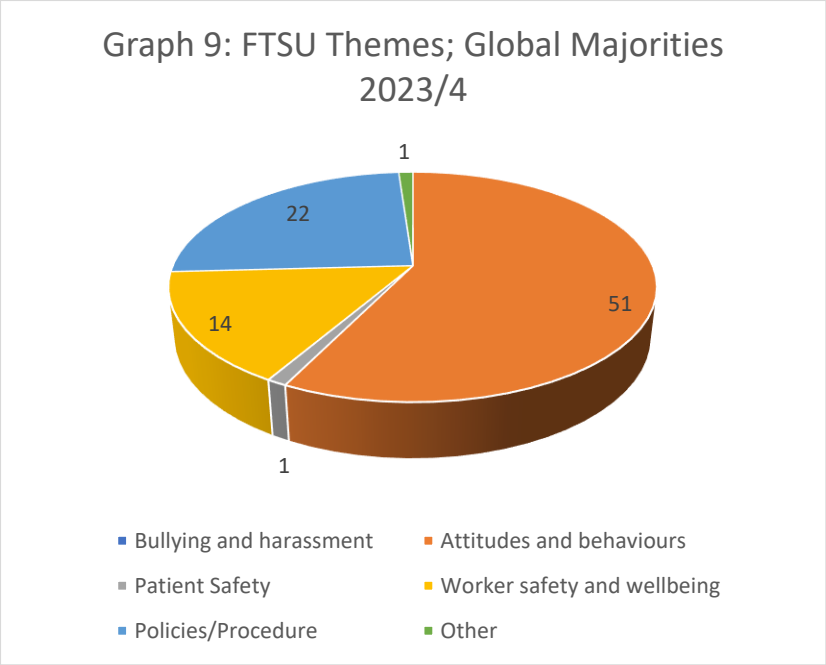
*Additional clinical services includes staff directly supporting those in clinical roles such as Health Care Support Workers (HCSWs), AHP support workers. They have a significant patient contact as part of their role.
#Additional professional scientific and technical include scientific staff including pharmacists, psychologists, social workers

Table 7 shows that our nurses and midwives accounted for the biggest portion (32%) of speaking up cases raised with FTSU team, followed by our administrative staff (23%) and Allied Health Professionals (9%).

Thirty-seven staff felt that they needed to remain anonymous (9%). This is an increase on previous 12months (14 staff; 5% of total referrals) and now is comparable to national figures of 9.3% (NGO annual report, 2023). The FTSU team in 2023/4 held a number of campaigns highlighting routes of referral that staff can make. The UHD app and its facility to make anonymous referrals to the FTSU team was particularly promoted which may explain its increase over the past 12 months.

The Francis Freedom to Speak Up review recognised back in 2015, that minority staff, including ethnic minority workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews, also showed that minority staff groups are more likely to suffer detriment for having spoken up. Since then, the NGO has carried out a number of case reviews at different Trusts across the country which has repeatedly validated this observation and therefore encourages every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.

Of the 412 staff who raised a FTSU concern, 22% (89 staff) were from a global majority background. Our most recent data using WRES mapping template, shows the percentage of overall workforce at UHD which is ethnic minority is now 21.5% (March 2023). Using the same calculation for the Bournemouth, Poole and Christchurch area the percentage of ethnic minority staff is 8.67%. This data suggests that our staff are highly represented from ethnic minority groups at UHD and that FTSU is making good progress to reaching and hearing the issues from this staff group.



Data from graph 9 show the predominant theme from our global majorities staff is attitudes and behaviours (51 staff; 57%). Concerns with elements of process and procedure (22 staff; 25%) then followed by staff wellbeing (14 staff; 16%).

"I have never experienced such unprofessional and rude behaviour as an International Medical Dr. It was undignified and made me feel isolated and not want to work at UHD".

It is important to trangulating our FTSU data with our staff survey and specifically Question 25f, which is highly regarded to reflect a speaking up culture. Data from those whom completed the survey show that more staff from a global majority background feel that they work in a culture of speaking up. Nearly 57% felt like this (Table 8).

Table 8: Question 25f	UHD	White	Global majority
If I spoke up about something that concerned me I am confident my organisation would address my concern.	50.80%	49.80%	56.90%

BME: Black Minority Ethnicity/Global Majorities

All staff are signposted to our DEN networks who were also able to support and advise. The FTSU team attend these meetings and forums to support but also to understand and raise issues.

The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee and will continue to work together to improve and support our ethnic minority employee experience.

The FTSU team have also implemented a new development programme for our international educated nursing (IEN) staff. This happens approximately 6 months post initial induction and is the result of feedback from our IENs wanting time and space to reflect on communication and culture since starting in their new workplaces. This programme has been really well evaluated.

4.4 Where are concerns being raised?

Significant effort has been made to ensure that the FTSU team visit and meet all members of staff across each site and the Ambassador model allows for this. Table 9 outlines the concerns raised across our care group structure. The FTSUG monitors this closely so to ensure that all areas are aware of the FTSU service and how to access it.

Table 9: The number of concerns raised in UHD

					23f
Care Group	**Directorate**	**PHT**	**RBCH**	**Total**	
Medical (113)	Emergency and Urgent	3	5	**8**	45.8.9%
	Acute and Ambulatory Medicine	9	4	**13**	45.7%
	Cardiology and Renal	3	1	**4**	57.4%
	Medical specialities	21	14	**35**	53.2%
	Older Persons and Neurosciences	21	32	**53**	53.1%
Surgical (48)	Surgery	5	9	**14**	45.4%
	Anaesthetics	9	8	**17**	48.8%
	Head and Neck	2	6	**8**	51.7%

	Trauma and Orthopaedics	5	3	**8**	46.9%
	Private	0	1	**1**	
WCCSS (108)	Cancer Care	11	3	**14**	57%
	Child Health	14	0	**14**	60.7%
	Women's Health	14	2	**16**	53.7%
	Radiology and Pharmacy	7	7	**14**	53.9%
	Clinical Support	11	18	**29**	50.5%
	Pathology	5	16	**21**	44.1%
Operations (19)	Clinical Site	0	0	0	
	Facilities	4	14	**18**	39.6%
	Partnership, integration and discharge	1	0	**1**	
	Emergency Planning	0	0	**0**	
	Operational Performance	0	0	**0**	
Corporate (87)		26	61	**87**	41.9%
Anon (37)		14	23	**37**	
TOTAL		**185**	**227**	**412**	

Interesting questions can be posed, and future work can be planned when triangulating the data from table 9 looking at the numbers of staff using FTSU route and the speaking up question, 23f on the Staff Survey, which is highly regarded to reflect a speaking up culture. Of concern are those staff whom are not using the FTSU route and have low confidence in raising concerns such as emergency. Further evaluation and future FTSU focus will be key in these areas for 2024.

5.0 Learning and reflections

Whilst each referral will have its own learning, themes can be drawn to help develop and embed into the culture at UHD. The following points are the learning and reflections of the FTSU team based on the information presented today:

- An urgent call for action to develop an invested and accountable civil and respectful cultural programme– looking at a clearer message, its infrastructure and tools to help staff and managers address poor behaviour in a consistent and rapid way.
- Merger is starting to feel real. Frustrations are being cited as final decisions to where/when moves are happening are often late, making practical life arrangements more difficult and stressful.
- Differences between Bournemouth and Poole sites; differences in work, policy and structure. This makes it difficult to feel #TeamUHD.
- Long and painful organisational restructures resulting in prolonged periods of stress for staff resulting often in a drain of talent. Do we invest time at the beginning of any re-structure or organisational change to explain the process and ensure staff wellbeing is in the forefront of minds? Do we share the learning from each department or make the same mistakes?
- Not belonging at our workplace –our overseas workforce feel that their work place is not interested in them as people with little time invested in getting to know them, their skills and journey. This makes forming safe relationships, navigating the work, the NHS way and British culture really difficult. Strong feelings of being mis-understood and judged.
- Struggles with cost of living and financial challenges.

- Being proud of our working environment and yet we have overflowing cigarette butts and litter. Signage remains an issue.
- Do we have robust processes in place to prevent staff feeling at detriment when speaking up and in those circumstances when a worker feels they have suffered detriment do we address this and offer the right support?
- The number of cases which have an element of patient safety is lower at UHD than the national average. Are we confident that we are capturing patient safety concerns or are staff not reporting?
- We hear staff say that they cannot go to their line manager as either they are the issue, or they are not addressing the issue; we need to promote our leaders to attend Compassionate and Inclusive leadership programmes and People Management modules.
- Large management portfolios make it difficult for line managers to be visible with their teams. Teams feel their leaders are too busy to speak with them and line managers are frustrated as they are tied to meetings. Issues are not resolved quickly and often escalate.
- Encourage our leaders to complete HEE/NGO Speak up, listen up and follow up modules on BEAT. There is a national steer to mandate these (speak up module).
- More staff are telling us that they use alternative channels to speak up as they are insecure of raising issues with their line managers. We need to upskill our leaders on how to create psychological safe working environments to speaking up.

6.0 Summary and Next Steps

Speaking up has never been as important as it is today and yet whilst improving, staff tell us that we do not address concerns nor make people feel safe to raise them. It is both futile and results in fear.

At UHD, it is everyone's business to encourage speaking up and to do this we need leaders to create psychologically safe working environments where every voice is heard, celebrated and action occurs.

We are #TeamUHD and collectively we need to Speak Up, Listen Up and Follow Up so to continually improve our culture of safety.

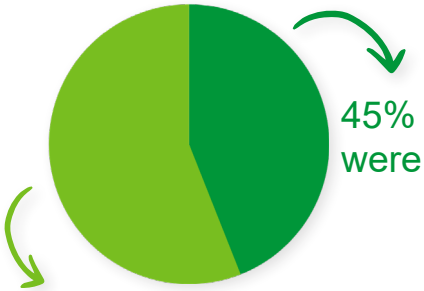
Supporting you to raise concerns

Freedom to speak up

FTSU data 2023/4

NHS University Hospitals Dorset NHS Foundation Trust

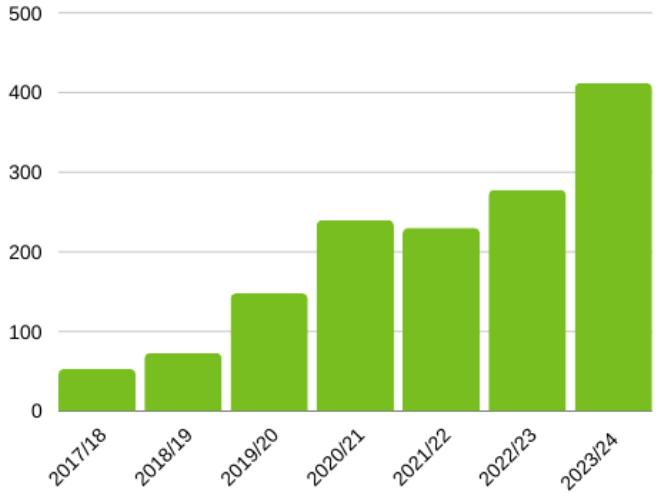
412 staff
came to speak to FTSU



45% of referrals were from Poole

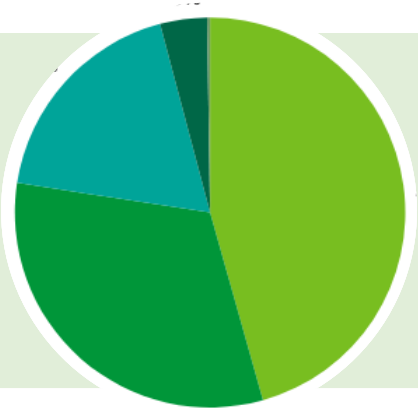
55% of referrals were from RBCH

Annual number of referrals to the FTSU team



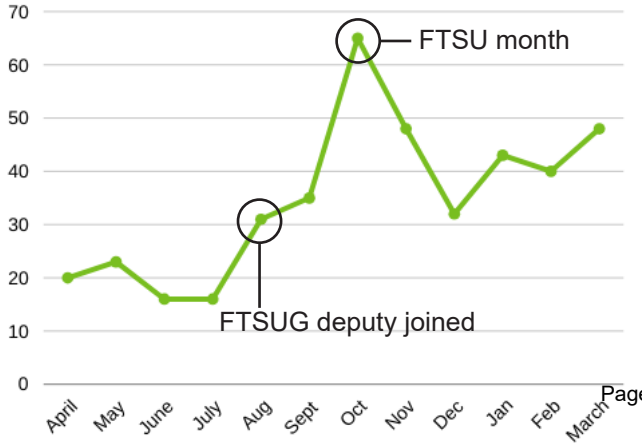
Themes

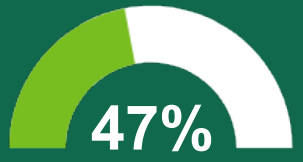
188 referrals for 'attitudes and behaviours'
131 referrals for 'policies and procedures'
76 referrals for 'worker safety and wellbeing'
16 referrals for 'patient safety'
1 referral for 'other'



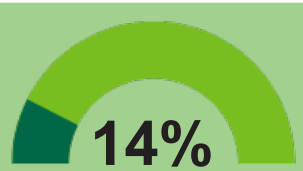
37
anonymous referrals via @UHD app.

Number of referrals to FTSU team in 2023/24





47%
of staff came to FTSU because they felt their manager was the issue or was not addressing the issue



14%
of staff came to FTSU because they felt unsafe to speak up

Staff who completed FTSU BEAT modules

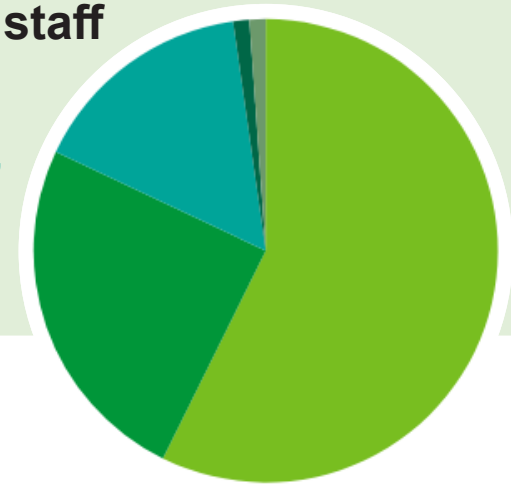
-Speak up–Listen up–Follow up→

132 **85** **46**

22% of referrals came from ethnically diverse staff
Of these, 57% were attitudes and behaviours

Themes from ethnically diverse staff

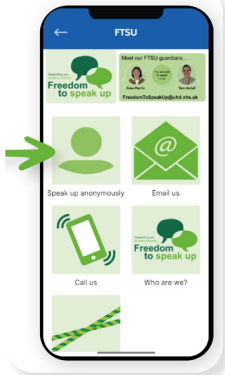
51 referrals for ‘attitudes and behaviours’
22 referrals for ‘policies and procedures’
14 referrals for ‘worker safety and wellbeing’
1 referral for ‘patient safety’
1 referral for ‘other’



What have we learnt?

The importance of a respectful and civil culture. Both verbal and written.
The importance of involving those impacted in big decisions.
Busy line managers are not visible. This frustrates line managers as they aren’t able to be present. This means issues are often escalated.
Merger stresses and differences continue across sites.
We leave roles because of the people we work with.
The importance of team working.
Our ethnically diverse staff speak up more about poor behaviours and not belonging.
Listening takes time and is at the core of good leadership.
Speaking up is everyone’s business.

2023/4 celebrations



Quotes from staff who used FTSU in qtr 3 2023

“FTSU are absolutely wonderful! They help in distress.”

“FTSU empowered me and I felt I was not alone”

“FTSU are the vital part of one’s working life...a lifeline of support”

“FTSU are a precious gem in the trust”

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 8.1

Subject:	Council of Governors 2024/25 Events Calendar
Prepared by:	Klaudia Zwolinska, Corporate Governance Assistant
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☐ ☒ ☐ ☐ ☐
BAF/Corporate Risk Register: (if applicable)	N/A	
Purpose of paper:	Decision/Approval	
Executive Summary:	The purpose of this paper is to present the proposed Governors engagement events for 2024/25 discussed at the Informal Council of Governors' Membership and Engagement Group (MEG) at its June 2024 meeting, which each applicable constituency is recommending for approval. The new events proposed by the MEG members are in red alongside the events already approved by the Council of Governors and are yet to take place.	
Background:	One of the Council of Governors' duties is to represent the represent the interests of the members of the Trust as a whole and the interests of the public. In addition, as part of the Governor Code of Conduct, "*Governors are accountable to the membership and should demonstrate this. They should attend events and provide opportunities to interface with the members or partner organisations they represent in order to best understand their views".* At the MEG meeting in June 2024, each of the public constituencies and staff constituency were asked to present their proposed engagement events and activities for 2024/25.	

	Governors were asked to take into account events and activities supporting achieving the objectives included in the 2023/26 Membership and Engagement Strategy and alignment with Transforming Care Together programme presented to the Council of Governors at the development session in February 2024. The Council of Governors is asked to review the 2024/24 events list and, if thought fit, approve it.
Key Recommendations:	To consider and, if thought fit, approve the Council of Governors 2024/25 event calendar.
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☐ System ☐ Delivery of the Membership and Engagement Strategy.
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Membership and Engagement Group	20/06/2024	Recommended events proposed by Christchurch, East Dorset and Rest of England to Council of Governors for approval

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐

Bournemouth	Christchurch	Poole	Staff
~~July 2024 – World of Love Festival~~	Ideas – membership quiz, members' social event, events in schools, target GPs, get text into GPs screens, focus contacts on orgs such as Rotary so not targeting individually	Presentation to St Clements' Ladies Fellowship – any second or fourth Tuesday afternoon – 2pm to 3:30pm	Trolley walkabouts across three hospital sites where staff Governors introduce themselves and talk to staff on duty
September 2024 – Listening Event – Castlepoint	Investigate: • Yoga in the Park • Ellingham Show • RNLI as venue		Surgeries – staff Governors to hold a regular slot
2 October 2024 – Talk – Winterbourne Kingston Women's' Institute	Ideas for talks: • Virtual wards • Orthopaedics • Dermatologist		Importance of being visible and having regular information stands
December 2024 – Christmas event in the Atrium at RBH	2 September 2024 – Listening Event – Saxon Square Christchurch		Staff Governor to lead an event once a year where a limited number of colleagues could join them for a run, walk etc. Funding request for refreshments from UHD Charity
	5 September 2024 – Talk to Bournemouth and Dorset Advanced Drivers – Wimborne Town Football Club		Cake sale led by staff Governors for a good cause
	13 December 2024 - Listening Event in Wimborne - The Allendale centre (Christmas theme)		
	2025 – Brockenhurst College – listening event at Brockfest to recruit and engage with younger population		

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 29 July 2024

Agenda item: 8.2

Subject:	Feedback from Council of Governor Informal Groups
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance Klaudia Zwolinska, Corporate Governance Assistant
Presented by:	Yasmin Dossabhoy, Associate Director of Corporate Governance Group members

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☒ ☒ ☐ ☐ ☐
BAF/Corporate Risk Register: (if applicable)	N/A	
Purpose of paper:	Review and Discussion	
Executive Summary:	The purpose of this document is to highlight the work of the four Informal Governors Groups since the Council of Governors meeting held in April 2024 when the feedback was last provided.	
Background:	Currently members of the Council of Governors have an opportunity to be a member of one of four Informal Governors Groups. <u>Constitution Review Group</u> – the Group has met four times since April 2024 and the outcome of the Group's work is outlined in 6.1 agenda item of this meeting pack. <u>Effectiveness Group</u> – the Group has met twice since April 2024, gained two new members, and considered the following: • The review of Governors observers at the Board Committee process and recommended a proposal which was discussed by the Council of Governors at its extraordinary meeting in May 2024 • The effectiveness of the Trust Chair and Non-Executive Directors appraisal process and	

considered how to increase response rates from Governors to feedback requests next year

- Additional training opportunities for Governors to support them in fulfilling their statutory duties, including NHS Providers courses
- The effectiveness of the Council of Governors assessment of collective performance process and how to provide additional support for Governors with this in future. This included proposals for a shorter form, dedicated time for completion after a meeting or development session and considering a different time of year for the process to take place. It was noted that the importance of Governors participating in the process should be highlighted

  There was a thematic discussion about Governors and their approach to them discharging their responsibilities as a governor.
- The development plan based on the responses provided by Governors during the annual review of effectiveness
- Governors' elections and how to encourage more people to apply
- Governors' pledges based on the practices from Northamptonshire Healthcare to enhance Governors' effectiveness

<u>Membership and Engagement Group (MEG)</u> – the Group has met once since April 2024, gained one new member, and considered the following:

- The engagement events covered in 8.1 agenda item of this meeting pack
- The support for Staff Governors which is included in the proposed leaflet to highlight the role, responsibilities and benefits of being a staff Governor
- Ideas to improve the Governors presentations for events to make it more engaging for the audience
- The proposed form to obtain valuable and effective feedback from Governor events. A proposed questionnaire was designed, particularly with a view to measuring the effectiveness of events and public awareness of the ongoing changes within the Trust. There was discussion about the questionnaire being available electronically
- A proposed welcome letter to be sent to members following their application for membership being accepted
- Together Magazine being only available online and how to make the transition process as smooth as possible for the members who receive the paper copy of the magazine.

<u>Quality Group</u> – The Group has met once since April 2024 and gained a new member. At its meeting in May 2024, the Group had an opportunity to discuss the

	2023/24 Quality Account and provide the feedback which is included in the final report. The approved document can be found here.
Key Recommendations:	To review and note the feedback from Council of Governor Informal Groups. The Council of Governors is asked to consider and if thought fit to approve the following: • The 2024/25 development plan for the Council of Governors
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
N/A	N/A	N/A

Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐

Assessment of Collective Performance 2023/24 – Council of Governors

Summary Plan for 2024/25

Action	Proposals on how to achieve it	Progress/Comments
Theme: Membership - representation • To target underrepresented groups (from a membership and engagement perspective) in the community through Governors' activities • To encourage young people to become University Hospitals Dorset (UHD) members	Proposal 1: representative membership • A key objective for the Membership and Engagement Group (MEG) was the focus upon building representative membership that reflects the population; this would include increasing membership diversity, which it was considered would also then support increasing the diversity of the Council of Governors *(referral to MEG)* • To consider planning events and activities to target particular demographics to increase diversity through the annual events plan *(referral to MEG)* • By considering the dates/timing of events to support maximum attendance *(referral to MEG)* Proposal 2: engagement with younger individuals • By creating an opportunity for Governors to engage with the younger individuals in the community, for example, through the Young People's Council, making the organisation attractive to them to become involved with, getting on their agenda and receiving their feedback *(referral to MEG)*	Progress on Proposal 1: representative membership • MEG members agreed to discuss plan of events with constituency members to support implementation of the Membership and Engagement Strategy • Annual calendar of events based on the above presented to April 2024 meeting of the Council of Governors, noting that further development needed • MEG meeting - June 2024 – events proposed by Christchurch, East Dorset and Rest of England constituency *Next steps:* Further input needed from relevant Execs and NEDs on potential programme of events with which Governors could support in relation to reconfiguration. More broadly, Chief People Officer already undertaking work related to engagement approach Progress on proposal 2: engagement with younger individuals • Presentation prepared and given to MEG at its February 2024 meeting by Associate Director of Corporate Governance in relation to proposed approaches to engaging young people *Next steps:* • What? Update to be provided by Lead Governor

		When? At July 2024 Council of Governors' meeting on Young People's Council/other youth forums • What? MEG to re-review presentation from February 2024 meeting and propose actions to be taken and timelines. One of the MEG members has suggested having Governor "champions" for particular members to help support with those demographic groups that may not be as well represented When? By next MEG meeting
Theme: Membership - engagement • To improve overall communications with members (*staff Governors*) • To further develop working between respective Council of Governors within the Dorset system partners (Dorset County Hospital and Dorset HealthCare) • To ensure that all Council of Governors activities in engaging with members, the wider public and stakeholders are effective, measurable, and also aligned with the Trust's Strategy • To ensure that the Council of Governors communicates with members to find out what	Proposal 3: Staff Governors • By holding regular surgeries, visiting staff areas with information trolleys, inviting speakers to do presentations, and incorporating staff-led events into the Governors' event calendar (*staff Governors*) Proposal 4: Joint Council of Governors Development Session • By organising a joint development session with partners to discuss best practices and learning from each other Proposal 5: Effective and measurable engagement • By creating a set of criteria to measure Governors' activities effectively *(TBC)* • By sending out suitable online questionnaires and gathering feedback at events • By working with/supporting the Board with engagement in relation to the transformation/reconfiguration programme (see above)	Progress on proposal 3: Staff Governors • Company Secretary Team have updated the staff Governor leaflet for prospective Governors. On the agenda for the July 2024 meeting of the Council of Governors • Proactive steps taken to support staff Governors to have time to carry out their role. Discussed with Chief People Officer. *Next steps:* What? Update to be provided at the July Council of Governors meeting. Planning meeting to be held with Company Secretary Team and Communications. When? July 2024 Progress on proposal 5: Effective and measurable engagement • Draft feedback form and feedback process discussed by Membership and Engagement Group

information they were particularly interested in • To make progress on the Membership and Engagement Strategy (the Strategy) implementation plan to achieve the objectives • To ensure that the process for planning and arranging engagement opportunities is clear for all Governors • To create a process for ad hoc engagement opportunities outside of MEG and Council of Governors cycle	Proposal 6: Progress on implementation of the Membership and Engagement Strategy • By discussing and proposing targeted events and engagement activities to achieve the Strategy's objectives at the next Membership and Engagement Group (MEG) meeting Proposal 7: Process for planning and arrangement engagement opportunities clear for all Governors • By reviewing and updating the process for organising events where ad hoc engagement opportunities outside of the MEG and Council of Governors' cycle arise	• Draft welcome letter prepared by Company Secretary Team for Council of Governors' review *Next steps:* What? Feedback form and feedback process to be finalised by Governors and Communications, supported by Company Secretary Team. When? TBC Progress on proposal 6: Progress on implementation of the Membership and Engagement Strategy: • MEG to review the Strategy Action Plan for year 1 to indemnify the progress made on achieving the objective at its September 2024 meeting Proposal 7: Process for planning and arrangement engagement opportunities clear for all Governors *Next steps:* What? MEG to review and propose updates/recommendations to Council of Governors (supported by Company Secretary Team) When? September 2024
Theme: Training/Development • To propose suitable development session topics for 2024/25 • To re-consider the timing of development sessions to support Governors who are in full time employment • To arrange a series of IT sessions to support Governors	Proposal 8: Council of Governors' Development Sessions • Proposed sessions are shown at end of this summary Proposal 9: IT issues • By creating a Frequently Asked Questions (FAQ) reference guide based on Governors'	Progress on proposal 8: Council of Governors' Development Sessions • Proposed sessions organised by the Company Secretary Team/those recently held in response to Governor feedback are shown at end of this summary • It was proposed at the July meeting of the Effectiveness Group that in addition to Development Sessions

in the effective use of Trust's devices in comfortable and open environment • To support Governors in resolving issues with IT promptly, to help them with having the tools to fulfil their role • To continue to keep Governors informed and involved, as appropriate, about significant developments taking place in the Trust, particularly about work within the Integrated Care System (ICS)	own experience with IT and their use of Trust's devices *(TBC)* • By distributing a further questionnaire to identify the IT training opportunities/ needs for Governors as a part of this training being built in to a development session Proposal 10: Patient First • By Governors receiving periodic updates on Patient First to better understand the impact of this methodology; continuing to inform on the Trust's work within the ICS and ICB Proposal 11: system working • To be further discussed by the Effectiveness Group as to current strengths in relation to keeping Governors informed about significant developments in relation to system working, what should continue and what Governors suggest needs to be added/amplified.	arranged by the Trust, that Governors undertake more self-study using NHS Providers toolkits, GovernWell training programme which provides Governors with useful information to support their role. This includes an overview of strategy and planning, appointment of NEDs, representing the interests of members and the public, the annual report and accounts. *(Note: as part of the new Governors' induction, the Company Secretary Team took into account the GovernWell induction materials).* *Next steps:* What? Draft programme for 2025 (including proposed timing) to be developed between Trust Chair and Company Secretary Team, taking account of Governor skills and knowledge (including feedback received). When? Draft to be shared with Governors by October 2024 Council of Governors meeting. Progress on proposal 9: IT issues • A further questionnaire prepared by the IT team to identify IT training needs was distributed to Governors. • Having regard to the feedback received from the additional IT questionnaire, an IT session was held led by IT and the Company Secretary Team on 6 June 2024. In addition, those Governors who felt that they would benefit from an individual session have had one to

		one sessions from the Company Secretary Team to help address specific support requests. *Next steps:* No further action at this stage but to be raised by Governors should the need arise. Progress on proposal 10: Patient First • The Council of Governors received an update on Patient First at the Board/CoG development session on 5 June 2024. *Next steps:* What? Away day including how Governors can use the Patient First methodology in their work. When: To be arranged for autumn 2024. Progress on proposal 11: system working *Next steps:* What? Effectiveness Group to further discuss current strengths in relation to keeping Governors informed about significant developments in relation to system working, what should continue and what Governors suggest needs to be added/amplified. When: Next meeting of the Effectiveness Group.
Theme: Effective collective working • To create an environment where everyone feels comfortable and encouraged to speak freely • To create ways of working to promote teamwork, picking up the best practices for the benefit of the Trust	Proposal 12: team building • By team building – reference made to a previous positive team building session organised by the Communications team for Governors • By organising an away day for Governors	Progress on proposal 12: team building • Code of Conduct reviewed and updated by the Company Secretary Team with draft being presented at July 2024 meeting of the Council of Governors.

		Next steps: What? Away day including how Governors can use the Patient First methodology in their work. When: To be arranged for autumn 2024. What? Governor pledges as part of collective working/effectiveness of the Council of Governors proposed to be discussed. When: July 2024 meeting of the Council of Governors.
Theme: Council of Governors – information received • To simplify information to support more effective participation by Governors in meetings • To receive only an executive summary for each of the agenda items and relevant documents to look for more details outside of the main meeting pack *(note: cover sheets already include an Executive Summary)*	Proposal 13: documentation presented to Governors • By providing a summary of the documents, including what has significantly changed • Implementing the Patient First A3 approach to reduce the volume of reporting	Progress on proposal 13: documentation presented to Governors • Enhancements already made to reporting (e.g. IPR) and continuing
Theme: Council of Governors – furthering opportunities to engage with Non-Executive Directors • To continue building good relationships with Non-Executive Directors (NEDs).	Proposal 14: Way of engaging with the Non-Executive Directors: • By creating opportunities to engage informally, including adding this as an agenda item at the Board/Council of Governors development session • By organising an away day for Governors and NEDs (subject to funds) • By organising more sessions in the marquee at Royal Bournemouth Hospital which supported a more informal approach and encouraged conversation	Progress on proposal 14: Ways of engaging with the Non-Executive Directors: • To be further reviewed

	• By arranging more break out group conversations during development sessions.	
Theme: Trust Chair and Non-Executive Directors' appraisal process • To further encourage and support Governors in the Trust Chair and NEDs appraisal process	Proposal 15: Trust Chair and NEDs appraisal process: • By providing short and informal briefings on the appraisal process as part of a development session • By continuing to share the framework for conducting annual appraisals of NHS chairs with Governors; and continuing to share the Trust Chair and NEDs' objectives with the Council of Governors shortly before distribution of the questionnaire	Progress on proposal 15: Trust Chair and NEDs appraisal process: At the Effectiveness Group meeting in July 2024, there was broad discussion about re-setting with Governors the importance of them engaging as part of performing their role. It was suggested that it should be clear to Governors that there should be an expectation from them that they provide feedback as part of the Trust Chair and NED appraisals when asked.

Development session subject proposed ("You Said")	Session(s) details held ("We did")
Trust transformation/reconfiguration	• **February 2024** – Board/Council of Governors development session – update, including Transforming Care Together and public engagement by Governors
Governors duties and responsibilities – refresher session	• **January 2024** – separate session organised for new Governors (as a part of their induction) • **February 2024** – Board/Council of Governors development session – Code of Governance particularly focused upon engaging with community and partners
Better understanding of the Annual Report	• **April 2024** – Board/Council of Governors development session
Patient First	• **June 2024** – Board/Council of Governors development session – update (following on from April 2023 Board/Council of Governors development session)
Better understanding of the Annual Accounts	• **June 2024** – Council of Governors development session – Andrew Monahan
Accessing Outlook, Teams meetings and papers on Trust's devices	• **June 2024** – Council of Governors development session • **Since June 2024** – individual sessions with Governors ongoing
Culture and values	*Specific focus to be discussed with Council of Governors ahead of session being arranged*

University Hospitals Dorset
NHS Foundation Trust

Information for prospective University Hospitals Dorset Staff Governors

#TeamUHD

We are caring | one team | listening to understand | open and honest | always improving | inclusive

Introduction from Rob Whiteman, trust chair and Siobhan Harrington, chief executive

On behalf of University Hospitals Dorset (UHD) NHS Foundation Trust, we would like to thank you for showing an interest in joining our Council of Governors.

Governors have an important role in making our Trust publicly accountable for the services we provide and bring a valuable perspective to all our activities.

You might know that being a member gives you a real opportunity to stay involved and play a part in shaping the future of the services within your community.

As a Governor, you will hold Non-Executive Directors to account for the performance of the board and represent the interests of NHS foundation trust members and the public. Our Governors play a vital role in helping us to connect with our members, staff, stakeholder groups and our local communities. In doing so, the Council of Governors has a key part to play in the delivery of our mission - which is, to provide excellent healthcare to our patients and the wider community and be a great place for all staff to work.

You can help make a difference for our patients by using your skills and knowledge in health services, in order to give something back. Our hospitals rely on Governors to engage with staff, the public and those who use our services to share information about what is happening and get feedback on how we are doing. With the exciting work taking place to strengthen Dorset-wide healthcare, which includes the rebuild of our trust's hospitals, there has never been a more vital time to help establish the links between our organisation and its patients and staff.

The work of the Council of Governors is extremely interesting, with the role being both challenging and rewarding. As you would expect, it requires time and commitment.

This guide introduces you to the Trust and provides an overview as to what is involved in being a governor. We hope this will encourage you to stand for election and in doing so, help us to continue providing high quality care and create a positive future for our patients and staff.

If you would like to hear more beyond this information, our Company Secretary Team will be pleased to assist you.

With best regards,

Rob Whiteman, Trust Chair and Siobhan Harrington, Chief Executive

About University Hospitals Dorset

University Hospitals Dorset NHS Foundation Trust serves Bournemouth, Poole and Christchurch, East Dorset and Purbeck, and parts of the New Forest for most hospital services. Of itself, it has a relatively youthful history, but with a long ancestry through its predecessor organisations of Poole Hospital NHS Foundation Trust and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Our specialist services also serve the whole of Dorset, South Wiltshire and part of Hampshire, for a population of around 750,000 people. These services include oncology, neurology, vascular, cardiac and interventional radiology, along with specialist areas in services like surgery.

Our Trust employs around 10,000 staff including via our staff bank. We are blessed with hundreds of volunteers and strong partners and have a thriving charity and allied independent charities. All this stands us in good stead for what are significant challenges to meet the health needs of our population which is ageing and growing, by about 1% per year. In addition, the local area remains popular for 30,000+ students and over one million visitors a year.

Our vision

To positively transform our health and care services as part of the Dorset Integrated Care System.

Our mission

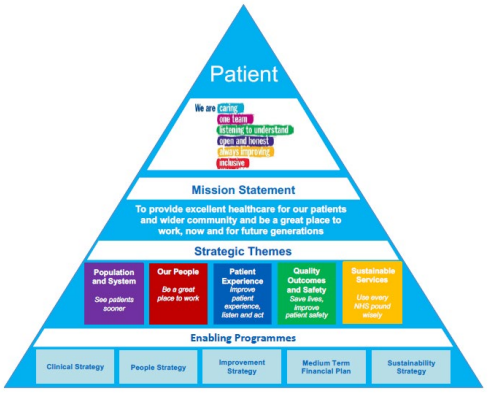
To provide excellent healthcare for our patients and wider community and be a great place to work, now and for future generations

Our values

Our values have been developed as a result of engaging with and listening to our staff to understand 'what is important to them?' This appreciative inquiry was carried out over many months with the support of our culture champions - a representative group and cross section of staff across our Trust.
Our values underpin our vision and mission. They are the standards shared by all of our staff. They guide our day-to-day decisions and the way we behave. They describe what is important to us and 'the way we do things around here'

Patient First

Patient First is a process of continuous improvement that focuses on giving frontline staff the time and freedom to identify opportunities for positive, sustainable change and the skills to make it happen. It is a way of uniting us all following the merger and the pandemic, to truly engage with our hardworking and dedicated staff and focus on the right things for patients.



About foundation trusts, members and Governors

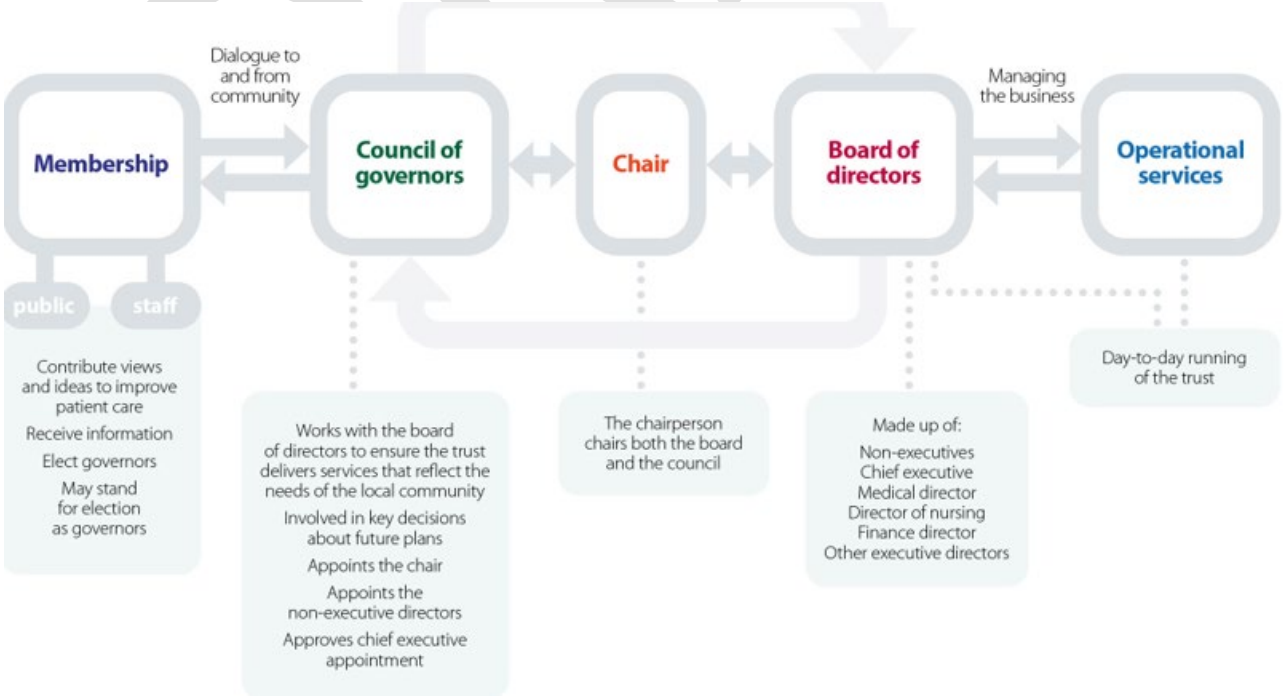
NHS foundation trusts are part of the NHS and provide healthcare according to core NHS principles: free care, based on need and not ability to pay. They have a degree of independence from the Department of Health and Social Care which means they can take certain managerial and financial decisions themselves and have more control over their own finances. As a foundation trust, we are subject to statutory requirements and have a duty to exercise functions effectively, efficiently and economically.

We have members that elect Governors of the Trust. Patients and local people that want to be more involved in our local health service can sign up to be members. This is part of our accountability to local communities.

The Council of Governors, which represents around 14,000 public members and around 9,000 staff members, is made up of public, staff and appointed Governors. Our staff automatically become members unless they choose to opt out from membership.

The Council of Governors plays an important role in members' views being heard and our publicly accountability for the services we provide. As a member of the Council of Governors, you would act as a link between the members and our Board of Directors.

Our Board of Directors is made up of full-time executives, who are responsible for the day-to-day running of the organisation, an independent Chair and part-time Non-Executive Directors. The Executive Directors work closely with the clinical leaders and managers throughout the hospitals in running the services. The Board of Directors also works closely with the Council of Governors, which hold the Non-Executive Directors to account for the performance of the Board.

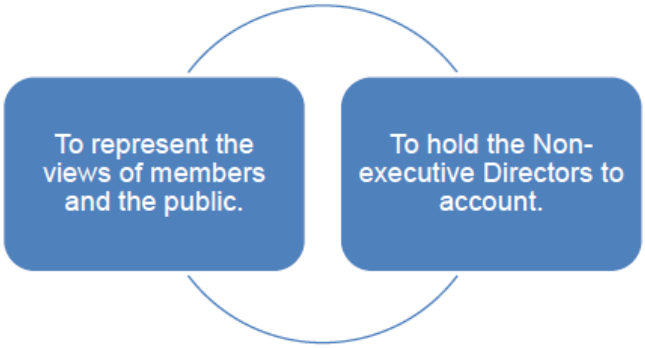


The role of the Council of Governors

The Council of Governors is made up of 17 publicly elected Governors, 5 staff Governors and 4 appointed Governors. Elected Governors are elected within their public constituencies and staff Governors are elected through the staff body. Appointed Governors represent stakeholder organisations such local councils, Bournemouth University, and our Volunteer Service.

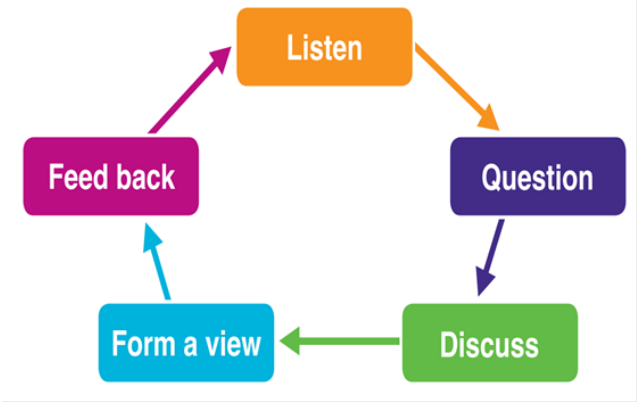
Governors have two main responsibilities:

- To represent the views of staff, patients, and the public, particularly in relation to the trust's strategic direction
- To hold the non-executive directors to account for the performance of the board



Representing the views of members. Staff Governors play a key role by informing the Council of Governors of staff views, especially if those views have an impact on issues of patient experience and quality of services. The Council of Governors helps the Board of Directors to make sure that the views of local communities, staff and people who use the Trust's services are taken into account when plans for services are being developed. Staff Governors also need to consider how they can support the Board to engage with the community across the integrated care system.

Holding the Non-Executive Directors to account. Governors are given various opportunities to hold Non-Executive Directors to account, for example by observing their activities, or meeting with them and asking questions. The holding to account process can be visualised by this cycle.



Other powers and duties

Governors perform a range of statutory duties. They are as follows:

- To appoint, and if appropriate, remove and decide upon the terms of office (including levels of remuneration) of the Chair and Non-Executive Directors of the Trust.
- To decide upon the terms of office (including levels of remuneration) of the Chair and Non-Executive Directors of the Trust.
- To approve the appointment of the Trust's Chief Executive
- To appoint and, if appropriate, remove the Trust's external auditor.
- To approve or not approve an application by the Trust to enter an acquisition, merger, separation, and dissolution.
- To approve or not approve increases to non-NHS income of more than five per cent of total income.
- To consider a report from the Board of Directors each year on the use of income from the provision of goods and services from sources other than the NHS in England.
- To approve changes to the Trust's Constitution jointly with the Board.
- To receive the annual report and accounts, and the auditor's report.
- To give a response when consulted by the Board on the Trust's annual plan.
- Significant transactions must be approved by the Governors. The Trust may choose to include a description of these in the constitution.

An effective Council of Governors is one that:

- Works closely and collaboratively with the board in an open and transparent way.
- Makes decisions collectively as a team.
- Explores issues through working groups or task and finish groups that report back to the whole council.
- Conducts most of its business through public meetings.
- Is well trained so they fully understand what forms part of their role and what does not, to make the best use of their time.
- Is well prepared.
- Has high standards of professionalism.
- Evaluates its effectiveness.

Michele Whitehurst – Lead Governor

Staff Governors are very important to our rust because they act as a conduit between hospital management and staff. They understand issues from both perspectives, ensuring that staff views are heard and considered. Also, Staff Governors contribute to transparency, employee well-being, and effective governance.

Some of the benefits of being a Staff Governor include getting an insight into the goals, challenges, and achievements of UHD. You gain firsthand knowledge of how the organisation operates and contributes to healthcare delivery. Also, being a Governor allows you to develop new skills and enhance your CV. It's an opportunity to learn and grow while contributing to UHD and the community. You'll meet new people and learn more about hospital life. Engaging with other Governors, staff, and patients can broaden your network and provide valuable connections.

What staff Governors do:

The Staff Governor role could, in simple terms, be compared to being a cross between a school governor and an MP. It involves:

- representing the interests of the people who use our services, as well as our staff who provide those services
- having a responsibility to the people who elect them
- talking and listening to staff about issues and concerns about what is working well, what could be improved, and providing feedback into the work of the Council of Governors
- attending training and development sessions, briefings, and meetings where Governors hear from Executive and Non-Executive Directors
- acting as a representative for widely held staff views and bringing these to the attention of the Council of Governors

What staff Governors do not do:

Staff Governors do not get involved in the day to day running of the hospitals, they:

- do not seek or act as a staff representative or union representative on employment issues e.g., disciplinary or grievance issues or changes to individual staff contracts as there are other channels for dealing with such concerns
- do not get involved in the detail of how services are run, outside of their own job remit, as this is the role of the board, clinicians, and managers
- do not deal with formal patient complaints. They should be signposted to the appropriate trust department, although Governors may wish to highlight if several complaints raised to them suggest a recurring issue with Trust services
- do not act as advocates for individual patients
- do not seek to be elected to represent a single issue or cause – Governors should seek to represent the interests of the whole constituency they represent
- do not need to scrutinise the performance of the hospitals, the Governor's job is to make sure that the Non-Executive Directors are doing this.

Kani Trehorn – staff governor for nursing, midwifery and healthcare assistants

I find the staff Governor role a privilege. I act collectively alongside a variety of Governors and maintain a healthy rapport with the trust board.
It's not a role to solve a problem but can sign post to the right arena or find suitable help. I enjoy the developmental activities and taking part in off-site governor events to promote UHD. I am glad to have supportive managers so that I can contribute to this unique role.
I have been fortunate to have acquired rich and a varied experience in my professional life and I found our Trust Board, the Company Secretary Team and the fellow Governors friendly, civil, non-judgemental, encouraging, inclusive and approachable! Above all, I keep the staff I am representing in my mind at all times.

Rob Flux – staff governor for administrative, clerical and management

I applied to become a staff Governor for UHD to have a greater visibility on what happens within our trust both from a clinical and non-clinical perspective. I was keen to understand more of what happens and why, both within the trust, but also across the wider community that we support, especially during this time of transition and change.

Being a member of non-clinical staff myself, I often see how day to day life across UHD can be both impacted and enhanced by ongoing changes and I wanted to be a part of the process in both a wider view and supporting my non-clinical colleagues across UHD during these challenging yet exciting times.

You can listen to why Rob decided to become staff governor here:
https://www.youtube.com/watch?v=Z5rv2CqudQQ&t=1s

Colin Hamilton – staff governor for estates and ancillary services

Joining other family members in the NHS, I started as a Bank Porter in 2020, after a 40-year career with Marks & Spencer in store, regional and programme management. As a porter, I spend a lot of time talking with patients across the services, hearing how they are feeling and getting an understanding of how we can improve their overall care and experience. I also have contact with a large range of colleagues across all roles.

My insights into the pressures and issues affecting them would enable me to represent their thoughts and opinions and articulate the impact of the forthcoming changes. I have come to care deeply about the NHS and UHD and I want the best healthcare for my community. With the skill, knowledge and energy I offer, I am in a perfect position to be an effective governor during this unprecedented period of pressure and change.

Eligibility to be Governor

Any permanent member of staff that is employed at University Hospitals Dorset, including bank staff, or has been on a fixed term contract for at least 12 months is eligible to become a Staff Governor. There are some restrictions that we apply to all Governors, whether they are publicly elected, appointed or a staff member. If you wish to put yourself forward for election, then you will be required to confirm that none of the exceptions applies.

You could be disqualified from being a governor for a number of reasons including bankruptcy or recent criminal convictions, for example. Our Constitution lists the exclusions in more detail and you can view the Trust's Constitution on the key publications page of our website: [link to current version of Constitution]

You are only eligible to stand as a Staff Governor in the constituency that you work in, providing there is a vacancy.

Terms of office for elected governors are up to three years, with the possibility of re-standing for election after then, subject to a maximum of three terms of office.

We ask all Governors to sign their agreement to a Code of Conduct before they take up their role. This highlights what is reasonably expected of individuals occupying the position of Governor. A copy of the Code of Conduct is available from our Company Secretary Team.

What are the benefits of becoming a Staff Governor?

Our Staff Governors tell us that they find their role rewarding and enjoy the opportunity to help to bring about positive change at the Trust. It also gives a wider perspective on the strategic challenges the Trust faces. Whilst the role is demanding it is also interesting, and Governors have a unique perspective of the hospitals and the NHS. Working alongside fellow Governors is also a great way to meet new people and to feel part of a team and can bring about greater personal confidence. On a professional level, becoming a Staff Governor will support your development and help you to build on existing skills and abilities in a new setting. It is also a positive addition to the CV.

What qualities should a Staff Governor have?

Enthusiasm, commitment, an interest in health, and the ability to work as part of a team are the most important qualities. It would be useful to have some skills in reading reports and working with people.
We will support all Governors with their development in the role, but would hope that anyone interested in becoming a Governor would have some or all of the following qualities:

- Good interpersonal and communication skills
- Sound, independent judgement, diplomacy and common sense
- Sufficient time and commitment to fulfil the role
- The ability to grasp relevant issues and understand relationships between interested parties
- An understanding and interest in health issues and a commitment to NHS values
- The ability to develop an understanding of the different legal duties, liabilities and responsibilities of Governors and Non-Executive Directors

What can Staff Governors give back to the people they represent?

Staff Governors represent the interest of staff in their classes. They provide a platform for staff to get their views, questions and concerns about the Trust heard by the Board of Directors. Staff Governors are also able to have an input in strategic decisions, giving the staff viewpoint in discussions over the Trust's plans and priorities, and feeding key information back to staff.

Time commitment and meetings

Many of our current Governors will tell you how much they enjoy the role but that the time commitment should not be underestimated. An estimated time commitment is **6-8 hours per month** to attend meetings and other events, to read reports and papers for meetings and to join in with membership engagement activities.

Staff Governors will generally attend a number of meetings:

Meeting	Frequency	Approximate Timing	During/Outside 9-5 Office Hours
Annual Members' Meeting*	Once a year	3-4 hours	During office hours
Observing Board Committees	3 times a year	2 hours	During office hours
Council of Governors*	4 times a year	3.5 hours	Outside office hours
Informal Governors' Groups	4 times a year	2 hours	During and outside office hours
Nomination, Evaluation and Remuneration Committee – only applicable if elected as a member of the Committee	4 times a year	1 hour	During office hours
Informal Governor Briefings and Development Sessions	10 times a year	2 hours	During office hours

** Mandatory for staff Governors but encouraged to attend as many meetings/events as possible.*

Our staff Governors are required to attend the Council of Governors meetings and the Annual Members' Meeting. There is a wide range of information that is discussed and shared across other meetings (as outlined above) that will enhance your knowledge and skills to carry out your role as a Staff Governor.

There are also four Informal Governor Groups which focus on specific responsibilities in the areas of quality, effectiveness, membership and constitution review. The informal Governor briefings include the Trust Chair providing an update on the matters of the private meeting of the Board and allows the Governors to ask questions. Governors are expected to attend a good mix of these meetings to ensure they are well informed and have the opportunity to raise queries and concerns on behalf of members.

Some development sessions are held in conjunction with the Board, which include giving Governors further opportunity to hear from our Non-Executive Directors and to enhance working relationships.

Governors can attend those Board meetings which are held in public. These are held six times a year and are currently scheduled for two hours and 45 minutes.

Other mechanisms of getting involved and fulfilling the role may include:

- Holding staff meetings for your constituency to improve engagement, listen to views, and ideas.
- Informing staff about the work of the Council of Governors.
- Representing the Council of Governors on major projects.
- Attending membership/engagement events.
- Submitting brief articles for the Governor brief and members' update.

As part of representing the views of the public, our Governors hold engagement events where they listen to feedback and also share information about the Trust and the changes taking place, as well as the role of Governors and Governor elections.

Whilst Staff Governors are required to represent the views of other staff members, as a representative of the Council, you are encouraged to participate in public events where possible to listen to the views of the public and to promote the work of the Trust.

Time offered to support Staff Governors in their role

The Trust is supportive of staff undertaking the role of a Staff Governor but as always it is courteous to discuss your request with your line manager before applying for a Staff Governor role.

To fulfil your duties as a Staff Governor, you are entitled to reasonable time away from your job to attend meetings, developments activities, engagement activities and events in relation to the role. You will be supported to undertake this within your contracted hours with the Trust.

Line managers will support you by being as flexible as possible, subject of course to the needs of the service. You will be notified of the meeting dates in advance to help you plan your time.

If your line manager would like to understand more about the role themselves, encourage them to review the information available or speak to someone in the Company Secretary Team.

Training and support for Staff Governors

An induction is scheduled at the beginning of the year for all newly elected Governors to attend. Existing Governors have attended previously to assist with any questions or apprehensions that you may have. The induction covers a wide range of topics and talks from a number of people from the Board of Directors. You will also be supplied with reference materials to assist you when you may need them. There is a course for newly elected Governors delivered by NHS Providers. We also have development sessions arranged for Governors and – as mentioned above - some of those are held with Board members, so there is always an opportunity for continuous learning whilst in the role.

Our Governors are a vital part of our work and we will endeavour to support you to carry out your duties successfully.

There is a wealth of experience from various backgrounds across our Council of Governors. Each new Governor is allocated a “buddy”, which means that you will have an experienced Governor that may be able to help with questions you have along the way as you start your journey as a member of our Council of Governors.

Contact

If there is anything that you would like to ask about being a Governor, you can get in touch with our Company Secretary Team at ftmembers@uhd.nhs.uk or you can speak to someone in person on 0300 019 8723.

If you have any special communication needs or would like this document in another format or language, please let the Company Secretary Team know.

The team are able to put you in touch with the most appropriate governor to speak to if you would rather speak to someone in the role. Keep up to date with our hospitals at www.uhd.nhs.uk and follow us on:

Proposed feedback form for Governors' events

Event title:
Date: Location:
Post code:

Age range:
16-30 31-50
51-80 80+
Prefer not to say

How did you learn about the event?
Members newsletter Social Media
UHD website Newspaper
Leaflet/Poster Can't remember

Are you associated with University Hospitals Dorset (UHD)?
Employee Volunteer
Member Other:
No

Have you – or anyone close you – had experience of UHD in the last?
3 months 6 months
12 months No

If so, for what? *(possible list of options?)*

Prefer not to say

On a scale of 1 – 10 how would you rate your experience?
(1 being very poor, 10 being excellent)

Why did you give this score:

Do you know about the changes taking place at the three hospitals that make up UHD?
Yes **No**

What is your opinion about these changes?

How did you hear about the changes?

Newspapers
TV News
Social media
Members newsletter
Attended an event
Leaflet
Other:

When all the changes have taken place do you think Poole hospital will be the biggest planned surgery hospital in:

Dorset
South of England
England

With the knowledge you have what is the one thing we could do better to improve at UHD?

What one thing will you take away from today?

Attendance at Council of Governors Part 1

		4 April 2024	31 May 2024 Extraordinary
Present	Rob Whiteman		
	Colin Blebta		
	Robert Bufton		
	Sharon Collett		
	Sue Comrie		
	Steve Dickens		
	Beryl Ezzard		
	Richard Ferns		
	Rob Flux		
	Colin Hamilton		A
	Paul Hilliard		
	Elizabeth McDermott		
	Andrew McLeod		A
	Keith Mitchell		
	Jeremy Scrivens		
	Diane Smelt		
	Carrie Stone		
	Kani Trehorn		
	Michele Whitehurst		
	Sandra Wilson	A	
In attendance	Debbie Anderson		
	Yasmin Dossabhoy		
	Ewan Gauvin		
	Judy Gillow		
	Siobhan Harrington		
	Fiona Hoskins		
	Judith May		
	Helena McKeown		
	Mark Mould		
	Pete Papworth		
	Richard Renaut		
	Tina Ricketts		
	Claire Whitaker		
	Peter Wilson		
	Klaudia Zwolinska		
Was the meeting quorate?		Y	Y

Key

	In attendance
	N/A
	Not in Attendance
A	Apologies
D	Delegate Sent