Respect
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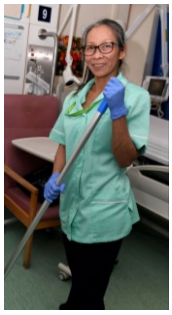
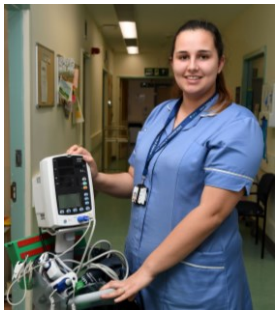
NHS
Dorset County Hospital
NHS Foundation Trust

Annual Report and Accounts

2020 - 2021




Outstanding care for people in ways which matter to them

Dorset County Hospital NHS Foundation Trust

Annual Report and Accounts 2020/21

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

Contents

Statement from the Chair and Chief Executive

No-one could have predicted the challenges the NHS as a whole and our Trust has faced over the past year. Bringing everyone through the COVID-19 pandemic as safely as possible has required exceptional dedication from all our people. Observing teams working together across the hospital and working from home, we have been incredibly proud of how staff have supported each other, recognising the individual value and contribution each person brings. Our Trust values have never been more important.

The pandemic has taken so much from so many and we know many staff have had to make personal sacrifices in order to continue to work and look after the most vulnerable. Their courage, resilience, and commitment to caring for our community is what makes Dorset County Hospital an organisation that is so very much appreciated by those we serve.

Thankfully with a vaccination programme being successfully rolled out across the country there is light at the end of the tunnel. Our focus now is on supporting staff to recover physically, emotionally, and psychologically from what has been a very challenging year so we can move forward and recover our services for our patients.

As we move towards the recovery of services, we acknowledge this will be a long-term process. We want to focus on sustainable recovery which will benefit our patients whilst taking the opportunity to build on the successful practices developed during the pandemic. This will only be possible by working closely with partners in both health and social care.

As we address the impact of the pandemic and the inequalities it has brought into sharp focus, we recognise the importance of strengthening diversity and creating a culture of inclusion. We are therefore building upon our existing work on equality, diversity, and inclusion. This year we embarked on a review of the organisational culture and will be launching a wide-reaching inclusion programme with the aim of making Dorset County Hospital a place where everyone feels welcomed and valued. We are clear discrimination, in any form, will not be tolerated and we are committed to creating a culture of inclusion with fairness, equity, and equality at its heart.

The above will only be possible with a strong foundation of quality improvement ensuring our staff are empowered and enabled to make changes to the way they work and the way they care for our patients. We have seen our teams achieve a great deal over this most challenging of years and we have much to look forward to, including the major development of clinical facilities on our site.

This year saw the launch of the Integrated Care System consultation, replacing Clinical Commissioning Groups from April 2022 and strengthening collaboration between health and local government. Moving forwards, we will continue to work with our partner organisations to design and develop the new Dorset Integrated Care System. This provides us with an opportunity to work more effectively with our provider partners with a focus on reducing health inequalities and improving the overall wellbeing of our most deprived communities.

Fundamental to this will be our Social Value Pledge. This pledge demonstrates our commitment to our local communities which stretches beyond health. Dorset County Hospital is the largest employer in West Dorset. As well as offering health services to our local community, we employ over two and a half thousand people, we spend millions of pounds each year on goods and services, including food, and we have a major impact on our local environment. As such, we are an anchor institution and have an important role to play in both the social and economic development of our communities following the

pandemic. We aim to create a lasting, positive social impact and legacy for the communities we serve.

We could not be prouder of our NHS people. We would like to take this opportunity to thank them for their dedication, commitment, and enthusiasm and also our communities for their unwavering support during what has been the most challenging year in the history of the NHS.

Mark Addison
Chairman

Patricia Miller
Chief Executive

Performance Report

Overview of the Trust

Purpose of the Overview

The purpose of the overview is to provide the reader with sufficient information to gain an understanding of Dorset County Hospital NHS Foundation Trust, our purpose, the key risks to the achievement of our objectives and how we have performed during the financial year 2020/21.

About the Trust

Dorset County Hospital NHS Foundation Trust's mission is to provide outstanding care for people in ways which matter to them. Our vision is that Dorset County Hospital, working with our health and social care partners, will be at the heart of improving the wellbeing of our communities.

Dorset County Hospital NHS Foundation Trust ("the Trust") achieved Foundation Trust status on 1 June 2007 under the Health and Social Care (Community Health and Standards Act 2003). The Trust took over the responsibilities, staff and facilities of its predecessor organisation, West Dorset General Hospital NHS Trust.

The Trust is the main provider of acute hospital care to the residents of West Dorset, North Dorset, Weymouth and Portland, a population of approximately 215,000 people. It also provides specialist services to the whole of Dorset and beyond including renal services in Bournemouth and Poole, and South Somerset. It serves an area with a higher than average elderly population and lower than average proportion of school aged children. Dorset continues to experience an increasing total population. The main hospital opened on its current site in 1987 and is situated close to the centre of the county town of Dorchester.

The geographical spread of the community the Trust serves requires it to deliver community based as well as hospital based services. This is achieved through providing services in GP practices, in patient homes through Acute Hospital at Home Discharge to Assess and at community hospitals in West Dorset, including Weymouth Community Hospital, Bridport Community Hospital, the Yeatman Community Hospital in Sherborne and Blandford Community Hospital. The Trust also works closely with other health providers, primary care and social services to ensure integrated services are provided.

As an NHS Foundation Trust, we are accountable to Parliament, rather than the Department of Health, and regulated by NHS Improvement. We are still part of the NHS and must meet national standards and targets. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

The Trust provides the following services for patients:

- Full Emergency Department services for major and minor accidents and trauma
- Emergency assessment and treatment services, including critical care (the hospital has trauma unit status)

- Acute and elective (planned) surgery and medical treatments, such as day surgery and endoscopy, outpatient services, services for older people, acute stroke care, cancer services and pharmacy services (not an inclusive list)
- Comprehensive maternity services including a midwife-led birthing service, community midwifery support, antenatal care, postnatal care and home births. We have a Special Care Baby Unit
- Children's services including, emergency assessment, inpatient and outpatient services
- Diagnostic services such as fully accredited pathology, liquid based cytology, CT scanning, MRI scanning, ultrasound, cardiac angiography and interventional radiology
- Renal services to all of Dorset and parts of Somerset
- A wide range of therapy services, including physiotherapy, occupational therapy and dietetics
- An integrated service with social services to provide a virtual ward enabling patients to be treated in their own homes

Our business model is based on managing expenditure within the context of agreed contracts with commissioners. The Trust has to manage its costs within the national tariff system to allow us to invest appropriately (staff and infrastructure) in order to provide safe, effective patient care.

The Trust is organised internally as follows. There are two Divisions in the Trust, the Urgent and Integrated Care Division and the Family and Surgical Services Division. Each Division has responsibility for general business: workforce, education, access and flow, space utilisation, and capital and strategic planning. In turn they also have responsibility for governance: safety, clinical effectiveness, safeguarding and patient experience. Each Division is then subdivided into a number of care groups which also hold their own speciality/department meetings.

The Divisions report into the Trust Board Committees on a monthly basis. The Committees and their remits are as follows:

- Finance and Performance Committee provides finance and access assurance
- Quality Committee provides quality assurance
- Risk and Audit Committee has a corporate governance responsibility to provide Board Assurance Framework, corporate risks, internal and external audit assurance
- The People and Culture Committee (formerly the Workforce Committee) oversees the Trust's People Strategy, monitors standard workforce metrics, and recruitment strategies and approaches

The Board of Directors meets on a bi-monthly basis and is supported by the assurance and performance sub-committees that it has established. The Board and sub committees have formal minutes and the Senior Management Team provides strategic and operational support to the Board of Directors and its sub-committees.

Highlights of the Year

Coronavirus pandemic

Staff at DCH have been overwhelmed by donations and messages of support and kindness throughout the coronavirus pandemic. Since the country entered lockdown, communities rallied together to show their appreciation for the NHS and to help support staff through what may be the most challenging time of their career. The Trust received hundreds of donations and every single one made a huge difference. Businesses provided free accommodation and Personal Protective Equipment, staff received endless gifts to brighten their days, from chocolate to hand cream, and wards have been decorated with children's colourful illustrations of rainbows. More than £158,000 was also raised through the DCH Charity's COVID-19 Appeal. The pandemic has highlighted the true meaning and value of community spirit and we will be forever grateful to all those who have supported us through it.

A couple from Portland tied the knot at DCH to celebrate their love amidst the coronavirus pandemic. Tina and Mick Hickton exchanged their vows in the hospital's chapel after they received a special licence to marry because of exceptional circumstances. Tina was undergoing cancer treatment at DCH and the couple's wedding plans had to be cancelled due to the pandemic. Lung Specialist Nurse Alex Hillcox-Smith, Associate Nurse Specialist Anita Burnham and Macmillan Cancer Support worker Sian Thomas-Cutts therefore stepped in to organise a ceremony.

A recovering coronavirus patient thanked staff at DCH for their care. Malcolm Cumber was admitted to DCH via the Emergency Department at the end of March after suffering from intense fatigue and shortness of breath. After testing positive for COVID-19 and not responding to initial treatment, Malcolm was transferred to intensive care and had to be put on a ventilator. Fortunately Malcolm's condition began to improve and weeks later he was discharged and reunited with his wife and dog Crumble.

Our amazing team of volunteers have been an incredible asset during the pandemic. They have packed and distributed masks, coordinated and distributed donations, assisted pharmacy with home deliveries, designed puzzles, written thank you letters, supported the DCH COVID-19 Vaccination Centre and much more.

In November, we were delighted to be one of the first NHS Trusts to trial the use of reusable PPE gowns. In partnership with NHS England and NHS Improvement and our laundry provider Salisbury Linen Services, the gowns are being trialled in key clinical areas. Each reusable gown replaces the need for up to 75 disposable gowns. This change will support the Trust's sustainability agenda, significantly reducing the amount of single use products put into clinical waste each day.

8 December 2020 marked a momentous day at DCH as we successfully held our first COVID-19 vaccination clinic as a hospital hub. We are immensely proud to have played a major role in the Dorset COVID-19 vaccination programme.

As part of the plan to increase inpatient capacity across the hospital, core discharge services, which were extended across seven days from the point of lockdown, are now co-located in one hub. The Hospital Discharge MDT are co-located with Social Care, Dorset HealthCare (in-reach) and Therapies to improve communication and collaboration between services to support rapid discharge from hospital for all patients.

Our Patient Action Tracker app allows actions to be recorded for all inpatients every single day to help prevent delays in discharging patients back home. This has been an amazing project accomplished during the pandemic between our Divisional, Business Intelligence, Transformation and IT teams. The app can be used on a variety of devices, phone, tablet, PC to input, review and monitor information and allows wards to directly escalate to matrons and managers where they require support. It is the way in which the Trust is able to record, use and report the status of each patient in the hospital.

The Same Day Emergency Care Team have been working closely with the Orthopaedics and Gynaecology Departments in efforts to restart services as quickly, but as safely as possible, during the coronavirus pandemic.

Our Cardiology Department has undergone a lot of changes over the past year and the team have worked incredibly hard to keep services running throughout the pandemic. They have been amazingly resilient and responded well to all the challenges they have faced.

Our on-site COVID-19 Testing Unit Team have been doing an incredible job during the pandemic, running seven days a week to ensure any symptomatic staff (or symptomatic members of their household) are tested as soon as possible.

Multi-storey car park development

Following incredible support from the local community, Dorset Council's Northern Area Planning Committee approved our application to build a multi-storey car park on 15 September 2020 to unlock the development of clinical services on the Dorchester site.

In February 2021, local people were invited to choose the images which will be used as artwork on the sides of our new multi-storey car park. The metal facades will be added to three sides of the building and feature images of local landscapes and landmarks, a theme chosen by hospital staff to illustrate the hospital's catchment area. The top three choices were photos of Portland Bill, Durdle Door and Corfe Castle which will be used to create images on perforated metal panels to cover elevations of the multi-storey car park.

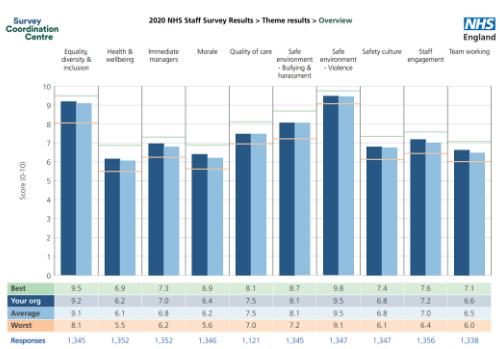
The start of construction work on our multi-storey car park was officially marked with a turf cutting ceremony. Representatives from the hospital, health and care property developer Prime and contractors Willmott Dixon gathered on site to see how work was progressing. The car park, due to be completed in summer 2022, is the first phase of the development of the hospital site to free up land for the expansion of clinical facilities, including a larger Emergency Department and Intensive Care Unit.

Other highlights

A new wi-fi network at DCH has enhanced the experience of patients, allowing them to stay better connected to loved ones during their stay. The Trust partnered with WiFi SPARK to launch a free NHS network for patients, visitors and staff. The network allows patients and visitors to browse online, use email and check in with social media. A staff network is also available for DCH employees. The project has been partially funded by the Friends of DCH.

A new state-of-the-art CT scanner was installed at DCH and is the first of its kind across the whole of the south. The scanner is the latest technology available and will greatly improve patient experience as it has the ability to perform scanning in a way that was not previously possible.

DCH and Dorset HealthCare jointly launched a new dedicated rehabilitation unit for people recovering from stroke and neurological illnesses or injuries. The 10-bedded unit based at the Yeatman Hospital in Sherborne opened its doors to patients on 4 August 2020. The service offers a fresh approach to rehabilitation to improve outcomes for patients in west and north Dorset. Patient feedback and engagement will shape how the service develops after a pilot period.



The Trust pledged to do more to ensure it is a fully inclusive employer following the publication of the NHS National Staff Survey. The pandemic has meant the year has been far from 'business as usual' for the NHS workforce. 1,358 members of staff completed the survey, 46% of staff. Positive highlights included 90% of staff feeling their role makes a difference to patients; 91% feeling trusted to do their job and 89% feeling encouraged to report errors, near misses or incidents.

During Inclusion Week in September 2020, we were proud to launch our Black Lives Matter pledge to show our commitment to creating a culture of inclusion. Our aim is for every colleague we work with and every patient we treat to feel equal and valued. The Trust Board have made their own personal pledges.

Earlier in the year we also created our nationality banners to show the diversity of Team DCH.

In October 2020 we were delighted to see the first baby born in The Cove – the new midwife-led unit at DCH. The Cove has been developed to enable women to have more choices about where they would like to give birth. The unit promotes a philosophy of normal and natural labour and childbirth for low risk women. The Cove is ideal for low risk first time mothers who might want a home-from-home experience but may feel anxious about choosing to have a home birth.

One of our most treasured possessions and an intrinsic presence at the Trust is currently on loan to a museum in Germany. Elisabeth Frink 'Dog' is on loan to The Gerhard-Marcks-Haus museum and in exchange we received 'Ponyrider'. ‘Dog’ will return to the Trust July 2021.

In November we launched a new exhibition at DCH. 'Unmasked' was a project by photographer Andy Scaysbrook and journalist Emma Pittard to reveal and celebrate the faces of health workers fighting the battle against COVID-19 in Dorset. Through a series of portraits, the project shined a light on the ‘humans’ behind the masks, capturing them in their lives both inside and outside the hospital.

Strategy and Objectives

Strategic Update

The Trust had planned to refresh the strategy for the start of 2020/21, however, the onset of the COVID-19 pandemic meant the process was paused. Therefore in 2020/21 the existing strategy remained in place.

COVID-19 has not fundamentally changed the challenges faced by the NHS or by the Trust; increasing demand, workforce shortages and limited finances. Rather it has exacerbated them whilst also bringing some issues to greater prominence, such as the impact of health inequalities on people's health and health care outcomes. The pandemic has also accelerated some of the potential opportunities to address these challenges such as the implementation of virtual healthcare.

In the second half of 2020/21 the Trust began the refresh of the strategy, set against the backdrop of the COVID-19 pandemic and the NHS consultation process on the future of Integrated Care Systems which will replace Clinic Commissioning Groups.

The Trust is now actively engaged with health and social care partners to design and implement the new Dorset Integrated Care System placing people and communities at its heart. As part of this work an Integrated Care System Board will be created and Dorset County Hospital will form part of this along with health and social care partners. All NHS providers will be part of 'provider collaboratives' and 'place based partnerships'; working together to deliver effective care and provide equal access to local communities.

The aims of Integrated Care Systems are:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS to support broader social and economic development

National legislative changes are expected in 2021/22 to formalise the role of Integrated Care Systems, which are likely to take effect from April 2022.

Ultimately, Dorset County Hospital is the designated planned care and emergency hospital with Accident and Emergency services for the west of the county and continues to work towards ensuring the hospital has the capacity to deliver these services in the long-term.

DCH Strategy

The final version of the refreshed strategy will be produced in early 2021/22. The key trends, and challenges, while exacerbated by COVID-19, remain true and therefore the Trust vision, mission and blueprint remain valid and will be retained.

The strategic themes and delivery programme will be refreshed and updated and will align to national and strategic direction. The NHS Long Term Plan remains relevant. The changes to Integrated Care Systems outlined above will impact the way Dorset County Hospital may seek to deliver services and the Trust Strategy reflects this whilst also being adaptable.

Our Mission
Outstanding care for people in ways which matter to them

Our Vision
Dorset County Hospital, working with our health and social care partners, will be at the heart of improving the wellbeing of our communities

Key Issues and Risks

The Trust's key strategic risks are captured, monitored and managed through our Board Assurance Framework. Mitigating these risks and issues is linked to the successful delivery of the Trust Strategy.

- Performance and workforce – achievement of the national and constitutional performance and access standards and the appropriate workforce in place to deliver services
- Emergency admissions and patient flow – reducing emergency admissions, occupied bed days and the number of patients with a delayed discharge
- Digital Dorset Care Record – having the ability to share digital care records across organisations in Dorset
- Senior medical leaders – successfully filling all medical leader posts
- Financial sustainability – a return to financial stability
- Estate – using the hospital estate efficiently and effectively to deliver safe services

Capacity for Change

The financial challenges facing the Trust requires focus on ensuring short-term sustainability, while also delivering long-term transformation. These must be delivered in parallel. The organisation must be flexible and respond and adapt quickly to emerging priorities, particularly in light of the dynamic nature of COVID-19. Currently, there is a challenge in creating the capacity to deliver strategic change while also maintaining day to day operational performance standards, a full complement of clinical workforce, financial sustainability and managing COVID-19.

Hospital Development and the New Hospitals Programme

The Trust's current Emergency Department and Intensive Care Unit capacity is exceeded by demand. Initially the Emergency Department was built for 22,000 attendances per year, however in a normal year we see close to 50,000 people. Additionally, the COVID-19 pandemic has highlighted the lack of Intensive Care Unit capacity available for local and regional populations. 2020/21 saw an significant amount of planning and consultation which helped the Trust to be named one of the 40 'New' Hospitals as part of the Government's New Hospital Programme.

As part of the Government's New Hospital Programme, Dorset has been allocated £350m with Dorset County Hospital expected to receive £80m of this to develop a new Emergency Department, Intensive Care Unit and Integrated Services which will provide the opportunity to fundamentally transform the way services are delivered and meet demand for a generation to come. This opportunity would increase the size of the existing departments, and bring a range of community services onto site and make these critical services sustainable. This is a long term project, with capital funding not expected until the mid-

2020s, as the Dorset County Hospital Project Team develop the detailed plans to demonstrate to central government.

In addition the Trust secured £15m funding, spread over the 2020/21 and 2021/22 financial years, to expand the capacity of the existing Emergency Department. This investment will enable the Trust to meet current demand for the next four to five years.

The Trust's transformation programmes have been the delivery vehicle for strategic change. Alignment and contribution to the strategic outcomes has been overseen by the Transformation Group; a regular meeting of all Trust Executives and senior managers. The Transformation agenda for 2020/21 was developed and approved weeks before COVID-19 became a pandemic and is now subject to change.

Separately the Trust developed a set of operational and business plans for its core divisions and corporate services which set out how the Trust will deliver key constitutional standards, improve safety, quality and patient experience and ensure we continue to meet our medium term financial plan to achieve financial sustainability.

Quality Improvement

In October 2020 the Trust Board approved the Quality Improvement Strategy with the aim of embedding and adopting a more systemic and organisational approach to quality improvement. The strategy builds on excellent quality improvement work across the organisation and a programme of quality improvement training was delivered to over 100 front line staff over the past 18 months.

Many staff routinely improve quality for the benefit of patents and the services. Building on that good work, quality improvement is designed to inspire all staff to improve quality wherever they are, by creating the right organisational environment for improvement to flourish and providing staff with the tools and training.

Additionally, through the pandemic, staff used the ethos and fundamental tools of quality improvement to plan and respond to create a permissive and enabling improvement culture. The Quality Improvement Strategy seeks to embed those approaches and learning across the organisation.

Staff Well-being

Trust staff have been magnificent over the past year. However, the impact of them pandemic should not be underestimated. The Trust's main priority is supporting the well-being and recovery of all our staff and we have developed a range of support and well-being initiatives which will be retained for as long as necessary.

The Trust's People Plan, due to be refreshed in 2021/22, will focus on making Dorset County Hospital a great place to work and will focus on:

- Creating the right culture
- Ensuring we are an inclusive employer
- Creating a sense of belonging
- Providing staff with the right support

COVID-19 Response and Recovery

In response to the COVID-19 pandemic the Trust implemented a considerable number of significant changes to the way in which it operates. Services were displaced and reorganised in order to accommodate COVID and non-COVID pathways ensuring infection, prevention and control guidelines were maintained. Planned services were suspended to deal with the pandemic however the Trust continued to see all urgent and priority patients and emergency services remained open to all those who needed care the most.

There has, and continues to be, a strong focus on staff wellbeing, implemtenting a myriad of supportive initiatives for the workforce including face to face on site councelling, dedicated safe spaces, food bank initiatives and annual leave buy back schemes recognising the economic impact on partners and spouces.

Managing COVID-19 over the past year has led to increased numbers of people waiting to be seen. The Trust is therefore focussed on seeing as many people as possible as quickly and safely as possible, based on clinical need. The Trust is seeking to do this by; increasing existing capacity, partnering with independent sector organisations, working with our health and social care partners, and finding new and innovative ways of delivering services.

Health Inequalities and Social Value

The pandemic highlighted the disproportionate impact on those from ethnic minority backgrounds and deprived communities. The Trust is focussing on ensuring we are collecting the right data to deliver services in an inclusive manner, focussed on delivering equity of access and outcomes.

The Trust Board confirmed its commitment to addressing health inequalities through a Social Value Pledge which was approved in October 2020. This pledge sets out the Trust's commitment to improving the economic, social and environmental well-being of our local communities. Social value will be integrated into our planning as a strategic thread across all activities and supports:

- Wider determinants of health
- Population health and well-being
- Reduction in health inequalities
- Sustainable development

Going Concern Statement

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust recorded an operating surplus of £0.4 million for the year ended 31 March 2021, with a cash balance of £17.7 million. The Trust has operated throughout the entire 2020/21 year under a fixed income financial regime. It was been confirmed that this arrangement will operate until at least 30 September 2021. The Trust is awaiting further guidance on planning for the remainder of the financial year, however, the current cash position, future funding and potential borrowing is expected to be sufficient to cover cash requirements for the remainder of the going concern period.

It is also noted that the cash regime within the NHS for new financial revenue support will be in the form of non-repayable Public Dividend Capital, rather than interest bearing loans. Therefore, should the Trust be in need of cash support it will not be in the form of repayable debt.

After making enquiries, the Directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the going concern period, being 12 months from the date of signing this Annual Report. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Performance Overview

Elective Care

As part of the response to the COVID-19 pandemic, a series of metrics were put in place to monitor and measure recovery of elective care.

These metrics were specific to the various waiting time metrics and are specified in this overview, the Trust set up a weekly recovery meeting and a suite of reports to monitor improvements in performance against these metrics. There were also system wide meetings established between all local providers (NHS and independent sector) so that all available capacity could be optimised and to ensure patients were treated in clinical priority order and ring fence cancer surgery.

In September 2020, guidance was issued to support the clinical prioritisation of elective waiting lists. This was agreed by all the Royal Colleges, and all patients on the elective treatment waiting lists were assigned, by the listing clinician, a priority code as the timeframe to treatment.

Many services moved to offering virtual appointment where this was both clinically appropriate and continued to meet the particular needs of patients. Having due regard to the public sector equality duty, the Trust has ensured regular review of those patients experiencing extended waiting times for assessment, diagnostic investigations and treatment; maintaining contact and engagement with patients in order to identify changing clinical priorities and offering support and advice to those that continue to wait.

Summary of performance: 18 weeks performance, waiting list size and long waiters

The Referral to Treatment (RTT) percentage performance has remained a constitutional standard, and whilst the Trust hasn't achieved the standard in this financial year, performance has been consistent.

Performance	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT % actual	52.55%	46.42%	40.37%	37.17%	42.31%	46.69%	49.41%	52.10%	53.25%	51.33%	50.53%	50.89%

The total waiting list has grown this year due the cessation for many services of non-emergency activity both outpatient and diagnostic, in quarters one and two. This has also had an effect on the composition of the waiting list.

Phase 3 RTT planning added new metrics relating to the volume of patients waiting in the following brackets: over 52 weeks, over 78 weeks and 104 weeks. The Trust is required to report on an exception basis to NHS England/Improvement, those patients in the latter two categories.

In addition to these key performance indicators, the following activity measures were put in place:

- Day case and inpatient activity volumes with a target of 80% of 2019/20 activity being delivered in September 2020 rising to 90% from October 2020
- Outpatient activity volumes, for both first and follow up appointments, with a target of 100% of 2019/20 activity from September 2020. This could be delivered through virtual or face to face appointments although the ambition was that 25% of appointments and 60% of all follow up appointments were conducted by telephone or video per national guidance

By March 2021 the Trust had recovered activity levels to pre-pandemic levels and higher for day cases, first appointments and follow up appointments. Inpatient activity levels were slightly below the activity levels of 2019/20 due to the second wave of the pandemic.

Summary of performance: Diagnostic Waiting Times
Following the outbreak of the pandemic, all non-emergency services and many diagnostic procedures with the potential to generate aerosol or faecal transmission of COVID-19 were suspended in line with national guidance and adversely impacted on compliance with standards for many modalities.

Phase 3 targets commenced from September, with a requirement to deliver 90% of 2019/20 activity in September, rising to 100% in October and onwards. By March 2021 all modalities were achieving in excess of 100% of the 2019/20 activity.

The reinstatement of diagnostic services saw performance improvements in those patients waiting over six weeks and performance against the standard.

Performance	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total waiting list	2387	3836	3992	4249	4471	4602	4191	4311	4270	3797	3454	3841
6ww+ (breaches)	1411	2269	1662	1696	1867	1809	1421	1172	1129	915	605	771
DM01%	40.89%	40.85%	58.37%	60.08%	58.24%	60.69%	66.09%	72.81%	73.56%	75.90%	82.48%	79.93%

**To note, the target is that no more than 1% of patients will wait over 6 weeks and this is how it is reported nationally. Locally it is reported as 99% of patients have had their diagnostic procedure within 6 weeks.*

Summary of performance: Cancer Waiting Time Standards
The Phase 3 requirement for cancer services is to fully restore all cancer services. The ambition is to reduce the number of patients waiting longer than 62 days on an urgent referral pathway and reduce the number of patients waiting over 31 days on a treatment pathway to pre-pandemic levels.

Two Week Referral Volume and Standard
Following the outbreak of the pandemic there was a noticeable drop in the number of urgent referrals for assessment within two weeks during the first quarter of the year. There was a steady increase in the number of referrals from July and by September the referral volume had returned to pre-pandemic levels.

2ww	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
referrals	414	522	757	865	771	810	881	882	833	732	811	1057
Performance	81.90%	95.50%	82.10%	69.30%	63.70%	54.50%	57.21%	65.39%	73.09%	61.68%	76.02%	79.25%

62 day PTL and Standard
Whilst the Trust has not achieved the 62 day standard in this financial year, performance against the standard has been consistent. This is because the Trust focussed capacity for surgery and other treatment modalities. There was a slight dip in performance in February due to the impact of the second wave and the volume of treatments undertaken.

Cancer 62d	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Performance	69.40%	71.60%	69.70%	72.70%	70.70%	68.50%	73.03%	76.12%	71.43%	75.74%	67.69%	83.02%

Following the outbreak of the pandemic the composition of the waiting list for patients on a 62 day pathway changed. This was due to decreased referrals and the cessation of some diagnostic elements, which impacted the length of the pathways for many patients and increased the number of patients waiting over 62 days during the first quarter.

Following the reinstatement of diagnostic services, the numbers of patients waiting over 62 days declined and has recovered to pre-pandemic levels. This has been an incredible achievement and is reflected in the performance in March 2021.

Equality of service delivery to different groups

The COVID-19 pandemic has further highlighted heath inequalities, particularly for patients from ethnic minority communities and those in social and economic deprivation. Throughout 2020/21, the Trust periodically reviewed all waiting lists (cancer, RTT and Diagnostics) to analyse if patients from these groups were waiting longer for treatment.

Whilst the analysis showed that this was not the case, the data sets were not complete, with over 20% of the waiting list entries missing ethnicity data. As part of the health inequality programme in 2021/22, the Trust is committed to capturing the required data to develop an accurate analysis of the waiting list. This links into the work being done in primary care and the wider system to not only report on such inequalities but to put plans in place to address them.

Financial Performance

In 2020/21, the Trust's financial plan reflected the impact of the COVID-19 pandemic and for the first half of the financial year a revised national finance regime was applied, steered by NHS England/Improvement. All Trusts were supported to deliver a breakeven position for the period April to September with a further revision to the regime updated for the second half of the financial year which resulted in the Trust submitting a planned deficit position of £11.6 million.

As the pandemic continued through the second six months of 2020/21, the Trust delivered a surplus of £0.4 million, which equates to approximately 0.2% of the Trust's turnover.

Table 1 below sets out the Trust's adjusted deficit of £0.1 million as assessed by NHS England/Improvement. This excludes the movements linked to donated capital assets of £0.3 million.

Table 1 : Financial Performance against plan	2020/21 Plan £ millions	2020/21 Actual £ millions	Variance £ millions
Total income	215.1	234.5	19.4
Total expenses	-226.8	-234.1	-7.3
Operating deficit/surplus	-11.7	0.4	12.1
Capital donations	-0.2	-0.6	-0.4
Donated depreciation	0.3	0.3	0.0
Adjusted deficit/surplus	-11.6	0.1	11.7

Performance Against Plan

The Trust achieved a breakeven position during the first half of the financial year, as expected, due to the design of the NHS financial regime during the first six months of the pandemic. Within this regime, the Trust was paid a fixed income amount each month designed to cover costs during this six month period. In addition to this, the Trust had the opportunity to apply for further monthly funding to cover the additional costs incurred as a direct response to COVID-19 in order to reach a break even position.

In the second half of the year, the regime was amended slightly and the funding available was predominantly fixed. The Trust was also expected to recover elective services to levels close to the pre-pandemic position. In order to do this the Trust was expecting to invest heavily to achieve this requirement and hence this resulted in the expectation that the Trust would deliver an £11.6m deficit. Due to the impact of additional nationwide lockdowns in the second half of the financial year, the Trust's COVID-19 restart plans and winter response schemes were significantly affected, and as a consequence, less activity was delivered and therefore less costs were incurred. The Trust also received additional unplanned income linked to the COVID-19 response during this period. These factors resulted in an adjusted surplus of £0.1 million during the second half of the financial year.

Income exceeded the financial plan, leading to a favourable variance of £19.4 million. Of this variance £5.9 million relates to additional employer pension contributions paid by NHS

England, £3.3 million for consumables (Personal Protective Equipment) from The Department of Health and Social Care, £1.5 million of NHS commissioner funding to support additional spending, £2.4 million of hosted project funding, £2.7 million of cancer drugs, £3.6 million of additional COVID-19 funding.

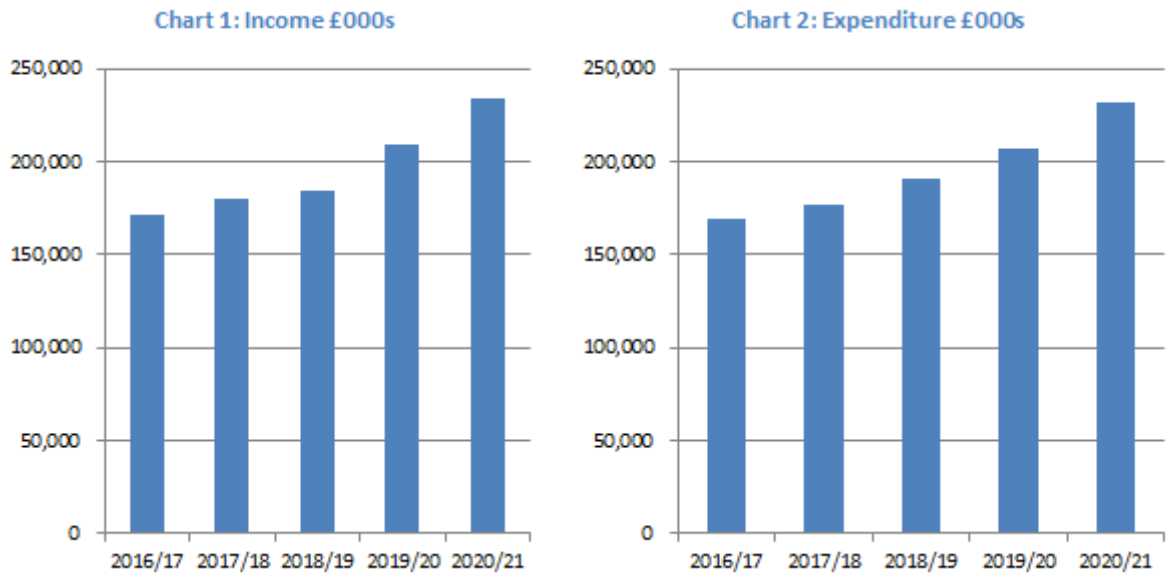
Expenditure was £7.3 million above plan, of which £5.9 million relates to the employer pension contributions paid by NHS England, £3.3 million of consumables (Personal Protective Equipment) from The Department of Health and Social Care , £2.4 million expenditure on hosted projects, £2.6m extra COVID-19 costs and £2.7m cancer drugs related to additional income received in year, offset by £9.6 million underachievement on COVID-19 restart plans and winter schemes.

The impact of donated assets was above the original expectations, set out in our financial plan by £0.3 million (net) due to equipment received from The Department of Health and Social Care for our COVID-19 response.

Trends in Income and Expenditure

The charts below show the trends in income and expenditure over the five-year period from 2016/17 to 2020/21

Trends in Income and Expenditure (Five Years)



Trends

Chart 1 shows the growth in income over the five-year period from April 2016 to March 2021. This growth in income is at an average rate of 9% a year over the five-year period. This is primarily the result of the non-recurring COVID-19 funding during 2020/21 and for previous years a result of Provider Sustainability Fund Income and additional central funding to cover pay increases including changes to employers' social security and pension costs

Chart 2 shows the growth in expenditure over the five-year period. Expenditure has grown significantly at an average rate of 9% a year. This is primarily the result of non-recurring COVID-19 costs during 2020/21 and for previous years a result of inflationary costs,

including changes to employers' social security and pension costs and additional staff recruited to maintain safe staffing levels.

Cash Flow

The Trust ended the year with £17.7 million cash at bank. This was an increase of £10.4 million during the year. The increase in the cash position is because of the timing of capital payments and an improvement in the working capital position, which was due to the changes in the NHS cash regime linked to the timing of payments and receipts between NHS bodies.

Charitable Funding

The Trust is fortunate to be supported by Dorset County Hospital Charity and a number of other local charities. All Dorset County Hospital Charity funds benefit the Trust. In 2020/21, the Trust received charitable grants for capital projects from the Charity of £0.1 million.

Capital Expenditure

Capital expenditure during 2020/21 was focused on COVID-19 response equipment, Emergency Department and Intensive Care Unit expansion, backlog maintenance, the provision of medical equipment and investment in IT projects. The Trust's capital plan is set through a risk based approach to ensure continuity of patient care. The Trust set its capital plan at £5.5 million and incurred expenditure of £20.6 million. The overspend was due to additional Public Dividend Capital of £15.5 million relating to project funding, the largest scheme being the Emergency Department and Intensive Care Unit of £5.1 million, backlog maintenance of £2.4 million, COVID-19 response equipment £2.7 million, increase in critical care beds of £1.4 million, Dorset wide medical staff rostering system of £1.4 million, and additional imaging equipment of £2.0 million.

Social Value

Following the Trust's introduction of a Social Value pledge, the Finance & Procurement teams will be supporting the Trust in the delivery of short-term and long-term objectives.

The key short-term objectives for the department to maximise local investment will be to:

- Establish levels of current local spend and set targets going forward
- Develop our website to allow local suppliers to have sight of upcoming projects and be able to contact through the internet
- Ensure the social value model is embedded in our evaluation of tenders
- Review spend in catering and estates to identify opportunities for using more local suppliers
- Request evidence of social value from current suppliers

The Finance & Procurement teams will also support other departments across the Trust by measuring and reporting social value outcomes and social return on investments.

Environmental Performance

In line with 'Delivering a 'Net Zero' National Health Service' the Trust is committed to achieving net zero carbon production by 2050.

For the emissions controlled directly by the NHS, Carbon Footprint plans are to reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. The Trust will be assessing and promoting to staff and general public how as a partnership we can reduce the organisations Carbon Footprint.

For the emissions the organisation can influence (our NHS Carbon Footprint Plus), reaching net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Plans continue for reduction of the organisations energy and water consumption. This year the Trust has changed a large proportion of lighting over to the much more efficient LED systems and plan to change over further areas as funding allows. This uses much less electricity and thus reduces our carbon footprint. Most areas are fitted with PIR detectors and timers to minimise lighting electricity costs. The sites plant is a combined heat and power system.

The organisation aims to eliminate unnecessary waste by continuing to "reduce, reuse, recycle" and improve the infrastructure to enable people to do so. Dorset County Hospital is constantly looking at ways to reduce waste, and increase the proportion recycled.

The Trust actively promotes the Dorset County Hospital Green Travel Plan for sustainable transport (public transport/ electric vehicles/cycling/walking/car share), and have provided a number of electric vehicle charging points, and ordered some electric vehicles to add the transport fleet. The new multi-storey car park will also provide further electric vehicle charging points. Investigations into the potential for electric transportation from outlying nurses' accommodation, where they can't be housed locally, rather than using conventional mini-buses are underway.

Improvement of green areas (e.g. biodiversity, visual attractiveness), and initiatating a Gardening Club, involving volunteers and staff has taken place. This will not only promote diversity of both flora and fauna, attracting bees, birds and other wildlife to our grounds, but also has health benefits for staff, patients, and visitors.

Sustainability is thoroughly communicated throughout the Trust. Sustainability is a key message in our induction process, and all new employees are trained and encouraged to think sustainably, in all their duties.

Partnership working with local groups and key stakeholders in order to support sustainable development within our community continues. Local volunteers are active on the Trust site, with the grounds upkeep and improvement, but also with sustainable transportation and distribution to the wards.

Being a major employer in the region, and actively contributing to a sustainable local economy, we not only provide employment for local people but purchasing of goods, services and materials is from local suppliers and contractors wherever possible. This not

only reduces the distance materials travel when supplied, but also cuts down on the commute for staff.

Our Estates and Facilities team were actively involved in the works made necessary by the COVID-19 pandemic. This included additional cleaning, portering within COVID-19 affected areas, installation of much screening used in tandem with social distancing measures to ensure contamination was reduced as far as possible. Additional doors were installed and ventilation regimes altered to ensure the correct balance of positive and negative pressure such that infection did not pass from wards to corridors etc.

The team also provided additional facilities to accommodate the Vaccination Hub, with the clinical space created within the Children's Centre, a waiting room outside, a protective walkway for the queue, and a security hut. Additional security was employed in order to manage the queue and parking in the area.

Social Community and Human Rights Issues

The Trust takes its responsibilities towards the community it serves very seriously and recognises the responsibility it has to:

- Meet the needs of the population it serves as safely, effectively and efficiently as possible
- Ensure that services are designed and delivered taking into account the views and opinions of patients
- Improving the wider economic, social and environmental well-being of the local population, through its social value commitments as an anchor institution.
- Take into account its status as a large employer and that decisions it makes may impact on the local economy and the health and wellbeing not only of staff but their families as well
- Take into account the impact it has on the environment. As set out in the sustainability report, the Trust is committed to reducing its environmental impact
- Take into account its responsibility to respect human rights and to ensure that actions and decisions do not have an adverse impact on human rights
- Ensure that staff feel motivated, empowered and are clear about the difference they are making to patient care and the achievement of the Trust's strategic objectives
- Ensure that the Trust is a positive place to work

Social Value

The Trust, as an anchor institution, commits to maximise the positive social value impact it has on our local communities, contributing to improving the economic, social and environmental well-being of the local population. Through our approach to delivering social value as an acute Trust, the aim is to reduce avoidable inequalities and improve health and well-being across the local communities.

Social Value Pledge

The Trust's Social Value 'Pledge' was approved by the Board in November 2020. It presents the Trust's commitment to helping to improve the overall well-being of the local communities, which are:

- **Maximise Local Investment:** we commit to maximise local investment, recognising the social, economic and environmental benefits of buying locally when procuring goods and services
  Increase Local Employment: we commit to increase employment and training opportunities for local people, especially from areas of high deprivation and unemployment
- **Recognised as a Good Employer:** to provide outstanding careers, ensuring our employees have a positive and fulfilling experience - empowering our staff to deliver outstanding services, sustainably, everyday
- **Champion Equality, Diversity & Inclusion:** we champion equality, diversity and inclusion recognising people from different backgrounds and experience make a valuable contribution to the way in which we work
- **Greener & Sustainable**: we recognise the impact we have on the environment and our responsibility to improve our sustainability and contribute to better health and well-being of our local community
- **Promote Civic Partnerships:** promote partnerships between DCH and our civic community, implementing local activities which contribute to reducing inequalities and improving health and well-being for all

The Trust's Social Value Programme Group is developing a Social Value Action Plan, aligned to the Trust Strategy. The Trust's social value commitments will be incorporated within our business planning processes; and progress against these commitments and our social value outcomes will be reported through the sub-Board Committees and to the Trust Board.

As we develop the programme we will communicate our social value aims and outcomes both internally and externally. The Trust's social value approach will contribute to reducing avoidable inequalities and improving health and wellbeing across the local community.

Charitable Activities

Dorset County Hospital Charity

The charity's purpose is to raise funds to enhance patient care and staff welfare at Dorset County Hospital; providing support that is above and beyond the NHS budget. The COVID-19 pandemic presented significant challenges for fundraising and the charity's income during the year. The DCH Charity COVID Appeal and NHS Charities Together COVID grants contributed major funding in support of staff well-being and patient welfare. The charity's new Strategy 2021-25 was approved, which aims to improve the charity's financial sustainability and rebuild income.

Friends of DCH

The charity's purpose is to provide comfort and help to patients at Dorset County Hospital. It operates a retail shop, manages the volunteer trolley service and fundraises in support of the hospital. Due to the pandemic its shop was temporarily closed and fundraising paused during the year.

Volunteering and Community involvement

The volunteer service at Dorset County Hospital is part of the Patient and Public Engagement team with an objective to support a positive patient experience. Our volunteer service also runs a Young Volunteer Programme which is supported by the 'Pears #iWill Fund' and which has developed opportunities for 16 to 24 year olds to volunteer in the hospital.

The impact of COVID-19 has seen significant changes to the service and in an increase in demand for volunteering services than ever before. COVID-19 restrictions meant that approximately 95% of the 250 volunteers were required to shield, either to protect themselves or their families, and many volunteer roles were immediately suspended. The volunteers who were able to remain on site stepped up to help where they were needed and together formed a response team. The team have been an integral part of the Trust's COVID-19 vaccination centre since it opened in December 2020.

Our volunteer patient and public engagement action group - 'Your Voice' resumed towards the end of the financial year and is working on a number of projects to help improve patient experience. Community projects will also resume, re-engaging with voluntary sector partners and the local community on activities to encourage and provide volunteer opportunities.

Human Rights

The Human Rights Act is integrated into the Trust's day to day operations and implemented through policies, procedures and strategy. It is essential that staff and service users are aware of the specific requirements of the Act and its application in a human rights based approach to healthcare. The principles of Human Rights are integrated within the Trust training programme and communicated to patients via the Patient Charter.

Overseas Operations

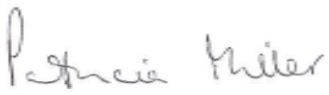
The Trust has no overseas operations.

Events After the Reporting Period

There have not been any significant events requiring disclosure after the reporting period to the date of this report.

Modern Slavery Act 2015

Dorset County Hospital NHS Foundation Trust supports the Government's Objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and in supporting victims. In particular, we are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Our Modern Slavery and human trafficking statement can be accessed on the hospital website: https://www.dchft.nhs.uk/about-us/procurement/modern-slavery-statement/



Patricia Miller
Chief Executive Officer
4 June 2021

Accountability Report

The Accountability Report has been compiled in accordance with the requirements of sections 415, 416 and 418 of the Companies Act 2006 (section 415 (4) and (5) and section 416 (5) and (6) do not apply to Foundation Trusts) as inserted by SI 20123 (1970) and Regulation 10 and Schedule 7 of the Large and Medium Companies and Groups (Accounts and Reports) Regulations 2008.

Individuals have been informed in advance of the intention to disclose information about them, invited to see what is intended to be published, and notified of their right to object under Article 21of the General Data Protection Regulation (GDPR).

Directors' Report

The Board of Directors, collectively and individually, are required to act with a view to promoting the success of the organisation so as to maximise the benefits for its members and the public. Paragraph 18A of Schedule 7 of the National Health Service Act (NHS Act 2006) (as inserted by the Health and Social Care Act (HSCA) 2012. The Foundation Trust Code states that 'Every Foundation Trust should be headed by an effective Board of Directors. The Board of Directors is collectively responsible for the performance of the Trust'.

Dorset County Hospital NHS Foundation Trust operates a unitary Board which comprises both Executive and Non-Executive Directors under the leadership of the Chair. In a unitary board, Directors are collectively and corporately accountable for the organisation's performance and benefit from the opportunity to share knowledge and experience gained from a variety of sectors.

The unitary Board of Directors comprises
Voting members:

- Mark Addison, Trust Chair
- Judy Gillow, Vice Chair
- Sue Atkinson, Senior Independent Director
- Margaret Blankson, Non-Executive Director
- Ian Metcalfe, Non-Executive Director
- Stephen Tilton, Non-Executive Director
- David Underwood, Non-Executive Director
- Patricia Miller, Chief Executive Officer
- Nick Johnson, Deputy Chief Executive Officer/Director of Strategy, Transformation and Partnerships
- Paul Goddard, Chief Financial Officer
- Alastair Hutchison, Chief Medical Officer
- Nicky Lucey, Chief Nursing Officer
- Inese Robotham, Chief Operating Officer
- Dawn Harvey, Chief People Officer (joined the Trust on 1 April 2021)

Non voting:

- Stephen Slough, Chief Information Officer

Dorset County Hospital operates a Fit and Proper Persons Requirement process for all Directors on appointment and on an annual basis and operates a code of conduct that builds on the values of the Trust and reflects the high standards of probity and responsibility. The Board has seen the following appointments in year:

- Internal appointment of the Director of Strategy, Transformation and Partnerships to the new role of Deputy Chief Executive Officer
- Two Non-Executive Directors, replacing those Directors at the end of their respective terms of office
- A further Non-Executive Director to replace a Director who left the Trust
- A Chief People Officer (from 1.4.21) replacing the Director of Workforce and Organisational Development.

Declarations of Interest

Dorset County Hospital NHS Foundation Trust is required to maintain a record of the details of company directorships and other significant interests held by Directors which may conflict with their management responsibilities. The Trust maintains a Register of Interests for Executive Directors, Non-Executive Directors, Governors and senior members of staff. The Register of Declarations of Interest for our Board members is available on the hospital website https://www.dchft.nhs.uk/wp-content/uploads/2021/04/BoD-Interests.pdf or on request from the Head of Corporate Governance.

HM Treasury Compliance

Dorset County Hospital NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political Donations

Dorset County Hospital NHS Foundation Trust has not made any political donations during 2020/21.

Better Payment Practice Code Compliance

The Trust has adopted the Better Payment Practice Code, which requires it to aim to pay all undisputed invoices by their due date, or within 30 days of receipt of goods or a valid invoice. The application of this policy resulted in a supplier payment period of 30 days for the Trust's trade payables as at 31 March 2021 (2020: 57 days). The Trust incurred interest and compensations charges of £343 during 2020/21 (2019/20 £378) under the Late Payment of Commercial Debt (Interest) Act 1998. The performance of the Trust in complying with the Code were as follows:

	2020/21		2019/20	
	Number	Value £000	Number	Value £000
Trade payables				
Total bills paid in year	**55,577**	**80,502**	56,953	67,648
Total bills paid within target	**50,981**	**73,909**	52,101	59,211
Percentage of bills paid within target	**92%**	**92%**	92%	88%
NHS payables				
Total bills paid in year	**1,353**	**9,508**	1,492	1,590
Total bills paid within target	**1,259**	**8,983**	1,306	1,308
Percentage of bills paid within target	**93%**	**95%**	88%	82%

Income disclosure

The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), by ensuring the income from the provision of goods and services for the purposes of the health service in England are greater than income from the provision of goods and services for any other purposes. The income from provision of goods and services for any other purpose was £617k which represents 0.26% of total Trust income. The Trust's financial planning ensures the requirement is maintained in the future and that any income for other purposes is contributing a profit for reinvestment into health services in England.

Disclosure relating to NHS Improvement's Well Led Framework

Dorset County Hospital has maintained due regard for NHS Improvement's Well Led Framework in arriving at its overall evaluation of the organisation's performance, internal control system and Board Assurance Framework. Formal review by the Care Quality Commission expected in year did not taken place due to the COVID-19 pandemic. The Trust has complied with national guidance throughout the pandemic period and taken steps to ensure effective leadership and decision making was balanced with the need to release operational capacity where needed. Changes to how the Trust has monitored and bench marked its performance throughout the pandemic can be found in the Performance Overview section of this report.

Excellent leadership has been demonstrated across all aspects of the Trust's clinical and support services teams throughout the year; delivering significant changes to the Trust's estate and ventilation systems, maintaining high standards of infection prevention and control to reduce COVID-19 transmission and in ensuring staff well-being through ensuring supply of personal protective equipment and staff support services and facilities. The Trust has actively promoted feedback mechanisms for staff and patients and the Board reviewed and streamlined its governance processes to focus on key decision making and risks, releasing operational capacity and maintaining safe staffing levels through the provision and receipt of mutual aid arrangements across the local system. Risk management was a key focus for the Board and an escalation process was introduced in year to ensure that the Board remained sighted on the work of its committees, which continued to meet on a monthly basis. Necessarily, some items of routine Board and committee business were deferred. These items were reviewed on a monthly basis as part of the agenda setting

process and this business is now being resumed as the nation emerges from the pandemic. Divisional representation at Board committees will resume in May 2021.

Working closely with other health and social care and third sector partners, the Trust has been able to maintain efficient patient flow and safe discharge arrangements for patients whilst maintaining high performance standards for emergency admission, ambulance transfer times and cancer services.

The Board has reviewed the learning acquired in year resulting from changed ways of working and will continue to strengthen its governance processes surrounding risk management and escalation whilst maintaining a clinical and joint partnership focus in order to develop further its position as an Anchor Institution within the region; addressing health inequalities and social deprivation issues.

In line with the conclusion of the Trust's strategy development, the Board will finalise its priorities and work programmes with its sub-committees; focussing on continued staff support and wellbeing, safe COVID-19 care provision and the restoration of deferred clinical service activities.

So far as the Directors are aware, there is no relevant audit information of which the Trust's Auditor is unaware. The Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's Auditor is aware of that information.

The Directors are required to, and accept responsibility for, preparing the annual report and accounts for each financial year. The Directors consider that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust performance, business model and strategy.

Remuneration Report

Annual Statement on Remuneration

As Chairman of the Remuneration and Terms of Service Committee, I am pleased to present the Remuneration Report for 2020/21.

The purpose of the Remuneration and Terms of Service Committee is to make recommendations to the Board of Directors in relation to the appointment and remuneration of the Chief Executive Officer and Executive Directors. The committee also reviews and makes recommendations regarding the Board of Directors' skill mix and balance, taking into account future challenges, risks and opportunities facing the Trust and the skills and expertise that the Board of Directors requires in order to meet these.

The Remuneration and Terms of Service Committee also ensures adequate succession planning arrangements for the Executive Team are in place. The committee has not employed the services of external advisors in executing its duties and therefore not incurred fees during the year in this respect.

The Remuneration and Terms of Service Committee met on four occasions and discussed the following:

- A redundancy proposal was considered and approved;
- Following the Board decision to introduce the role of Deputy Chief Executive, to enable greater involvement of the Chief Executive in regional and national programme developments, a proposal to appoint from within the existing Executive team and a salary uplift was approved;
- Senior Managers salary benchmarking. No decision was made, pending the outcome of a number of pay review bodies and union discussions.

Mark Addison
Remuneration and Terms of Service Committee Chair

Senior Managers Remuneration Policy

Policy on Remunerations of Senior Managers

The Trust's senior management remuneration policy requires the use of benchmark information and the Trust makes reference to the Foundation Trust Network Annual Salary Comparison Report.

With the exception of Executive Directors, the remuneration of all staff is set nationally in accordance with the NHS Agenda for Change (for non-medical staff) or Pay and Conditions of Service for Doctors and Dentists. Performance Related Pay is not applicable for any Trust staff, including Executive Directors. Future policy on senior manager remuneration will remain in line with national terms and conditions.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with three months' notice, or six months' notice in the case of the Chief Executive. The Trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NSH redundancy terms for all staff.

The total remuneration for each of the Trust's Executive Directors comprises the following elements:

Salary + Pension and Benefits = Total remuneration

Future Policy Table
The Trust's remuneration policy in respect of each of the above is outlined in the tables on the next page.

Salary – (Fees and Salary)

Purpose and Link to Strategy
- Helps to recruit, reward and retain
- Reflects competitive market level, role, skills, experience and individual contribution

Operation
Base salaries are set to provide the appropriate rate of remuneration for the job, taking into account relevant recruitment markets, business sectors and geographical regions.
The Remuneration Committee considers the following parameters when reviewing base salary levels:
- Pay increases for other employees across the Trust
- Economic conditions and governance trends
- The individual's performance, skill and responsibilities through appraisals
- Base Salaries at NHS organisations of similar size are benchmarked against Dorset County Hospital NHS Foundation Trust
- Base Salaries are paid in 12 equal monthly instalments via the regular monthly employee payroll
- The Executive Directors do not receive performance related pay.

Opportunity
The Remuneration Committee ensures levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully but avoid paying more than is necessary though using benchmarking.

National and Local benchmarking data was reviewed by the Remuneration Committee who reviewed the relative position of each Executive.

Performance Conditions
None, although performance of both the Trust and the individual are taken into account when determining whether there is a base salary increase each year. The individual receives an annual appraisal to review performance and set objectives.

Performance Period
Annual Appraisal covers a 12 month period

Pension and Benefits

Purpose and Link to Strategy

- Help to recruit and retain
- NHS Pension scheme arrangements provide a competitive level of retirement income

Operation

Executive Directors are eligible to receive pension and benefits in line with the policy for other employees.

Executive Directors are entitled to join the NHS Pension Scheme, which from April 2015 is a Career Average Revalued Earnings scheme.

Where an individual is a member of a legacy NHS defined benefit pension scheme section (1995 or 2008) and is subsequently appointed to the Board, he or she retain the benefits accrued from these schemes.

The principal features and benefits of the NHS Pension Scheme are set out in a table in the Remuneration Report.

Pension related benefit is the annual increase in pension entitlement accrued during the current financial year from total NHS career service.

Opportunity

The maximum Employers' contribution to NHS Pension Scheme is 20.68% (14.38% paid by the Trust and 6.3% is paid by NHS England) of base salary for all employees including Executive.

Performance Conditions

None

Performance Period

None

Differences in Remuneration for Other Employees

The remuneration approach for Executive Directors is consistent with The UK Corporate Governance Code, NHS Foundation Trust Code of Governance and NHS Policy. This guidance requires that remuneration committees ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully.

The Structure of the reward package for wider employee population based on the national NHS remuneration frameworks for Medical, Dental and Non-Medical Staff. Non-Medical Staff remuneration is in line with the Agenda for Change Framework, which assesses remuneration is in line with the framework for Medical and Dental Staff remuneration. All staff are eligible to join and participate in the NHS Pension Scheme.

Where one or more senior managers are paid more than £150,000, the committee is required to ensure this remuneration is reasonable. The Trust has three senior managers paid more than £150,000. The committee is satisfied the salary of this individual is reasonable when compared to the benchmarking provided in setting the senior managers' salaries.

The Trust's policy for Equality, Diversity Inclusion has the aim to define the approach that will be taken to promoting and championing a culture of diversity and equality of opportunity, access, dignity, respect and fairness in the services the Trust provides and in employment practices. The activities and decisions of the Remuneration and Terms of Service Committee are in accordance with the Trusts Equality,

Policy on Remuneration of Non-Executive Directors

Element	Purpose and link to strategy	Overview
Fees	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity	The remuneration and expenses for the Trust Chairman and Non-Executives are determined by the Council of Governors.
Appointment		The Council of Governors appoint the Non-Executive Directors in accordance with the Trust's constitution which allows them to serve two three year terms. Any term beyond six years is subject to rigorous review, and takes into account the need for progressive refreshing of the board and their independence. This is subject to annual re-appointment approved by the Council of Governors.

Annual Report on Remuneration

The following sections of the Remuneration Report are not subject to audit.

Remuneration and Terms of Service Committee

Remuneration and Terms of Service for the Chief Executive and Executive Directors is considered by a Remuneration and Terms of Service Committee consisting of the Chair and Non-Executive Directors. The Chief Executive Officer and Director of Workforce and Organisational Development are invited to attend the committee as and when required.

The Committee's attendance record is set out in the table below:

Name	Attendance/Meetings eligible to attend
Mr M Addison (Trust Chair) (Chair)	3/4
Prof S Atkinson	4/4
Ms M Blankson (from 01/01/21)	1/1
Ms J Gillow	3/4
Ms V Hodges (to 30/09/20)	1/2
Mr I Metcalfe	4/4
Mr M Rose (to 16/06/20)	0/0
Mr S Tilton (from 01/06/20)	4/4
Mr D Underwood	4/4

Senior Managers Service Contracts

The table below contains contract information on the Trust's Senior Managers for the financial year 2020/21.

Name	Title	Current Tenure	Notice Period
Non- Executive Directors			
Mr Mark Addison	Chair	24/03/2019-23/03/22 (second term)	3 months
Mr Matthew Rose	NED	17/06/17 – 16/06/20 (second term)	3 months
Ms Victoria Hodges	NED	01/09/19 – 30/08/22 (left 30/09/20)	3 months
Ms Judy Gillow	NED, Vice Chair	01/09/19 – 31/08/22 (second term)	3 months
Prof Sue Atkinson	NED	01/09/19 – 31/08/22 (second term)	3 months
Mr Ian Metcalfe	NED	01/11/20 – 31/10/23 (second term)	3 months
Mr David Underwood	NED	01/03/20 – 28/02/23	3 months
Mr Stephen Tilton	NED	01/06/20 – 31/05/23	3 months
Ms Margaret Blankson	NED	01/01/21 – 31/12/23	3 months
Executive Directors			
Ms Patricia Miller	Chief Executive	Commenced 15/09/14	6 months
Mr Paul Goddard	Chief Financial Officer	Commenced 18/06/18	6 months
Mr Alastair Hutchison	Chief Medical Officer	Commenced 02/07/18	6 months
Ms Inese Robotham	Chief Operating Officer	Commenced 19/11/18	6 months
Mr Mark Warner	Director of Workforce and Organisational Development	Commenced 02/03/15 Left the Trust 31/10/20	6 months
Ms Nicky Lucey	Chief Nursing Officer	Commenced 01/09/16	6 months
Mr Nick Johnson	Deputy Chief Executive/Director of Strategy, Transformation and Partnerships	Commenced 01/02/16	6 months
Mr Stephen Slough	Chief Information Officer	Commenced 01/06/19	6 months

Expenses of Governors and Directors

The expenses incurred or reimbursed by the Trust relating to Governors and Directors were:

	2020/21 Number receiving expenses / total	£	2019/20 Number Receiving Expenses / total	£
Governors	**0 / 23**	**0**	**4 / 23**	**868**
Chairman and non-executive directors	**2 / 8**	**1,014**	**2 / 8**	**3,931**
Executive directors	**2 / 7**	**64**	**7 / 7**	**8,745**
Total expenses		**1,078**		**13,544**

The following sections of the Remuneration Report are subject to audit

The total remuneration of directors and senior managers for 2020/21 was £1,018,000 (2019/20: £978,100).

Remuneration of Directors - 2020/21	Fees and salary (Bands of £5,000) £ 000s	Taxable benefits (neares t £100)	Pension related benefits (Bands of £2,500) £ 000s	**2020/21 Total (Bands of £5,000) £ 000s**
Chairman				
Mr M Addison	40 – 45	-	-	**40 – 45**
Non-executive Directors				
Mr D Underwood	10 – 15	-	-	**10 – 15**
Ms J Gillow	10 – 15	-	-	**10 – 15**
Prof S Atkinson	10 – 15	-	-	**10 – 15**
Ms V Hodges[1]	5 – 10	-	-	**5 – 10**
Mr M Rose[2]	0 – 5	-	-	**0 – 5**
Mr I Metcalfe	10 – 15	-	-	**10 – 15**
Mr S Tilton[3]	10 – 15	-	-	**10 – 15**
Ms M Blankson[4]	0 – 5	-	-	**0 – 5**
Executive Directors				
Ms P Miller, Chief Executive[5]	165 –170	-	45 – 47.5	**210 –215**
Prof. A Hutchison, Chief Medical Officer	200 –205	-	0 – 2.5	**200 –205**
Ms N Lucey, Chief Nursing Officer	125 –130	-	7.5 – 10	**130 –135**
Mr P Goddard, Chief Financial Officer	125 –130	-	15 – 17.5	**140 –145**
Ms I Robotham, Chief Operating Officer	120 –125	-	20 – 22.5	**140 –145**
Mr M Warner, Director of Workforce[6] and Organisational Development	190 –195	-	7.5 – 10	**200 –205**
Mr Nick Johnson, Deputy Chief Executive/Director of Strategy, Transformation and Partnerships[7]	125 –130	-	25 – 27.5	**150 –155**

Stephen Slough, Chief Information Officer was appointed on 01/06/2019 and is paid by NHS Dorset CCG and details of remuneration and expenses are included within their Annual Report.

Professor A Hutchison remuneration includes payment of clinical sessions.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

Remuneration of Directors - 2019/20	Fees and salary (Bands of £5,000) £ 000s	Taxable benefits (nearest £100)	Pension related benefits (Bands of £2,500) £ 000s	**2019/20 Total (Bands of £5,000) £ 000s**
Chairman				
Mr M Addison	40 – 45	-	-	**40 – 45**
Non-executive Directors				
Mr P Greensmith[8]	0 – 5	-	-	**0 – 5**
Mr D Underwood[9]	0 – 5	-	-	**0 – 5**
Ms J Gillow	10 – 15	-	-	**10 – 15**
Prof S Atkinson	10 – 15	-	-	**10 – 15**
Ms V Hodges	10 – 15	-	-	**10 – 15**
Mr M Rose	10 – 15	-	-	**10 – 15**
Mr I Metcalfe	10 – 15	-	-	**10 – 15**
Executive Directors				
Ms P Miller, Chief Executive[10]	165 –170	-	40 – 42.5	**205 –210**
Prof. A Hutchison, Chief Medical Officer	200 –205	-	542.5 – 545	**745 –750**
Ms N Lucey, Chief Nursing Officer	125 –130	-	37.5 – 40	**165 –170**
Mr P Goddard, Chief Financial Officer	125 –130	-	40 – 42.5	**165 –170**
Ms I Robotham, Chief Operating Officer	120 –125	-	15.0 – 17.5	**135 –140**
Mr M Warner, Director of Workforce and Organisational Development	120 –125	-	32.5 – 35	**150 –155**
Mr Nick Johnson, Deputy Chief Executive/Director of Strategy, Transformation and Partnerships[11]	110 –115	-	25 – 27.5	**140 –145**

1 – Until on 30 September 2020
2 – Until on 16 June 2020
3 – Appointed on 01 June 2020
4 – Appointed on 01 January 2021
5 – Not available between 28 February 2020 to 22 June 2020
6 – Until on 31 October 2020
7 – Acting between 01 March 2020 to 21 June 2020
8 – Until on 31 May 2019
9 – Appointed on 01 March 2020
10 – Not available between 28 February 2020 to 22 June 2020
11 – Acting between 01 March 2020 to 21 June 2020

There were no annual performance related or long term performance related bonuses paid during the year 2020/21 or 2019/20.

The above table for 2020/21 includes a loss of office payment in the fees and salary figure of the Director of Workforce and Organisational Development for redundancy of £47k during 2020/21 (2019/20: Nil).

There have been no payments to past senior managers during 2020/21 or 2019/20.

Fair Pay Multiple Statement
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director of the Trust and the median remuneration of the Trust's workforce.

The banded remuneration of the highest-paid director in the Trust in financial year 2020/21 was £200,001 to £205,000 (2019/20: £200,001 to £205,000). This was 7.39 times (2019/20: 7.43 times) the median remuneration of the workforce, which was £27,416 (2019/20: £27,260).

In 2020/21, one (2019/20: nil) employees received remuneration in excess of the highest paid director. Remuneration was in the banding range of £220,000 to £225,000 (2019/20: nil).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. The median remuneration of the workforce is the total remuneration of the staff member lying in the middle of the linear distribution of the total staff in the Trust, excluding the highest paid director. This is based on an annualised full time equivalent remuneration as at the reporting period date.

The multiple for 2020/21 has decreased due to the increase in the median remuneration.

The median remuneration of the workforce in 2020/21 falls within the salary range of a Band 5 position under Agenda for Change terms and conditions that apply to all non-medical staff (2019/20 falls within the salary range of a Band 5 position under Agenda for Change terms and conditions that apply to all non-medical staff). The actual salary of staff within each band is dependent on a number of factors, the most significant being the number of years they have served in that position.

Pension Arrangements
All executive directors of the Trust are eligible to join the NHS Pension Scheme. The Chairman and non-executive directors are not eligible to join the scheme and are not accruing any retirement benefits in respect of their services to the Trust. The Trust did not make any contributions to any other pension arrangements for directors and senior managers during the year.

The principle features and benefits of the NHS Pension Scheme are set out in the table below.

	1995 section	2008 section	2015 section
Member contributions	5% - 13.3% depending on rate of pensionable pay		
Pension	A pension worth 1/80th of final year's pensionable pay per year of membership	A pension worth 1/60th of reckonable pay per year of membership	A pension worth 1/54th of Career Average Re-valued Earnings of pensionable pay per year of membership
Retirement lump sum	3 x pension. Option to exchange part of pension for more cash up to 25% of capital value	Option to exchange part of pension for cash at retirement, up to 25% of capital value. Some members may have a compulsory amount of lump sum	Option to exchange part of pension for a lump sum up to 25% of capital value
Normal retirement age	60	65	Equal to an individuals' State Pension Age or age 65 if that is later
Death in membership lump sum	2 x final years' pensionable pay (actual pensionable pay for part-time workers)	2 x reckonable pay (actual reckonable pay for part-time workers)	The higher of (2 x the relevant earnings in the last 12 months of pensionable service) or (2 x the revalued pensionable earnings for the Scheme year up to 10 years earlier with the highest revalued pensionable earnings
Pensionable pay	Normal pay and certain regular allowances		

The tables on the next page set out details of the retirement benefits that executive directors have accrued as members of the NHS Pension Scheme. All of the executive directors that are accruing benefits under these Schemes with their normal retirement age in line with the table above.

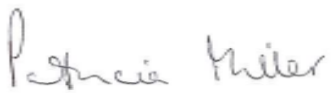
	Real Increase in pension at retirement (bands of £2,500) £000	Real Increase in lump sum at retirement (bands of £2,500) £000	Total accrued pension at retirement at 31/03/2021 (bands of £5,000) £000	Related lump sum at retirement at 31/03/2021 (bands of £5,000) £000
Ms P Miller, Chief Executive	2.5 - 5.0	0 - 2.5	45 – 50	85 – 90
Mr M Warner Director of Organisational Development and Workforce	0 – 2.5	0 - 2.5	25 – 30	0 – 5
Ms Inese Robotham Chief Operating Officer	0 - 2.5	0 - 2.5	30 – 35	60 – 65
Mr P Goddard, Chief Financial Officer	0 - 2.5	0 – 2.5	55 – 60	130 – 135
Ms N Lucey, Chief Nursing Officer	0 – 2.5	0 – 2.5	50 – 55	150 – 155
Prof. A Hutchison, Chief Medical Officer	0 – 2.5	2.5 – 5.0	90 – 95	280 – 285
Mr Nick Johnson Deputy Chief Executive/Director of Strategy, Transformation and Partnerships	0 - 2.5	0 - 2.5	0 – 5	-

	Cash Equivalent Transfer Value at 01/04/2020 £000	Cash Equivalent Transfer Value at 31/03/2021 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000s
Ms P Miller, Chief Executive	818	898	42	-
Mr M Warner Director of Organisational Development and Workforce	343	367	4	-
Ms Inese Robotham Chief Operating Officer	550	557	n/a	-
Mr P Goddard, Chief Financial Officer	1053	1115	25	-
Ms N Lucey, Chief Nursing Officer	1046	1099	17	-
Prof. A Hutchison, Chief Medical Officer	n/a	n/a	n/a	-
Mr Nick Johnson Deputy Chief Executive/Director of Strategy, Transformation and Partnerships	21	43	3	-

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETVs are not disclosed for scheme members who have reached their normal retirement date.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS Pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

The real increase in CETV represents the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the year.



Patricia Miller
Chief Executive
4 June 2021

Staff Report

Valuing Our Staff

As a major local employer of over 2,500 staff, who fulfil a wide range of professional and multidisciplinary roles, we recognise that our workforce defines who we are and how we are viewed by the patients and we serve. We strive to ensure our staff are highly skilled and well supported in their working environment, in order that they are able to deliver the highest standards of compassionate and safe care. Investment in the recruitment, education, training, support and well-being of our staff remains at the heart of what we do at DCH.

COVID-19

In the past year we have seen unprecedented challenges within the Heath Service. The COVID-19 pandemic placed NHS staff under extreme pressure. Staff had to balance their personal and professional commitments and values, for example in considering their risk of infection to themselves and their family, alongside their duty to care for patients. At times, staff had to isolate themselves from family and friends.

The staff at DCH showed extraordinary commitment and resilience during the pandemic. Many staff experienced changes to their working environment and many were temporarily redeployed to alternative roles. At the start of the pandemic a comprehensive suite of COVID-19 training packages were devised and rolled out at pace, helping clinical staff to feel adequately prepared for the challenges ahead. Changes to working practices were also implemented very quickly, including permitting those who were able to work from home to do so. Latterly, whilst responding to wave two of the pandemic, the Trust successfully set up and ran a Hospital Vaccination Hub, delivering in excess of 20,000 vaccines to Health and Social Care staff from the West of the county. The incredible response to the pandemic at DCH was a true testament to the teamwork and dedication of the staff.

Recruitment

The past 12 months have seen a continuation of the pressures in recruiting to nursing and medical staff posts, with the added challenge COVID-19 has brought. The Trust has implemented a number of methods to further increase successful recruitment, whilst adjusting to the new world the pandemic has created. As a Trust we have removed face to face interviews allowing for virtual interviews to take place, this has been a particular help for those looking to relocate to Dorset as they have not had to travel during lockdown. We have attended a limited number of virtual recruitment events and worked closely with our Dorset CCG partner to collaboratively improve recruitment levels.

We have continued to work with our recruitment agency Medacs and have employed a total of 70 internationally trained nurses by January 2021. We have a further 83 expected by December 2021 across a variety of wards and departments. We have started a programme of recruitment through Medacs for employing internationally trained Radiographers as the domestic market is not able to meet the demand.

Recruitment for Healthcare Support Workers has been high priority and we have been supported with this by additional funding from NHS Improvement to reach zero vacancies by March 2021. Despite COVID-19 challenges, our Preceptorship recruitment has continued

with a total of 35 newly qualified staff joining us by March 2021, and a further 18 offered ahead of September. We aim to recruit 30 newly qualified staff nurses for September.

Throughout 2020 we recruited 41 Allied Health Professionals and Professional Scientific and Technical staff, 178 clinical staff and 68 administration and clerical staff. Towards the beginning of the pandemic we had a particular focus on Estates and Facilities running a bespoke local recruitment campaign to attract paid and unpaid support in preparation for the forecasted impact on patients and staff of COVID-19.

We have completed recruitment to a number of senior posts including Chief People Officer, Deputy Director of Finance, Divisional Manager and a Non-Executive Director with a particular focus on organisational design and culture change.

In regards to our medical staff, we have continued to see an increase in internationally trained doctors joining the Trust, and have worked through the various obstacles the current climate has placed in terms of on boarding staff from abroad. We have supported new recruits through periods of required self-isolation and in terms of their welfare and induction. We had a reduced number of staff on placement with the Trust this year through the Widening Access to Specialist Training scheme and we put a pause on placements through the Medical Training Initiative due to the pandemic.

We have been successful in recruiting a number of Consultants across a range of specialties including harder to fill roles such as Ophthalmology, ENT, Acute Medicine and Renal but we continue to have challenges with areas such as Microbiology, Histopathology and Respiratory. We saw a small number of Consultants return to practise to support during the pandemics and vaccination programme via Unpaid Honorary contracts.

We have commenced more bespoke social media campaigns with videos and engagement with current staff to provide a more personal touch to advertise the Trust as a place to work. We have started work on a campaign with other NHS Trusts across Dorset to showcase Dorset and what it offers as a place to live and work. This work is aimed at all roles including medical and clinical positions to boost our domestic recruitment.

Employment Policies

The Trust has in excess of 50 employment policies in place which have been designed to provide guidance to our staff and to ensure we meet our legal obligations to them. The effectiveness of each policy is reviewed in conjunction with staff side representatives every three years as a minimum, but most are reviewed more frequently due to changes to employment law, best practice or in response to feedback from staff. During 2020, 26 of our employment policies were reviewed to ensure effectiveness and adherence to legal requirements as well as taking into account necessary amendments dictated by the changing government advice relating to the ongoing coronavirus pandemic.

Appraisal Process

Staff Appraisals were put on hold whilst the Trust addressed the ever changing demands of the pandemic. With many departments having spent much of the past year adapting to new ways of working it is recognised that it is difficult to review performance. It is however more

important than ever that regular one-to-one discussions are held with staff and that the focus of those discussions should be wellbeing and the identification of ongoing support needs.

Prior to the pandemic a review of the appraisal process had taken place, with the aim of creating a shorter process to be used on a quarterly basis. We had hoped to trial this, but with appraisals on hold this was possible. Further work will be undertaken in the coming year to improve the appraisal process and informing wider talent management and succession planning. In the interim, whilst we catch up on overdue appraisals, a shorter process has been issued to support staff and managers in their appraisal discussion.

Staff Gender Analysis (as at 31 March 2021)
A full report on the Trust's gender pay gap statistics was provided to the Workforce Committee in August 2020, but formal public reporting is not required until October 2021.

The current DCH Gender Pay Gap Report is available to view here: https://gender-pay-gap.service.gov.uk/Employer/DQEcAlqU/2019

The gender pay gap calculation is based on the average hourly rate paid to men and women. This calculation makes use of two types of averages; a mean average and a median average. In simple terms, the mean is the average hourly rate and the median is the mid-point hourly rate for men and for women in the workforce. The mean figure is the figure most commonly used.

The Trust's overall results across our entire workforce our mean gender pay gap is 31%. This means that the average hourly pay rate for men is 31% higher than for women. This is a two percentage point increase from 2018/19. Our overall median gender pay gap is 22% - this means that the mid-point hourly rate for men is 22% higher than for women, which is an eleven percentage point increase on 2018/19.

Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2020) are as follows:

- Our mean gender pay gap is 31%
- Our median gender pay gap is 22%
- Our mean bonus gender pay gap is 31%
- Our median bonus gender pay gap is 50%
- Our proportion of males receiving a bonus payment is 6%
- Our proportion of females receiving a bonus payment is 0.5%

For Gender Pay Gap calculations, our bonus payments relate to Clinical Excellence Awards only. These award consultants and academic GPs who perform 'over and above' the standard expected of their role. The only bonus payments paid by the Trust are local and national Clinical Excellence Awards, paid to eligible medical Consultants.

While men make up only 18% of the workforce, there is a disproportionate number of males, 39% in the highest paid quartile.

The Trust's mean gender pay gap is 31% in favour of men (women earn 31% less than men) compared to the national average of 17.3% in favour of men (source: Annual Survey of Hours and Earnings, Office for National Statistics, 2019).

Based on the Government's methodology, as of 31 March 2018 (latest figures), the NHS as a whole had a mean gender pay gap of 19%, and a median gender pay gap of 22%.

This is not the same as saying women and men are being paid differently for doing the same job (which would be an equal pay issue).

At DCH, whilst we have a higher proportion of female staff in our workforce, we also have a significant proportion of our male workforce now at the point in their careers where they are senior medical staff and therefore are higher up the pay grades than some more junior members of staff. This is reflected in our overall gender pay gap and, as a Trust, we recognise that this is a generational and societal issue. We know, however, that an increasing number of women are choosing to pursue medicine and other previously male-dominated roles as a career.

	At 31 March 2021
Board directors by gender:	
Male	7
Female	6
Employee headcount by gender	
Male	724
Female	2,523
Total	3,247

Staff Sickness

The staff sickness information for the Trust can be found at the following website: - https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Turnover

The Trust's turnover rate for 01 April 2020 – 31 March 2021 is 8.05%. This remains within the Trust's acceptable range of 8% - 12%. The turnover by staff group is detailed in the table below. Turnover data is reported on a monthly basis to the Trust's People and Culture Committee.

Staff Group	Headcount
Add Prof Scientific and Technic	9.65%
Additional Clinical Services	8.85%
Administrative and Clerical	8.45%
Allied Health Professionals	8.82%
Estates and Ancillary	11.74%
Healthcare Scientists	8.38%
Medical and Dental	8.17%
Nursing and Midwifery Registered	5.78%

Diversity and Inclusion

A full EDI Report was submitted to the Trust Board in July 2020 and is published on the DCHFT website:
https://www.dchft.nhs.uk/wp-content/uploads/2021/02/EDI-Trust-Board-Report-July2020.pdf

A further EDI update was provided to the People & Culture Committee in December 2020 and another planned for April 2021.

DCH continues to have a firm commitment to equality, diversity and inclusion. Progress on ED&I activity is monitored by the Trust's Equality, Diversity and Inclusion Steering Group (EDISG), chaired by Nick Johnson, along with the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). An overarching Action Plan joins up all aspects of EDI work.

The Diversity Staff Network, for staff from minority ethnic communities, has recently appointed a new Chair. The group meets regularly and feeds into the EDISG. Members of the group have been working with Board Executives to start developing policies and frameworks to ensure staff processes and procedures are inclusive fair and equitable.

Two further Staff Networks are in the process of being set up, following Chairs being identified to take forward work on the LGBTQ+ and Disability/Long term health condition

Staff Networks. Each Chair will be given protected time to carry out their role, and those chairing and supporting networks will be offered learning and development opportunities - all are attending an 'Empowering Employee Networks' conference in April 2021.

To mark Inclusion Week 2020 the Trust launched its #IAm photo exhibition to highlight and celebrate the diversity of our amazing staff here at Team DCH! We lined the corridors with images of our staff to show that although we all come from different backgrounds, we are one team. The exhibition now has a permanent home in Damers Restaurant.

The Trust Board has issued two Inclusion Statements during the year:

- The Black Lives Matter movement has shone a light on the racism and discrimination our Black, Asian and Minority Ethnic colleagues and friends continue to face throughout the world. Each member of our Trust Board made their own personal pledge in support of the Black Lives Matter Movement in October 2020.

- The report from the Commission on Race and Ethnic Disparities, published on 31 March 2021, says that the UK no longer has a system rigged against people from ethnic minorities. The Board of Dorset County Hospital NHS Foundation Trust has clearly stated that it disagrees with these conclusions of this report. It is important that the narrative within this report is challenged as it denies the lived experience of members of our ethnic minority communities who face racism and discrimination on a daily basis. We are proud of the diversity of our staff and we must celebrate this. Staff from minority communities play a fundamental part in, and make a vital contribution to, the NHS in Dorset.

Our Mental Health First Aid (MHFA) Programme has provided us with a network of MHFA Champions and there are plans to offer the one-day MHFA Champion training to all line managers across the Trust. This will help to further increase awareness and reduce stigma for both staff and patients experiencing mental health issues.

A Leading and Managing for Inclusion Programme has been commissioned and will run throughout 2021/22. This programme is initially aimed at all Band 7+ managers with line management responsibility. The programme aligns with the NHS People Plan which aims to create a sense of belonging and to tackle discrimination.

The Trust's first EDI Strategy is in the final stages of being drafted and will be considered for ratification in April/May 2021.The Strategy will reflect the Trust's commitment that everyone who works at, or comes into contact with DCHFT feels welcomed, respected and included. The belief that equality, diversity and inclusion is everybody's business will sit at the heart of organisational culture. Our vision for EDI at the Trust is that it becomes the 'golden thread' running through everything we do.

Ethnicity	Permanent	Fixed Term Temp	Other	Bank	Grand Total
Not completed	38	26	4	42	110
Minority Ethnic	242	101	3	55	401
Not Stated	58	17	8	22	105
White	2501	264	20	791	3576
Grand Total	2839	408	35	910	4192

Consultation, Partnership Working and Staff Engagement

We have a number of established mechanisms of communicating information across the Trust, including a weekly email bulletin, a weekly email briefing from the Chief Executive and monthly team briefing sessions; the frequency and content of all adjusted accordingly throughout the pandemic. The Trust also communicates stories of interest via social and local media.

Our established consulting and negotiating bodies, the Partnership Forum (for non-medical staff) and Local Negotiating Committee (for medical staff), continue to make an important contribution to promoting effective staff engagement and partnership working and in ensuring these are underpinned by a commitment to: promoting the success of the organisation; recognising the respective parties' legitimate interests; operating in an honest and transparent manner; focusing on the quality of working life and its benefit to the quality of patient care; maintaining, as far as possible, employment security.

With agreement with respective Staff Side Chairs, we stood down some committee meetings as a direct result of the pandemic and staff capacity however these have now been fully reinstated albeit virtually but this is working successfully.

People Strategy

As we come to the end of our previous three year strategy, it is now time to refresh our People Strategy. Our updated People Strategy will be based on the principles of the NHS People Plan and aligned with our refreshed Trust strategy.

The Interim NHS People Plan 2019 sets a vision for how people working in the NHS will be supported to deliver care and identifies the actions needed to help them. The five principles of the People Plan are:

1. Making the NHS the best place to work
2. Improving the leadership culture
3. Tackling the nursing challenge
4. Delivering 21st century care
5. A new operating model for workforce

The ‘We Are The NHS: People Plan for 2020/2021 - action for us all’ document was published in 2020. This plan sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care. The principles underpinning the action through 2020/21 must endure beyond that time. From a Dorset system perspective 13 priority system and employer led actions have been identified. Both will provide a foundation for our refreshed People Strategy, our response to the NHS People Plan and collaborative system working.

Workforce Planning

Work continues within the Trust and as part of the Integrated Care System (ICS) to ensure robust workforce planning supports national, regional, system, Trust and departmental workforce priorities.

An ongoing priority is to embed new ways of working. A plan has been agreed and a project is underway to both grow our own and recruit more Nursing Associates into the workforce as part of a refreshed approach to developing our nursing career offer and to support future workforce supply, retention and succession planning ensuring that this recognises the diversity of our nursing workforce.

Work is underway to work with leaders to take forward the incorporation of new roles such as Physician Associate and Advanced Clinical practitioners to support the future nursing, therapy, health care science and medical workforce. This will be a feature of workforce planning to support the future major change initiatives including the expansion of Critical Care and new ED and Integrated Community Hub.

Action is underway in tandem with the Recruitment and Education teams to take action to increase overall workforce supply across areas of the Trust and to broaden the health and care workforce supply pipeline. This supports the delivery of the Trust’s social value pledge acknowledging the role of the Trust as an anchor organisation within the local economy.

Work also continues to improve reporting and use of data to support projects and the regular and ad hoc national regional and local reporting requirements. The provision of data and analysis also supports service and departmental workforce planning. The team also deals with freedom of information requests. Data helps to support evidenced based planning and the Trust is working closely with ICS partners to support the automatic feed of Trust workforce data into the Dorset Information and Intelligence Service Dashboard (Diis). Work continues to support wider workforce planning priorities including exploring opportunities for more rotational and system wide approaches to service delivery.

Health and Wellbeing

One of the key focuses of the pandemic response was the health and wellbeing of our staff. A variety of regional and national offerings were made available to NHS staff, including several apps and helplines and the details of these were widely shared. Locally the Trust received charitable donations which facilitated many improvements for staff including water

coolers and the introduction of two dedicated ‘safe space’ areas for staff to take quiet time away from their work areas.

A HR Hub was set up 7 days a week in order to answer questions and support staff. Twice weekly ‘Wellbeing Walkarounds’ were held to visit teams in their workplace, ask how they are doing, answer or take back questions, and provide information on the services available. Psychological First Aid group sessions were delivered to frontline teams including Critical Care by the Dorset Healthcare Clinical psychology team.

During the pandemic the Trust began offering on-site, face to face counselling for staff five days a week. This service has been extremely well received by staff and was quickly extended to offer provision 7 days a week, with options for evenings, and virtual sessions for those shielding and working from home. This service remains in place so as to support staff during the recovery phase. The Trust also has a cohort of 30 staff trained as Mental Health First Aiders who offer support to staff, alongside the chaplaincy team who provide additional support for both staff and patients.

Alongside these additional offerings, staff continued to have access to occupational health and wellbeing services provided by Optima Health who are a leading UK Occupational Health & Wellbeing company. Optima provide proactive and preventative support, undertakes health checks, vaccinations and immunisation programmes besides dealing with work related issues such as needlestick injuries. Advice and support are offered to employees and managers in relation to the rehabilitation of staff returning to work following illness or with a known disability.

Staff also have access to Care First; our Employee Assistance Programme. Care First are a leading provider of professional counselling, information and advice offering support for issues arising from home or work. They employ professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues. All staff can access Care First, who will provide additional support in both work and non-work related matters.

The Trust took part in the seasonal flu campaign, aiming to vaccinate as many frontline staff as possible against the influenza virus in order to protect patients, visitors to the hospital, staff and their families. 91% of frontline staff received the flu vaccine, a 2% improvement on last year’s uptake rate.

Moving into 2021 our focus remains on supporting staff to recover physically, emotionally and psychologically from the effects of the pandemic.

Countering Fraud and Corruption

The Trust’s Counter Fraud Policy sets out the standards of honesty and propriety expected of staff and encourages employees to report any suspicious activity that might indicate fraud or corruption promptly. The policy links to the Trust’s Raising Matters of Concern (Whistleblowing) and Disciplinary policies and various NHS publications on this subject.

The Trust’s counter fraud service continues to be provided by TIAA who report directly to the Chief Financial Officer and also report regularly to the Audit Committee throughout the year.

Raising awareness of the need to counter fraud and corruption is taken seriously by the Trust and is communicated via a variety of methods, including leaflets, counter fraud newsletters and notices, staff bulletins, staff awareness presentations, induction training and the Trust's intranet. TIAA undertake a number of proactive work fraud check streams throughout the year to support the Trust's commitment to this area.

The Trust's Freedom to Speak Up Guardian (FTSUG) is supported by a network of Freedom to Speak Up Champions. The FTSUG has a regular meeting with the Chief Executive, Chief People Officer and Senior Independent Officer, to discuss and raise any concerns.

The Trust's Senior Independent Officer (SIO) and Whistleblowing Lead is one of our Non-Executive Board members. This role is in place to ensure there is a direct point of contact on the Board, and to provide Board level visibility of any potential issues.

What our Staff Say

Annually, we participate in the NHS national staff survey. The annual survey gives an important insight into what it's like working in NHS Trusts throughout the country and the results are used to review and improve staff's working lives.

1,358 completed responses were received giving a response rate of 46.4%. This was an increase of 3.5% (1.5 percentage points) from 2019, taking the Trust to just above the average response rate for 2020 and 1% above average for Acute Trusts in England (45%).

These latest results cover 2020 so the COVID-19 pandemic has meant the year has been far from 'business as usual' for the NHS workforce. However, the NHS Staff Survey has measured staff experience in a consistent way to previous years with the same methodology, timings and questions to maintain comparability of the data and allow NHS organisations to compare question responses and theme scores to life before COVID-19.

The questionnaire content is agreed nationally and normally covers 11 themes relating to the working environment and staff experience within the workplace. For 2020, the theme of 'Quality of Appraisal' has not been included as part of a national agreement to suspend normal expectations around appraisal, so only 10 themes are reported on.

DCH scored above or the same as the national average for all 10 key themes in the 2020 results – equality, diversity and inclusion; health and wellbeing; immediate managers; morale; quality of care; safe environment; violence; safety culture; staff engagement and team working. 9 out of 10 theme areas in 2020 showed no statistically significant change from 2019.

However, the theme of Equality, Diversity & Inclusivity was reported as having a statistically significant lower score in 2020, whilst at 9.2 was still very slightly above the average for Acute Trusts. The recently published Workforce Race Equality Standard (WRES) report places DCH amongst the worst Acute Trusts in the country for bullying and harassment of staff from ethnic minority communities. This downward trend was anticipated as we have just started a programme of work on EDI and we have been encouraging staff from ethnic minority communities to speak up when they are subjected to racism or discrimination.

	2020/21		2019/20		2018/19	
	Trust	**Benchmarking**	**Trust**	**Benchmarking**	**Trust**	**Benchmarking**
Equality, Diversity and Inclusion	9.2	9.1	9.4	9.1	9.4	9.1
Health & Wellbeing	6.2	6.1	6.1	5.9	6.1	5.9
Immediate Managers	7	6.8	7.1	6.9	7	6.8
Morale	6.4	6.2	6.4	6.1	6.3	6.1
Quality of Care	7.5	7.5	7.4	7.5	7.3	7.4
Safe environment - Bullying and harassment	8.1	8.1	8.1	8	8.1	8
Safe environment - violence	9.5	9.5	9.5	9.4	9.5	9.4
Safety culture	6.8	6.8	6.8	6.7	6.7	6.7
Staff engagement	7.2	7	7.2	7	7.2	7
Team Working	6.6	6.5	6.8	6.6	6.7	6.6

As with any survey, the most critical aspect of the process is not just about reviewing the results but being clear about where we want to be as an organisation and what needs to be done differently to ensure we are. The Trust continues to take actions to improve staff satisfaction and experience and in turn, improved patient care and outcomes.

Staff engagement routes such as the Freedom to Speak Up process (through our Guardian and Champions), our Health & Wellbeing (HWB) Champions and HWB and EDI Steering Groups and Staff Networks, provide us with data and direction to inform our strategies and interventions.

Positive highlights included 90% of staff feeling their role makes a difference to patients and service users; 91% feeling trusted to do their job and 89% feeling encouraged to report errors, near misses or incidents.

88% of staff feel the organisation acts fairly with regard to career progression and promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Both nationally and here at DCH, all three scores for 'Recommendation of the organisation as a place to work/receive treatment' have increased – which is a testament to our staff, and the pride in their organisations across the NHS in this most challenging year.

Celebrating Success

Every day, individuals and teams within the Trust go above and beyond the call of duty; and throughout 2020 and the coronavirus pandemic this was even more evident.

Usually the Trust would hold its annual Going the Extra Mile (GEM) Awards, which has become a well-established means of recognising and honouring staff and volunteers for their service and outstanding contribution to the care of patients and running of the hospital. Unfortunately, it was not possible to hold the awards in 2020. In its place we ran a COVID-19 Hero and Act of Kindness nomination process which was open to all staff and we ran a virtual Junior Doctor Award nomination process prior to their August rotation. We commissioned a commemorative pin badge which was issued to each member of staff in recognition of their contribution to the Trust in 2020.

We continue to run our Hospital Heroes Scheme. To help honour our Hospital Heroes, we encourage patients, carers, family member and colleagues to thank both teams and individual members of staff who have provided outstanding care to patients. We have adapted the scheme in light of the pandemic and staff are now recognised remotely, with details published in the Trust's weekly Celebrating Success communications briefing.

Volunteering

The last 12 months has seen the volunteer service impacted by COVID-19 with most roles suspended by April 2020 with approximately 95% of our volunteers having to stop volunteering to shield in line with government restrictions. Following guidance from NHSEI Voluntary Partnerships we took the decision not to suspend all volunteering and worked with departments across the hospital to identify need for volunteer support. By the middle of April we had stood up a Response service taking on responsibility for the packing and distribution of Surgical Masks and all donations coming into the hospital. We recruited a small number of volunteers to support those who were able and willing to continue volunteering and deploy into the newly formed Response Volunteer Team. Whilst Response Volunteering was part of the plans for 2020 we were working in a very different way to what had been planned and it saw volunteers work closer together than ever before. Volunteers gave up numerous hours of their time to support this and have remained flexible and patient throughout the last year. It was busy and has been busy since and the tasks we have carried out have developed and changed to continue to meet the need. To ensure we could do what was needed, recruitment processes were adapted and to ensure safety we have only recruited new volunteers as needed.

As we adapted to working in a very different environment, we gradually saw requests to support again in former and new areas. Working with our Response Volunteer team therefore we have been able to shape how the Response role looks and this has been the key focus for us since July/August 2020. We have been able through this process to look at former roles and how these can best be delivered and this has seen an amalgamation of some roles and a different model used to achieve role objectives.

The Voluntary service team were able to increase capacity due to funding from the NHSEI Voluntary Winter volunteering programme 2019/20 and recruited a volunteer administrator to the team who started in April 2020. Office space and department moves did impact the smooth introduction for the new team member and subsequent and on-going moves and uncertainty on space for the volunteers continues to have an impact on the whole team and how we are working but we hope this will be resolved soon. The team have continued to adapt though to meet the changing needs. Working across the NHS voluntary services network we have been able to ensure best practice and share ideas to support our volunteers. This has included setting up a return to volunteering process to ensure any volunteers coming back to volunteering have a full safety briefing and have completed required paperwork and training prior to returning. Recruitment also opened up again properly in January which has seen new volunteers join the response team giving it a much needed boost as demand for volunteer support has increased. The team now support and manage the volunteers more closely than ever before essentially providing the volunteer management for the response team.

The health and wellbeing of our volunteers has been a priority for us this year and it has been important to ensure the voluntary services team have been available for them and be present so that they can talk to us about anything which they are worried or concerned about within the hospital and also just to allow them a chance to process what has become a challenging time for us all. They have given so much over the last year and done so with a smile on their faces but it's also been a time where we have seen lots of anxiety so we have wanted to ensure we can do everything we can to support their health and wellbeing. As well as ensuring we are accessible, we also send out weekly Trust communication updates to the team and ensure we include any health and wellbeing updates on this. As a team volunteers are working more closely together than they have done previously and this has been really positive as they have formed their own friendships and support network.

By the end of March 2021 the response team comprised three key roles:

- Healthy Hospital – Tasks supporting the hospital – i.e. PPE distribution and COVID Vaccinations but with a view that this will develop moving forward to include the 2019 (Pre-COVID) objective of supporting patient flow and discharge.
- Healthy Stay – Supporting patients on In Patient Wards and ED.
- Healthy Visit – Supporting Patients coming in for Outpatient appointments and visitors combining our former Guiding and Patient Liaison Roles. This also currently supports the Dialysis Unit every morning to support the changeover of patients between AM and PM.

Alongside this our Patient Research Ambassador Volunteers and Your Voice group volunteers are also active but largely offsite. We are also supporting other departments to resume roles including the Chaplaincy Assistants and the Friends of DCH. Communication continues with our inactive volunteers who are still shielding.

The table below gives an approximate indication of volunteer status by end of March 2021.

Volunteer Status – Up to 31 March 2021			
Total Active Onsite (including Young volunteers)	**Total Currently Active Offsite**	**Total Inactive (including the FDCH)**	**Total Young Volunteers**
71 (approx 17 not currently regularly volunteering – due to temporary role suspension or external factors – ie school / re-shielding)	16	174 (115 = FDCH)	28 (13 not regularly volunteering)
Volunteer Role Status – 31 March 2021			
Active Roles		**Inactive Roles**	
• Response • Patient and Public Engagement (Your Voice) • Patient Research Ambassadors • Specific Activity (Gardening / ICT)		• Chaplaincy Assistant (currently suspended) • Specific Activity (PAT dogs and music) • Play Assistant • Friends of DCH	
Volunteer Hours - 01 January - 31 March 2021			
Vaccination POD	**PPE Distribution**	**Healthy Stay**	**Healthy Visit**
1217	315	663	621
Total Hours (approximate and reflective only of above active on-site roles)		2816	

Reimagining is a word being used widely now across the volunteer sector as we look at how 'volunteering' can be best delivered and managed in the future. We have certainly had to do this and will continue to do this. 2021/22 will see us recommence plans for our Young Volunteer Programme and continue to develop our Response Service alongside working with other Volunteer services within our ICS to develop consistent practices and implement new volunteer management software. Capacity to continue and expand will depend on the current situation which we have with space. We had to move out of the space which had been set up to use as a volunteer hub at the end of December and in order to sustain the service we made a temporary arrangement to operate the hub from the FDCH shop. They return in May 2021 and as yet there is no alternative accommodation for the volunteer hub. The volunteer office move to THQ in August 2020 means that co-location with the volunteer hub is not feasible. The loss of the hub will severely impact what we are able to do in the future not to mention the effect it is already having on the moral and feeling of value to the volunteers themselves. We hope to report in 2022 that the suspension of the service was not necessary and we will do everything we can to continue to do what we can.

Education, Learning and Development

The Education, Learning and Development team are committed to the inclusive development of knowledge, skills and capabilities of the whole workforce. Regardless of role, all staff are encouraged to undertake and complete training as part of their ongoing development which is discussed at their annual appraisal. We are committed as an organisation to develop our staff and enable them to deliver or contribute to safe, high quality, evidenced based patient care.

The Trust's Education Centre offers a wide range of education, learning and development opportunities, not only for our staff, but also for the wider healthcare community including under graduate and post graduate students of all disciplines. We are constantly developing new and innovative ways of delivering ongoing learning. An annual training needs analysis is conducted each year to ensure that the resources are targeted to areas that will directly benefit patients and link to workforce transformation or service redesign. We are committed to working with our local organisations within the Dorset ICS to streamline, innovate and improve access to education, learning and development for all staff.

Due to the coronavirus pandemic the last 12 months have created a number of challenges for us as an education function and we have had to adapt to working differently both face to face with social distancing measures in place and also have had to implement virtual delivery of training and education. During the first wave we supported the delivery of 3,525 episodes of training in COVID-19 related subjects. We have successfully managed to keep the majority of education and training running throughout the pandemic to ensure staff who are on an educational programs complete their studies with minimal delay as well as ensuring mandatory training requirements are met as much as possible to keep our patients and staff safe.

Despite the pandemic the education function has continued to be actively involved in the training of staff as part of NHSI/E initiatives this has included achieving a target of 0% vacancy rates for Health Care Support Worker posts by April 21 who all requiring care certificate training, Increased recruitment of International nurses, requiring pastoral support and Objective Structured Clinical Examination (OSCE) training and the new Department of Work and Pensions Kickstart scheme which will see us recruit 46 new trainees over the coming months.

Preceptorship

The Preceptorship Programme is a 12 month long development program for all non-medical newly qualified heath care professionals and we continue to run a minimum of two intakes a year. Our numbers for 2020/21 have been positive with 96 newly qualified professionals undertaking the programme and accessing the support of the practice educator team. As far as possible during COVID-19, teaching sessions were continued for all preceptorship programmes but some dates were inevitably cancelled. All these dates have subsequently been re-scheduled and extensions of up to six months for the affected cohorts (Autumn 2019 and Spring 2020) were negotiated.

During the last year we have committed to investing in further recruitment of overseas nurses. 2020/21 saw us welcome and employ 26 overseas nurses and we have supported their education through NMC OSCE (Objective Structured Clinical Examination) preparation sessions and mock exams as well as providing support for them in clinical practice and pastorally through isolation. A virtual programme was developed for our overseas nurses to complete whilst in isolation. The NMC temporary register was opened in 2020 and 33 overseas nurses were supported whilst waiting for OSCE exams as exam centres closed for a period of time between March and July 2020. More recently a further six overseas nurses have been supported on this register.

Leadership Development

Unfortunately the face-to-face Leadership Engagement session for senior leaders that was scheduled for May 2020 had to be cancelled due to COVID-19. However our second event in November was re-organised and delivered virtually. It was well attended and well-received for our first ever large-scale virtual event with over 90 attendees. This particular session was used to launch our Culture Review.

The roll out of our Leadership Programmes continues, with the exception of the Clinical Leadership Programme. Following the completion of the initial cohorts, it was agreed in spring 2020 to pause and review. The feedback from participants highlighted the positive benefits in networking with immediate peers and exploring of real-life situations, but also indicated that the programme could be more engaging and more fully take account of the wide range of prior knowledge and experience amongst the participants. The Advanced Leadership Programme was temporarily paused and then re-started with in the autumn. Sessions were face-to-face, whilst adhering to social distancing requirements and as a result some adaptations were made to the programme to allow it to go ahead. Two cohorts, involving a total of 26 participants, successfully completed their programmes in December 2020 and March 2021 respectively. An evaluation process is currently underway with the external training organisation responsible for delivering this programme. Similarly the Fundamentals Leadership programmes scheduled for the spring of 2020 were delayed and began during the autumn instead. Sixteen participants completed this programme and the feedback continues to be positive.

In light of a focus on inclusive leadership from 2021 onwards, all of our internal leadership programmes will be evaluated and updated to ensure they are fit for purpose. A Leading and Managing for Inclusion Programme has been commissioned and will run throughout 2021-22 for managers at Band 7 and above with line management responsibility. Tailored versions will ensure a wider staff group benefits from the content and approach, throughout 2021/22 and beyond.

Much of our own Management Toolbox and NHS Leadership Academy (national and regional) offerings were also paused during 2020. However our membership of NHS Elect allowed individuals to continue to access a wide variety of virtual webinars and interactive events on leadership and management topics. Coaching also continued to be accessible via the Our Dorset System's shared Mye-coach platform, with 54 coaching relationships completed either face-to-face, virtually or a combination of the two.

The Dorset System Talent Management Programme was rebranded and relaunched as the Dorset System Leadership Programme and the Trust was invited to nominate 3 senior managers to take up places in January 2021 (delayed from 2020). The new programme is being delivered virtually, over a shortened timescale taking account of feedback from the first programme participants in 2019.

Organisational Development

A new Head of Organisational Development (OD) was appointed in October 2020, with a priority remit of undertaking a Trust-wide Culture Review. Culture shapes our behaviour and values at work and impacts upon all of us and our experience working here at DCH.

The Culture Review was formally launched during November 2020 at Leadership Forums, using the concept of 'Discover, Design, Deliver' to start an in-depth exploration of the current culture, how it aligns with the Trust Values and the vision for the Trust moving forwards. The initial work has had a particular focus on Equality, Diversity and Inclusivity.

At the Leadership Forums we set out to discover from our Band 7s and above, something about their lived reality at work. We spent time considering ideas such as feeling safe, feeling like you belong and feeling that you matter, using dialogic approaches in small group with plenary feedback to gather thoughts, views and themes.

The same topics were explored with wider staff groups through face to face and virtual forums and an online survey, during a focused 'discovery' phase in December.

The OD Team gathered data from a variety of other sources to add to the feedback acquired during the focused discovery phase, recognising that there are multiple staff engagement routes we can use (e.g. staff networks, the Freedom to Speak Up process, staff training events, other surveys). The team started to identify recurring themes and saw some 'hot spots' emerge that have focused our attention. 'Hot spots' may point us to a particular individual, area of service or staff group (e.g. Bank Staff report feeling unsupported and disrespected, particularly on certain wards, where rude and unwelcoming behaviour has been experienced).

One of the commitments at the Leadership Forums in November was to take early action on 'hot spot' areas as evidence emerged. Whilst some data needs further investigation, including triangulation of data covering risk, patient safety and HR elements, in some cases we have been in a position to commence engaging with key business areas or teams to start dialogue and agree appropriate interventions.

Staff perform best when they feel psychologically safe. Psychological safety requires an environment where people are encouraged to understand each other's points of view, share ideas and refine thinking in a receptive way, so we can empower staff to call out inappropriate behaviour. Recognising the principles of Civility Saves Lives and how incivility can be a gateway to bullying and create patient and staff safety issues, supporting managers to have productive conversations with their team members and to manage conflict effectively will be key. The development of a Management Toolkit, with launch commencing in May 2021, will support management development needs.

The forthcoming Leading and Managing for Inclusion Programme, Development Programme for staff from ethnic minority communities and ongoing development work at Executive level, combined with other interventions such as a focus on Dignity and Respect at Work (particularly enhancing the current induction offer) will all form aspects of the Trust's cultural development journey over the next few years, helping to shift mindsets and behaviours across the Trust towards a culture where we model support and compassion, value diversity and fairness and build cohesive and effective team working.

Recent successful business cases will see the OD Team expand significantly during 2021, to ensure sufficient staff are in place, with the right mix of skills and experience, to progress the ambitious programme of work outlined in this report.

Library

With adaptations to layout and ways of working, the Library has stayed open and staffed throughout this challenging year. Staff have demonstrated their adaptability and support for the Trust's COVID-19-related activities, assisting with recruitment and providing administrative support to the vaccination hub. The Librarian conducted an extensive review of the medical literature for the DCHFT COVID-19 Learnings Project, working closely with the Research team.

A new regional library management system was rolled out to all NHS South libraries in 2020, which entailed a steep learning curve for all library staff while we adapt to different processes. Our Librarian has been working with Public Health Dorset and the Deputy CEO on the health inequalities agenda. The Library offers Shared Reading sessions for staff which have been well attended. We routinely send an "impact survey" to users of our literature search service and other users. The data demonstrates how the high quality evidence and the services we provide have a positive impact in improving patient care, developing guidelines, teaching and advising others, and research.

Access to Healthcare Careers

Apprenticeships

In 2020/21 we had 73 new enrolments onto apprenticeship courses across the Trust in numerous subject areas and from Level 2 to Level 7, despite the pandemic this was an increase of 12 from the previous year. The pandemic did impact on Apprentices across the Trust, some having to take breaks in their courses due to exam boards and educational providers pausing courses and exams. The majority of our apprentices continued with their courses and we were able to continue to support timely completions by offering invigilation on site for some exams. We continued to work with the Dorset ICS to have cohorts of Registered Degree Nurses and Nursing Associate apprentices. The Apprenticeship Team work with the Workforce Planning and Recruitment teams to promote Apprenticeships across the Trust. To support staff wishing to progress onto apprenticeship courses we have worked with a local college to offer functional skills. For National Apprenticeship Week in February 2021 we promoted our Apprenticeships through our website and internal communications. We recognise the achievements of each apprentice though our Celebrating Success communication, a weekly email bulletin to all staff.

Kickstart Scheme

In support of our social value pledge we are proud to be offering 46 Kickstart placements across the Trust in clinical and non-clinical roles, to young people at risk of long term unemployment. We have a dedicated Kickstart Co-ordinator to support managers and Kickstart employees to gain workability skills and experience over their six month placements and to deliver a training programme to enhance their future employment.

Work Experience and Supported Internships

COVID-19 had a huge impact on our local colleges and schools and our ability to work together to offer placements for supported interns and work experience. We have a directory of work areas across the Trust for future applicants to select their preferred area for

work experience and we are confident that we will be able to resume supporting our local young people and our local schools and colleges with these schemes in the Autumn of 2021.

The Care Certificate

The Care Certificate is a nationally recognised development program for all new Health Care Support Workers. We continue to achieve excellent rates of achievement and on completion staff can progress to the apprenticeship if they wish to continue their education. We also offer a concise version for existing staff who wish to progress their healthcare education. In early response to the COVID-19 Pandemic we commenced delivery of an adapted version of the Care Certificate for both clinical and non-clinical existing staff which enabled them to be ready for redeployment into clinical areas if necessary.

Non-Medical Undergraduate Education

The organisation supports 70 non-medical undergraduate students on clinical placements per week. At the start of the pandemic all students were withdrawn from clinical practice on safety grounds until the end of April. Once risk assessments had been completed students were allowed to return on paid placements to support the organisation during the pandemic as well as ensuring they were able to continue with their clinical practice assessments. Between April and July 2020 we provided paid placements for 90 non-medical students (Nursing, Midwifery, Physiotherapy, Occupational Therapy and Operating department practice)each week supporting many of them to qualify earlier than planned and join the NHS workforce. Student placements remain a challenge although all students resumed normal placements in September 2020 and continue to be supported. The practice education team provide support and training for all our existing and Practice Supervisors and Assessors.

Medical Education

Nationally the impact of the pandemic on junior doctor morale has been significant. Here at DCH we have been able to keep the junior doctors' Mess open, and the Mess committee has done an excellent job of welcoming new staff who have commenced in their training post during COVID. We recognise that the staggered start for those who began Foundation Year 1 last year has posed unique problems, but also created opportunities for medical students acting as Doctors' assistants. Junior doctors have played a part in agreeing redeployment at different surge points, and in the planning for winter activity. We appointed our first ever Junior Doctor Education Fellow; she and our Chief Registrar have helped in these projects, in offering extra Simulation training during Coronavirus, but also in work being done to support junior doctor wellbeing.

We have set up a new placement for medical students in Acute Care and created a new offer to accommodate medical student electives. We have launched a new scheme for Clinical Attachments aimed at overseas doctors who would like to spend a time observing prior to applying for NHS posts. Our work towards supporting Locally Employed Doctors (those not on training schemes) and doctors who are International Medical Graduates continues. These actions will help to boost our profile to enable future recruitment and retention. Teaching and training has been a challenge at all grades; the investment in the Education Centre AV technology has allowed virtual attendance of both audience and lecturers and has been invaluable for preserving the opportunity for learning.

Trade Union Facility Time

Relevant union officials

Number of employees who were relevant union officials during the relevant period	FTE employee number
8	2323

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	-
1-50%	8
51%-99%	-
100%	-

Percentage of pay bill spent on facility time

	Figures
Provide the total cost of facility time	£3,368
Provide the total pay bill	£156,092,884
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.002%

Paid trade union activities

Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	5%

The following sections of the Staff Report are subject to audit

Consultancy

The NHS has additional controls for spending on consultancy contracts over the value of £50,000 to ensure value for money. The Trust had no contracts which exceeded the £50,000 limit.

	2020/21 £000s
Finance	24
Human Resources	142
IT/IS Consultancy	21
Legal Consultancy	2
Marketing & Communications	5
Property and Construction	46
Strategy	56
Technical	29
Total	**325**

Reporting High Paid Off-payroll Arrangements

The Trust has a policy on the engagement of staff off-payroll to ensure compliance with employment law, tax law and HM Treasury guidance for government bodies. This contains a procedure to ensure appointees give assurances to the Trust that they are meeting their Income tax and National Insurance obligations.

The policy includes controls for highly paid staff including board members and senior officials, individuals under these sections require Accounting Officer approval and should only last longer than six months in exceptional circumstances.

For any off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months	Number of engagements
Number of existing engagements as of 31 March 2021	6
Of which: No. that have existed for less than one year at time of reporting	6

All off-payroll workers engaged at any point during the year ended 31 March 2021, for more than £245 per day	Number of engagements
Number of new engagements during the year ended 31 March 2021	548
Of which…	
Not subject to off-payroll legislation	525
Subject to off-payroll legislation and determined as in-scope of IR35	23
Subject to off-payroll legislation and determined as out-of-scope of IR35	Nil
Number of engagement reassessed for compliance or assurance purposes during the year	Nil
Of which; No of engagements that saw a change to IR35 status following review	Nil

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	16

The Trust has made no payments for off payroll arrangements to individuals through their own companies during 2020/21.

The following sections of the Staff Report are subject to audit.

Average number of employees (WTE basis)

	Average for year ended 31 March 2021		
	Total number	Permanent number	Other number
Medical and dental	388	369	19
Administration and estates	448	443	5
Healthcare assistants and other support staff	915	911	4
Nursing, midwifery and health visiting staff	836	763	73
Nursing, midwifery and health visiting learners	21	21	-
Scientific, therapeutic and technical staff	244	240	4
Healthcare science staff	86	81	5
Social care and staff	1	-	1
Other	2	2	
Total	2,941	2,830	111
Of which: Engaged on capital projects	13	13	-

The average number of employees is calculated on the basis of the number of worked hours reported. This means that the reporting of staff numbers and staff costs incurred are on a more consistent basis.

Employee Expenses

	Total £000	Permanent employed £000	Other total £000
Salaries and Wages	115,262	114,257	1,005
Social security costs	10,688	10,688	-
Apprenticeship levy	551	551	-
Pension cost – NHS pensions	13,227	13,227	-
Pension cost – Employer contributions paid by NHSE	5,765	5,765	-
Pension cost – other	48	48	-
Termination benefits	169	169	-
Temporary staff – Agency/contract staff	10,383	-	10,383
Total Gross Staff Costs	**156,093**	**144,705**	**11,388**
Included within; costs capitalised as part of assets	1,234	1,234	-

Exit Packages

2020/21 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	16	16
£10,001 - £25,000	-	2	2
£100,001 - £150,000	-	1	1
Total number of exit packages by type	-	19	19
Total resource cost (£000)	-	169	169

2019/20 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	28	28
£10,001 - £25,000	-	1	1
Total number of exit packages by type	-	29	29
Total resource cost (£000)	-	96	96

The payments included in ‘Other departures’ agreed for 2020/21 are nineteen in respect of contractual payments made in lieu of notice and one voluntary redundancy (2019/20 twenty-nine payments for lieu of notice). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in this table.

Corporate Governance Report

Dorset County Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'Comply or Explain' basis. The NHS Foundation Trust Code of Governance (July 2014) reflects the principles of the UK Corporate Governance Code 2012 and aims to promote best governance practice. Whilst the NHS Foundation Trust Code of Governance is a guidance document, it requires that Foundation Trusts disclose any deviation from it, providing a reason for deviation from the Code and explanation as to how alternative arrangements meet the requirement of the Code.

The Board of Directors implements the Code of Governance through a number of key governance documents which include:

- The Constitution
- Standing Orders and Standing Financial Instructions
- Scheme of Delegation and Matters Reserved to the Board
- Code of Conduct – Board of Directors and Council of Governors
- Annual Plan
- The Board Committee Governance Structure.

Board of Directors Profiles

Chair

Mark Addison – first term 24/3/2016 – 23/3/2019, second term 24/3/2019 – 23/3/2022

Mark has had an executive career in central government, working in senior operational and policy roles in a number of departments. He was the Chief Executive of the Crown Prosecution Service, Director General for Operations in the Department of Environment, Food and Rural Affairs, and was for a short spell the permanent Secretary of that Department and Chief Executive of the Rural Payments Agency. He has previously held non-executive roles, sitting on the boards of The National Archives and the Which? Council. He was a Civil Service Commissioner and a Public Appointments Assessor. He was the Chair of the Nursing and Midwifery Council. Mark is also the Vice Chair of the Charity for Civil Servants and the Chair of the State Honours Committee. He continues to undertake some public appointments work. These commitments have no impact upon his ability to chair Dorset County Hospital NHS Foundation Trust.

Chief Executive Officer

Patricia Miller – appointed substantive Chief Executive Officer 15 September 2014

Patricia has worked for the NHS for 30 years and holds a Masters degree in Health Care Management. She is a graduate of the East of England Aspiring Directors Programme, the 'Breaking Through' Leadership Programme, the Athena Leadership Programme for Executive Women and more recently the Collaborative Leadership Programme at the Kings Fund. Patricia joined Dorset County Hospital NHS Foundation Trust as Chief Operating Officer in 2011 and after leading a successful turnaround programme, Patricia was appointed as Chief Executive in September 2014. Whilst working in the NHS Patricia has remained passionate about improving the lives of patients and staff in ways that matter to them. She has led a range of innovative and successful initiatives to improve patient safety and quality. Patricia, together with two CEO colleagues of neighbouring Trusts, was successful in an application for the Acute Care Collaboration Vanguard and is currently a key partner in the Our Dorset system, a wave one Integrated Care System. Patricia has a strong focus on equality, diversity, inclusion and health inequalities and is currently co-chair

of the provider Chairs and CEOs network, a member of the NHS England's health inequalities oversight group and is a member of the newly created NHS Race and Health Observatory Board. Patricia is a member by distinction of the Faculty of Public Health and has been a member of the NHS Assembly since its inception. Patricia is also one of only 8 BAME CEOs in the NHS hospital sector. Patricia was named as one of 25 Rising Stars of the NHS in 2013, one of the top 50 CEOs in 2019, amongst the top 50 BAME figures who will exercise the most power and/or influence in the NHS and health policy 2020 and was awarded an OBE in the Queen's Birthday Honours list for services to the NHS.

Non-Executive Directors

Sue Atkinson - first term 1/09/16 – 31/8/19, second term 1/09/2019 – 31/08/22, Senior Independent Director from 01/10/20

Sue has considerable experience in Public Health, clinical medicine, commissioning, as a chief executive, executive director and non-executive director in the NHS and DoH. She was Regional Director of Public Health (RDPH) for London and developed the role as Health Advisor to the Mayor and Greater London Authority. She was previously RDPH and Medical Director of South Thames, South West Region and Wessex. Her work includes health strategy, inequalities and partnership working, including with national and local government and the third sector. Sue holds a number of non-executive and academic posts, including founding Director and Chair of PHAST (Public Health Action Support Team – a not for profit social enterprise). She is a Board Member of the Faculty of Public Health, Visiting Professor at UCL, Co-Chairs the Climate and Health Council and was a board member of the Food Standards Agency.

Margaret Blankson – first term 01/01/21 – 31/12/24

Promoting issues of diversity and inclusion have been core tenets throughout Margaret's personal life and professional career. Following a career in local government, Margaret established her own consultancy providing strategic advice on transformation, regeneration and CSR programmes, with a focus on the embedding issues of diversity inclusion into mainstream delivery. Margaret's clients extend across all three sectors and have included Nike UK, Unilever, Lloyds Banking and the FA. Margaret spent several years involved in training Metropolitan Police Service officers in diversity and inclusion. She has held a number of advisory roles including Chair for the charity IMPACT and advisory Board member for Choice FM Radio. Margaret is currently a Trustee of Over the Wall a charity providing breaks for children facing serious health challenges and is the founder of the Foodbank DoorSteppers an organisation she established in response to COVID 19. Margaret is currently undertaking an MA in Consulting and Leadership in Psychodynamic and Systemic Approaches at the Tavistock Institute, London.

Judy Gillow – first term 1/9/16 – 31/8/19, Vice Chair from 02/09/19, second term 1/09/2019 – 31/08/22

Judy has had an extensive and successful career in the NHS in clinical, operational management, educational and Executive Director roles. She was awarded an MBE in 2010 for her work on improving hospital infection rates and in 2016 she was awarded an honorary doctorate by Southampton University for her work on developing clinical academic careers for nurses and health professionals. Her most recent post was Director of Nursing at University Hospital Southampton where she led the quality improvement agenda. She has previously worked as Senior Nurse Advisor for Health Education England, Wessex Branch.

Judy is also currently a lay member of West Hampshire Clinical Commissioning Group is a Specialist Advisor for the Care Quality Commission.

Victoria Hodges – first term 1/9/16 – 31/8/19, second term 1/09/2019 – 31/09/2020
Victoria has had an executive career of over 25 years in the retail sector, with her remit covering all aspects of Human Resources and in particular organisation design, culture, change and leadership development. She has extensive experience of working with boards to drive business strategy and performance. Her most recent role was as People & Culture Director at White Stuff, which was ranked in the 'Times Top 100 Best Companies To Work For' for nine successive years under her leadership.

Ian Metcalfe - first term 1/11/17 – 31/10/20, second term 01/11/20 – 31/10/23
Ian is an experienced Finance Director and a qualified management accountant who started his career in the commercial sector, but for the past twenty years has worked as an executive and non-executive director in the not-for-profit, charity and health sectors, and more recently in arts organisations. Ian has served on a number of Boards, including eight years as a non-executive director with Royal Bournemouth Hospital, where he was Chair of a number of committees, including the project board which led the re-build of Christchurch Hospital as a health and care community. He is currently a Trustee of Lighthouse, Poole's centre for the arts, and has re-joined the Board of Activate, an arts enabling organisation based in Dorchester.

Matthew Rose – first term 17/6/14 – 16/6/17, second term 17/6/17 – 16/6/20
Matthew is a qualified accountant and a member of the Chartered Institute of Management Accountants. He has had a number of senior finance roles including previously working for Portsmouth Hospitals NHS Trust. He is a highly experience senior commercial finance professional and has worked for New Look retailers based in Weymouth for the last 17 years. In his roles as Head of Finance he has the responsibility to implement the financial strategy to optimise the trading performance across all channels. He has extensive experience on strategic financial planning and budgeting and has a strong track record of challenging existing resources, systems and ways of working.

Stephen Tilton – first term 01/06/20 to 31/05/23
Stephen qualified as a Chartered Accountant with Price Waterhouse and is a Fellow of the ICAEW. He has held a series of senior executive roles in the financial services sector specialising in regulation, risk and governance, including over 10 years as director of legal and compliance at a global private equity firm. He joins DCH having spent nearly four years as a non-executive director at Worcestershire Health and Care NHS Trust where he chaired the Audit and Charitable Funds committees and was a member of the Quality and Safety committee. Stephen is also an accomplished musician, and for 10 years was Master of Music at the Chapels Royal, HM Tower of London, having been a choral scholar at King's College, Cambridge from where he graduated with a degree in Classics.

David Underwood – first term 1/03/20 – 28/02/23
Dave is an experienced senior leader having worked first at the Civil Aviation Authority as an Air Traffic Control Scientist and Research Manager before joining the Met Office, in 1998, to lead their Civil Aviation Business. Over 20 years with the Met Office Dave undertook a range of senior executive roles including Group Head of Public Sector Business, Deputy Director of Technology and Information Systems and latterly Deputy Director of High

Performance Computing. In addition to his executive roles Dave has more than 10 years non-executive leadership experience gained in the fields of Environmental Business, Further Education (serving on the Board of Exeter College) and most recently as a Non-Executive Independent Advisor to the Royal Devon & Exeter NHS Foundation Trust with regard to their MyCare Technology enabled Transformation Programme. Dave is passionate about delivering effective leadership of change and promoting the benefits of careers in science, technology, engineering, mathematics and medicine

Executive Directors

Chief Financial Officer: Paul Goddard – appointed 18 June 2018
Paul is a fellow of the Association of Chartered Certified Accountants and has over 30 years' experience in NHS finance. He joined the Trust in June 2019 from University Hospital Southampton Foundation Trust where he spent 10 years rising from Assistant Director of Finance to the role of Director of Finance which included a directorship of the wholly owned subsidiaries. He has worked extensively across the NHS sector at a senior level within both provider and commissioning organisations and also gained valuable experience working in a commercial role within a large US owned facilities management company.

Chief Medical Officer: Professor Alastair Hutchison – appointed 1 July 2018
Alastair joined the Trust in July 2018 from Manchester Royal Infirmary, where he was Clinical Head of Division for Specialist Medicine and Clinical Professor of Kidney Medicine (University of Manchester). He has worked in clinical leadership roles in Manchester for over 15 years, including being Clinical Director for Renal Medicine, the Royal College Tutor in Medicine, Associate Clinical Head of the Division of Medicine, and most recently the Clinical Head for Specialist Medicine. He has clinically supervised the development and introduction of new IT systems as well as having a major interest in infection control. Alastair has wide-ranging experience in managing complex clinical services, and is actively involved in research into acute and chronic kidney disease with around 100 publications in peer-reviewed journals and books. He has written chapters for both the Oxford Textbook of Medicine and the Oxford Textbook of Clinical Nephrology.

Director of Strategy Transformation and Partnerships: Nick Johnson – appointed 1 February 2016 and Deputy Chief Executive Officer from 19 October 2021
Nick joined the Trust from University Hospital Southampton NHS Foundation Trust where he was responsible for strategy and commercial development projects, including establishing and innovative commercial development joint venture, for which he was a Board Member. Prior to that, he was responsible for business development and bid management at a large, multi-national infrastructure and support services provider focusing on strategic public private partnerships. Nick has also worked in a number of local authorities delivering innovative strategic partnerships, contract management and service transformation. Nick has an MSc from Warwick Business School and started his career on the National Graduate Management Scheme for Local Government.

Chief Nursing Officer: Nicky Lucey – appointed 1 September 2016
Nicky joined the Trust from Kent Community Health NHS Foundation Trust where she was Director of Nursing and Quality. During her career Nicky has held a number of senior roles, including director of clinical standards at Portsmouth Hospitals NHS Trust. Her wealth of experience includes having successfully led many initiatives, such as workforce redesign involving education and career development, as well as patient care improvements. Nicky, who trained at Uxbridge, Middlesex, also has an MBA from Solent University. She has a professional background in cardiothoracic and critical care.

Chief Operating Officer: Inese Robotham – appointed 19 November 2018
Inese joined the Trust in November 2018 from Worcestershire Acute Hospitals NHS Trust where she held a variety of roles, the last one being Acting Chief Operating Officer. She has worked for the NHS for over 18 years in both highly performing and challenged organisations and has led a number of complex service redesign and improvement initiatives. Inese is passionate about improving the quality of patient care and experience and holds a Masters Degree in Leadership for Healthcare Improvement from the University of Birmingham. She is also a Leadership Fellow with the Health Foundation.

Chief Information Officer: Stephen Slough – appointed 1 June 2019 (non-voting)
Stephen joined DCHFT as the first CIO on the Trust Board. He is a Chartered Fellow of the British Computer Society and a Leading Practitioner for the newly launched national FED-IP digital healthcare leadership framework, and brings experience from a variety of national, European and global leadership roles he held for Siemens over a 20 plus year career in the private sector, before joining the NHS in Dorset in 2016. Since joining the NHS he has led the creation of the digital transformation portfolio for the Dorset ICS, driving forward the digital agenda for the county with an ambition to provide sustainable digital services to the staff and public alike. Living close to Dorchester with his family he is a Scout Leader and a volunteer with Dorset Search and Rescue in his spare time.

Director of Workforce and Organisational Development: Mark Warner – appointed 2 March 2015 to 31 October 2020
Mark formerly worked for Buckinghamshire Healthcare NHS Trust from July 2013 and was responsible for leading the people agenda for the Trust. Previously, he was Head of Human Resources at West Sussex County Council. Mark has more than 25 years' experience in the field of HR, including 18 years in the airline industry with British Airways.

The Board of Directors

The Board of Directors is responsible for establishing the strategy of the Trust and for the operation of the Trust's business; ensuring compliance with the Trust's Constitution, NHS Provider License, Statutory requirements and contractual obligations. Details of the composition of the Board can be found in the Directors' Report above. Terms of office and remunerations details are contained in the Remuneration Report above.

Individual members of the Board of Directors undertaken annual appraisal in order to establish performance objectives for the coming year. The process includes a self-assessment, peer review and feedback from Governors and external stakeholders. The Trust Chair's appraisal in undertaken by the Senior Independent Director and submitted to

NHS Improvement. The Board has considered the skills, expertise and experience needed to ensure appropriate balance and completeness to meet the ongoing requirements of the Trust and has reflected these requirements in the appointments made to the Board of Directors during the year.

Attendance at Trust Board Meetings 2020/21

P1 = Public P2 = Private D = Development	April 2020	May 2020	June 2020		July 2020		Aug 2020		Sept 2020		Oct 2020		Nov 2020		Dec 2020	Jan 2021	Feb 2021	March 2021	
	P2	P1	P1	P2	P1	P2	P1	P2	P1	P2	P2	D	P1	P2	D	P2	P2	P1	P2
Non-Executive Directors																			
Mark Addison	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Atkinson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Margaret Blankson (from 01/01/21)																✓	A	✓	✓
Judy Gillow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Victoria Hodges (to 30/09/20)	✓	✓	✓	✓	A	A	✓	✓	✓	✓									
Ian Metcalfe	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matthew Rose (to 16/06/20)	✓																		
Stephen Tilton (from 01/06/20)			✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dave Underwood	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Executive Directors																			
Patricia Miller	A	A	A	A	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓
Paul Goddard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	A	✓	✓
Alastair Hutchison	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A
Nick Johnson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nicky Lucey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inese Robotham	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Slough	✓	A	✓	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mark Warner (to 31/10/20)	✓	✓	✓	✓	✓	✓	A	A	A	A	A	A							

During the pandemic, the Board revised their usual cycle of meetings and implemented a programme of monthly focussed meetings. Further details are contained within the Well Led section of this report.

Risk and Audit Committee

The Risk and Audit Committee comprises a Non-Executive Chair with accounting experience and four other Non- Executive Directors, Chief Medical Officer, Chief Nursing Officer, Chief Operating Officer, Deputy Chief Executive and Chief Financial Officer. The Committee is also supported by external and internal auditors and representation from the Counter Fraud Authority. The work of the committee is regularly observed by members of the Council of Governors.

The purpose of the committee is to maintain oversight of the Trust's systems of internal control, governance and quality safety on behalf if the Board of Director; seeking assurances from Non-Executive committee chairs, supported by Executive Directors. The committee approves and monitors the Internal Audit Work Programme and any revisions throughout the year. The programme of audits and subsequent report provide clear statements of assurance regarding the adequacy of controls in place and facilitates and informs the Head of Internal Audit Opinion that is included in the Annual Report at year end.

External Auditors attend the Risk and Audit Committee in order to review the plan of work, review risks and mitigations and provide conclusions. They undertake a formal audit of the Accounts and Annual Report on an annual basis. As part of the audit, the Risk and Audit Committee considered the following significant audit risks identified by external audit: Management override of controls – valuation of Land and Buildings, Fraudulent recognition of revenue, fraudulent recognition of non-pay expenditure and Management Override of Controls.

The Committee considered the Annual Report and Audited Accounts for 2020-21 at a meeting held on the 18 May 2021 and concluded that there were no significant issues requiring action pursuant to the Corporate Governance Code.

Non-Executive Director Attendance at Risk and Audit Committee 2020-21

Name	Attendance/Meetings eligible to attend*
Sue Atkinson	3/6
Judy Gillow	6/6
Ian Metcalfe (Committee Chair)	6/6
Matthew Rose (to 16/06/20)	1/1
Stephen Tilton (from 01/06/20)	5/5
Dave Underwood	5/6

* Meetings of the Risk and Audit Committee took place in May, July, September, November, January and March.

Remuneration and Terms of Service Committee

Information about this committee and its activities can be found in the Remuneration Report above.

Effectiveness Evaluation

The Board of Directors has a programme of Staff and Patient Stories at each formal Board meeting, providing direct feedback from staff and patients and their carers. This programme has operated intermittently in year as COVID restrictions have allowed.

The Board has undertaken a comprehensive review of its sub-committee performance in order to extract learning from changes made during the pandemic year and in order to strengthen cross committee communication, data triangulation and risk assurance processes. The review will, alongside the refreshed Strategy for the Trust, inform future information requirements through the identification of priorities and work programmes, promote greater Board sight on both corporate and strategic risks and inform respective committee Terms of Reference as we move beyond the pandemic to focus on staff and service recovery.

Compliance with the Code

The Trust has been compliant with the NHS Foundation Trust Code of Governance throughout the year. The Board of Directors has maintained effective leadership through revisions to the Board and committee governance arrangements to enable focus on key decisions and risks whilst releasing operational capacity to address the pandemic.

Information Governance

Information Governance arrangements were strengthened in year with the appointment of an Information Governance Manager who is the Trust's Data Protection Officer. Significant work has been undertaken to strengthen the Trust's compliance with the Data Security and Protection Toolkit requirements and General Data Protection Regulations; including Data Protection Impact Assessments and Data Flow Mapping. The Trust is working to ensuring a fully compliant submission.

The Council of Governors

The Council of Governors represent the interests of the communities served by the Trust and partner organisations. The Council has a duty to hold Non-Executive Directors to account individually and collectively for the performance of the Board of Directors, providing and gaining feedback on the Trust's performance to stakeholder organisations and members. The Chair of the Council of Governor is also the Chair of the Board of Directors and is responsible for the performance of Non-Executive Directors.

The Council of Governors receives the Annual Report and Accounts and has responsibility for conducting an Annual Members' meeting.

Members of the Council of Governors and the constituencies they represent are included below.

Governors' contact details are available on the Trust's website www.dchft.nhs.uk or correspondence can be sent to the Trust Secretary, Dorset County Hospital NHS Foundation Trust, Trust HQ, Williams Avenue, Dorchester, Dorset, DT1 2JY.

Governors and Terms of Office and Attendance at Council of Governors' Meeting 2020/21

ELECTED GOVERNORS

Name	Constituency	Current Tenure*	Attendance at Council of Governors meetings/Meetings eligible to attend**
Simon Bishop	East Dorset	01/10/20 – 30/09/23 (second term)	4/4
Christine McGee	North Dorset	09/07/18 – 08/07/21 (third term)	4/4
Maurice Perks	North Dorset	09/07/18 – 08/07/21 (first term)	4/4
Sarah Carney	West Dorset	09/07/18 – 08/07/21 (first term)	2/4
David Cove (Lead Governor)	West Dorset	01/10/20 – 30/09/23 (third term)	3/4
Wally Gundry	West Dorset	09/07/18 – 08/07/21 (first term)	1/4
Kathryn Harrison	West Dorset	01/10/20 – 30/09/23 (first term)	3/3
Naomi Patterson	West Dorset	09/07/18 – 08/07/21 (first term)	1/4
David Tett	West Dorset	09/07/18 – 08/07/21 (second term)	0/4
Margaret Alsop	Weymouth and Portland	01/10/20 – 30/09/23 (second term)	3/4
Mike Byatt	Weymouth and Portland	01/10/20 – 30/09/23 (first term)	2/3
Marion Levick	Weymouth and Portland	01/10/20 – 30/09/23 (first term)	2/3
Stephen Mason	Weymouth and Portland	09/07/18 – 08/07/21 (first term)	4/4
Sharon Waight	Weymouth and Portland	09/07/18 – 08/07/21 (second term)	1/4
Tracy Glen	Staff	01/10/20 – 30/09/23 (third term)	4/4
VACANCIES			
1 VACANCY	East Dorset	-	-
1 VACANCY	South Somerset and Rest of England	-	-
3 VACANCIES	Staff	-	-

APPOINTED GOVERNORS

Name	Organisation	Current Term Ends	Attendance at Council of Governors meetings/Meetings eligible to attend**
David Thorp	Age UK	31/12/2024 (first term)	1/1
Tony Alford	Dorset Council	04/07/22 (first term)	4/4
Annette Kent/Barbara Purnell	Friends of DCH	04/10/2022 (second term)	2/4
Davina Smith	Weldmar Hospice Care Trust	23/10/2021 (second term)	3/4

GOVERNORS WHO LEFT DURING THE YEAR

Name	Constituency/Organisation	Leaving Date	Attendance at Council of Governors meetings/Meetings eligible to attend**
Peter Wood	Age UK	Tenure Ended 30/09/20	1/1
Jenny Bubb	Dorset Clinical Commissioning Group	Stepped Down 30/09/20	0/1
Gavin Maxwell	West Dorset	Tenure Ended 30/09/20	1/1
Dave Stebbing	Weymouth and Portland	Tenure Ended 30/09/20	0/1
Tony James	Staff	Tenure Ended 30/09/20	1/1
Neal Cleaver	Staff	Stepped Down 28/02/21	0/3

*The Governor Elections 2020 were paused due to the COVID pandemic. Governors whose terms were due to end in May had their tenures extended as non-voting members of the Council of Governors from 31 May 2020 to 30 September 2020.

**The Council of Governors met on the following dates in 2019/20: 7 September 2020, 9 November 2020 (part one meeting only), 11 November 2020 (part two meeting only) and 22 February 2021. The meeting scheduled for 5 May 2020 was cancelled due to emergency governance arrangements in place during the COVID pandemic.

Governor Activities

In line with guidance from NHS England/Improvement and NHS Providers, social distancing and lockdown rules and the Trust's emergency governance arrangements, Governor activities were curtailed during 2020/21.

During the pandemic, engagement with the Council of Governors has been maintained via the use of video conferencing and regular virtual meetings to ensure Governors were fully apprised of the local and region situation and continued work of the Trust. The Trust has

actively engaged and consulted with Governors in the review of the Trust's Strategy and will continue to work closely with Governors to ensure that the Trust plays an active leadership role in the development of the Integrated Care System and that membership remains reflective of the communities we serve.

In addition to the Council of Governors' meetings, the Governors usually meet on a more informal basis four times a year at the Governors' Working Group. These meetings are attended by Non-Executive Directors on a rotational basis. However, during 2020/21 due to the pandemic, the Governors' Working Group meetings were replaced with regular COVID Update Sessions to enable Governors to keep up to date with the local COVID situation. These meetings were held 11 times during 2020/21 and were chaired by the Trust Chairman and attended by the Chief Executive Officer or their representative.

During 2020/21 the majority of the Council of Governors' committee work was stood down in line with the emergency governance arrangements. This meant that the following committees did not meet during 2020/21:

- Membership Development Committee
- Constitution Review Committee

To enable the Governor to engage with the work to refresh the Trust strategy, the Strategic Plan Committee met twice, in December 2020 and February 2021. So that all Governors could participate in this important work, the invitation to attend these sessions with the Deputy CEO/Director of Strategy, Transformation and Partnerships was extended to all Governors, not just the members of the Strategic Plan Committee.

Details of the activity of the Governors' Nominations and Remunerations Committee are given below.

Plans are in place to recommence all Governor activities in the new financial year.

Nomination and Remuneration Committee (Council of Governors' sub-committee)

The Nomination and Remuneration Committee is a sub- committee of the Council of Governors and is responsible for appointment of the Trust Chair and Non-Executive Directors and determining the rate of remuneration for Non-Executive Directors.

The committee met on two occasions, in September and November to consider the appointment in year to a vacant Non-Executive Director post. Members of the committee were involved in the shortlisting and interviewing for the appointment, and a unanimous recommendation was made by the committee to the Council of Governors in November 2020 to appoint Margaret Blankson as a Non-Executive Director.

Attendance at Nominations and Remuneration Committee 2020/21

Name	Title	Attendance/ Meetings invited to or required to attend
Mark Addison (Chair)	Trust Chair	2/2
Neal Cleaver	Staff Governor	0/1
David Cove	Lead Governor	2/2
Wally Gundry	Public Governor	0/2
Stephen Mason	Public Governor	2/2
Christine McGee	Public Governor	2/2
Davina Smith	Appointed Governor	1/1
David Tett	Public Governor	0/2
Peter Wood	Appointed Governor	1/1

How the Board and Governors Work Together

Due to the emergency governance framework that has been in place for much of 2020/21, some of the usual mechanisms for the Board and Governors working together have been reduced. However the Trust has endeavoured to ensure that the Board and Governors maintain contact via Governor observers at Board Committee meetings, executive and non-executive attendance at Council of Governor meetings, executive attendance at Governors' COVID Update Sessions, and an open invitation for Governor attendance at Part One Board meetings. Governors have also had contact with the executive and non-executive team through two induction sessions in 2020 which, although run for the newly elected Governors, were open to all Governors.

Governors have continued to be able to ask questions of the Board via the Governor Matters item at Council of Governors' meetings and via the Corporate Governance team as required.

In the event of a disagreement between the Council of Governors and the Board of Directors, the Dispute Resolution process referred to in the Trust's Constitution (Annex 8) will be invoked.

Director Attendance at Public Council of Governors' Meetings during 2019/20

Date of Council of Governors' Meeting	Executive Attendance*	Non-Executive Attendance**
7 September 2020	Chief Executive Officer Chief Financial Officer	Mark Addison (Chair) Ian Metcalfe
9 November 2020 (part one meeting only),	Chief Executive Officer Deputy CEO/Director of Strategy, Transformation and Partnerships Chief Financial Officer Chief Medical Officer Chief Operating Officer	Mark Addison (Chair) Judy Gillow
11 November 2020 (part two meeting only)	N/A	Mark Addison (Chair)
22 February 2021	Chief Executive Officer Head of Contracting (for the Chief Financial Officer)	Mark Addison (Chair) Margaret Blankson Sue Atkinson

* Executives attend the Council of Governors as requested to present relevant reports. Governors also have the right to request members of the executive team attend the meetings, but the Council of Governors has not exercised this right during 2020/21.
** In addition to the Chair's attendance, Non-Executive Directors are invited to attend Part One Council of Governor meetings on a rota basis.

Governor Elections

In 2020/21 the Trust held Governor elections in East Dorset, West Dorset, Weymouth and Portland, and the Staff constituency. The Governor Elections 2020 which were due to end in May 2020 were paused in light of the COVID-19 pandemic and in line with advice and guidance from NHS England/Improvement and NHS Providers. The Trust felt that this was the best way to ensure a fair and democratic process for its constituents, nominees and Governors. Governors whose terms were due to end in May had their tenures extended as non-voting members of the Council of Governors from 31 May 2020 to 30 September 2020. The election process commenced in February 2020 and was paused from April. The process recommenced in August with the result being announced on 1 October 2020. There were elections for contested seats in West Dorset and Weymouth and Portland, with Governors in East Dorset and the Staff constituency being elected unopposed. The election turnout was 31% in West Dorset and also 31% in Weymouth and Portland.

The following Governors were elected:

Neal Cleaver (staff)
Mike Byatt (Weymouth and Portland)
Marion Levick (Weymouth and Portland)
Kathryn Harrison (West Dorset)

The following Governors were re-elected:

Simon Bishop (East Dorset)
David Cove (West Dorset)
Margaret Alsop (Weymouth and Portland)
Tracy Glen (staff)

The following Governors left the Council of Governors at the end of the election process:

Dave Stebbing (did not stand)
Tony James (did not stand)
Gavin Maxwell (not re-elected)
Peter Wood (end of third term)

Membership

Foundation Trusts have a responsibility to engage with the communities that they service and listen to community views when planning services.

The Trust has two types of membership: public and staff. The Trust encourages people who live within its constituency boundaries to register as public members. Being a member demonstrates support for the hospital and the services it provides and gives the opportunity to share views with the Trust to help it best meet patient needs.

Membership is open to people ages 16+ years who are resident in England. Registration as a member can be via a membership application form, online at www.dchft.nhs.uk, via email to foundation@dchft.nhs.uk, or by phoning 01305 255419.

The Council of Governors has established a Membership Development Committee which meets on a quarterly basis to keep the Membership Development Strategy under review and to oversee membership communications, events and recruitment. The Trust has maintained a fairly steady level of membership throughout 2020/21. In line with guidance from NHS England / Improvement and NHS Providers, the work of the Governors' Membership Development Committee has been in abeyance during 2020/21. The Trust has continued to keep in contact with its members via the Trust's website, social media and the publication of the DCH Way newsletter. Plans are in place to re-establish the Membership Development Committee in the new financial year.

Constituency	2020/21	2019/20
East Dorset	224	230
North Dorset	237	249
South Somerset and the Rest of England	90	95
West Dorset	1184	1,226
Weymouth and Portland	703	715
Total Public Members	2438	2,515
Staff Members	4,097	3,865
Total	6,535	6,380

NHS Oversight Framework

NHS England and NHS Improvement's Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these theses, providers are segmented from 1 to 4, where "4" reflects providers receiving the most support, and "1" reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

NHS Improvement has placed the Trust in Segment 2 as at 31 March 2021. Segment 2 is Providers offered targeted support. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Dorset County Hospital NHS Foundation Trust.

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

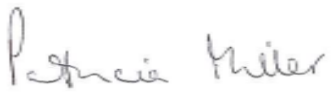
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Dorset County Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Dorset County Hospital NHS foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual)* have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*



Patricia Miller
Chief Executive Officer
4 June 2021

Annual Governance Statement

Scope of Responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Purpose of the System of Internal Control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.
The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Dorset County Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

The Trust has maintained a robust system of internal control throughout the COVID-19 pandemic incident; revising how it both responded to the operational crisis and ensured that the Board and Council of Governors remained fully briefed on the operational response whilst maintaining oversight of the risks to delivery of strategic priorities and progress in key areas of programmed work where this has been possible.

Capacity to Handle Risk
During the pandemic, the Board revised how best to conduct Board and subcommittee business in line with national guidance 'reducing the burden'. Meetings of the Board and its committees were conducted via video conferencing and agendas were reduced to focus on key risks and issues and essential decision making; releasing operational capacity to address the crisis. The frequency of Board and sub-committee meetings remained unchanged in order that the board could continue to make essential decisions in a timely manner and additional short Non-Executive briefing meetings were introduced in order that NEDs could be apprised of the emergent situation and provide support to executive colleagues.

The Board continued to receive regular reports against key quality metrics and performance; being benchmarked with other regional partners on metrics for urgent care, cancer and diagnostic services and waiting times. The opportunity to receive patient and staff feedback was considerably reduced during the year, although patient and staff stories were positively received by the Board when circumstances intermittently permitted in year.

The Chief Nursing Officer is the executive lead for risk management and is supported in this by the Head of Risk Management and Quality Assurance. The Trust has a Safety Group, which reviews risks, incidents and Health and Safety matters. It reports by exception to the Quality Committee. The Risk Management Framework sets out the Board's requirement that a systematic approach to identify and manage risks is adopted across the Trust and that systems are in place to mitigate those risks where possible. The Framework also stipulates that it is essential that all Trust staff are made aware and have an understanding of the procedures in place to identify, report, assess, monitor and reduce or mitigate risk as far as possible.

The Trust's approach to risk management is pro-active and does not differentiate the processes applied to clinical and non-clinical issues. Common systems for the reporting, identification, assessment, evaluation and monitoring of risk have been developed within the Trust and apply to all risk issues, regardless of type. The risk management approach involves:

- Identifying sources of potential risk and proactively assessing risk situations, and mitigating those risks as far as possible
- Identifying risk issues through the reporting of serious untoward incidents, adverse incidents, near misses, complaints and claims, and internal and external review reports
- Investigating and analysing the root causes of incidents
- Undertaking aggregated root cause analysis (RCA) which includes consideration of incidents, complaints, claims and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) data
- Taking action to eliminate or minimise harmful risks
- Monitoring the delivery and effectiveness of actions taken to control risk;
- Learning from near misses, risk events, legal claims and complaints and sharing the lessons learned across the organisation
- Continuation of a 'Learning from Incidents' Panel, which is chaired by the Medical Director and the Director of Nursing and Quality, which provides a positive challenge on root causation, learning and helps to identify notable practice. Learning is shared following each panel meeting via the Chief Executive weekly briefing and cascaded through respective divisions through their local governance and risk groups

Effective implementation of the strategy facilitates the delivery of a quality service and, alongside staff training and support, provides an improved awareness of the measures needed to prevent, control and contain risk. To achieve this, the Trust:

- Ensures all staff and stakeholders have access to a copy of the Risk Management Framework
- Produces a register of risks across the Trust which is subject to regular review at Divisional level, by the Senior Management Team, Safety Group, Risk and Audit Committee and the Board
- Communicates to staff any action to be taken in respect of risk issues;
- Has developed policies, procedures and guidelines based on the results of assessments and identified risks
- Ensures that training programmes raise and sustain awareness throughout the Trust of the importance of individual responsibility in identifying and managing risk
- Ensures that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with the strategy
- Monitors and reviews the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk

The Trust has well developed business continuity plans in place and established an incident management centre in order to respond to the COVID-19 crisis. Whilst some supply chain difficulties were experienced in the initial phases of the pandemic, the Trust has had sufficient protective and other essential equipment and retained capacity to deal with cases, swabbing and vaccination requirements throughout.

The Board and Risk and Audit Committee review the Corporate Risk Register and the Board Assurance Framework every two months.

Risk training forms part of the Trust Induction programme for clinical and non-clinical staff. Risk training is also included in preceptorship and junior doctor training. Specific training in Root Cause Analysis, statement writing and investigations is provided on a bi-monthly basis by the Risk Management team.

The Risk and Control Framework
The Trust acknowledges that effective risk management is a key enabler to ensuring continuous improvement in the quality of care delivered and that all members of staff have an important role to play in identifying, assessing and managing risk. This is achieved, through proactive risk assessment, or reactively, through review of risk events, complaints and legal claims. To support staff in this role, the Trust provides a fair, consistent environment that encourages a culture of openness and willingness to admit mistakes. All staff are encouraged to report when things have, or could have, gone wrong. At the heart of the Trust's Risk Management Framework is the desire to learn from incidents and near misses, complaints and claims, in order to continuously improve management processes and clinical practice.

The Trust has in place clear policies and systems for identifying, evaluating and monitoring risk. These include:

- The Risk Framework
- Trust policies and procedures
- Service, Divisional and Corporate Risk Registers that contain both clinical and non-clinical risks together with the Board Assurance Framework
- Designated appointments to support the Board and staff in the management of risk including the Executive Nurse, Head of Risk and Quality Assurance, Health and Safety Manager, Emergency Planning lead and identified Divisional leads

Trust-wide risk profiling is an on-going process and managers are required to ensure that risk assessment and audit is undertaken within their areas of responsibility is recorded within the Trust's incident and risk assessment system and that findings are acted upon and adequately monitored. Audit of the centralised system ensures that managers review assessments as required.

The Trust's Risk Event Reporting Policy requires staff to report all adverse incidents, both actual and potential (near misses), and sets out the methodology and responsibilities for assessing and evaluating the risks. The impact of a risk will dictate at which level of the organisation the risk event is investigated and reported, with the lowest category (green) being managed at a local level and the highest (red) managed at executive level with reports made to the Board and statutory external agencies.

The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, with the constraints of the regulatory environment.

Risk appetite can be defined as the amount of risk an organisation is prepared to accept in pursuit of its strategic objectives and defines the level of risk an organisation is prepared to tolerate or be exposed to at any point in time. Outlining the strategic risk appetite provides

clear leadership direction about the level of acceptable risk and assists in the identification further mitigating actions.

The Trust has reviewed its appetite for risk in year; reaffirming its position across the following seven areas of operation:

- Quality and safety
- Compliance and regulation
- Innovation and transformation
- Finance
- Commercial
- Reputation and
- Workforce

Inclusion of the risk appetite in Board and Committee cover sheets has raised the profile and awareness of the Trusts appetite amongst senior managers and decision makers.

Quality
The Chief Nursing Officer is the executive lead for quality and safety governance, supported by the Medical Director and the Chief Operating Officer.

During what has been an exceptional year in which reporting of contractual performance indicators were suspended due to the pandemic, the Trust has maintained oversight of key quality performance and activity metrics, benchmarking these with regional and national partners. The Trust has been assured that it has provided consistently good performance in respect to urgent and emergency care and cancer services standards.

The CQC suspended all onsite inspections during the COVID-19 Pandemic. Quarterly engagement meetings continued with our Local and Regional Inspectors via virtual meetings. Monthly virtual catch up meetings have also taken place with the DCH Quality Assurance Manager and the CQC local inspector. There are no current issues or risks raised with the Trust.

The CQC has continued to virtually attend the ICS Quality Surveillance Group to provide further scrutiny on quality in the Trust, with wider regulation and non-regulatory partners. Throughout the year the Trust has maintained under ‘routine surveillance’, meaning no concerns raised for escalated scrutiny.

A transitional regulatory approach has been introduced and this has taken place for specific services with a broad mix of specialty leads in attendance.

Consultations on the CQC Strategy and regulatory processes have been undertaken nationally and the results of these consultations will steer the direction that inspections take and how ratings will be applied going forward.

The Trust continues to self-assess itself and continues to strive to provide outstanding quality care.

The Quality Committee has continued to scrutinise quality governance arrangements and performance in the Trust and provide assurance to the Board. The Chief Nursing Officer and the Medical Director are Executive leads at the Quality Committee which continued to meet on a monthly basis and received key reports in support of effective infection prevention and control practices and staff and public safety.

Additionally, the Finance and Performance Committee also met on a monthly basis and the Chief Finance Officer and the Chief Operating Officer are the Executive leads. The focus of business during the pandemic remained on delivery of urgent care, diagnostic and cancer services and in ensuring that essential changes to the Trust's estate, required as a result of the pandemic and national guidance requirements, were completed in line with the Trust's Standing Financial Instructions.

The role of the Workforce Committee was reviewed in year and recognised the need for a greater focus on people and culture. The role of Chief People Officer was advertised with appointment commencing in the new financial year 2021/22. Staff wellbeing and support has been a key focus of the committee during the pandemic ensuring that staff have access to ongoing support and wellbeing services and facilities.

The Risk and Audit Committee has maintained oversight of the Trust's system of internal control and the Non-Executive Chair is supported by the Chief Finance Officer who is the identified Executive lead. Delivery of the Internal Audit Programme has been acknowledged as difficult during the year although a number of audits continued to be undertaken; providing assurances on areas of key risk identified within the programme.

Key Risks
The following risks are recorded within the Board Assurance Framework against the respective strategic objectives of the Trust and are risk rated 16 or above:

1. Delivering Outstanding Services Everyday - Not having the appropriate workforce in place to deliver our patient needs;

2. Delivering Outstanding Services Everyday - Not achieving national and constitutional performance and access standards;

3. Joining up our services - Emergency Department admissions continuing to increase per 100,000 population;

4. Joining up our services - Not achieving an integrated community health care hub based on the DCH site;

5. Sustainable, productive, effective and efficient - Failure to secure sufficient funding to ensure financial sustainability;

6. Sustainable, productive, effective and efficient - Not returning to financial sustainability, with an operating surplus of 1% and self-sufficient in terms of cash.

The Trust is able to assure itself of the validity of its Corporate Governance statement; (NHS Foundation Trust Licence Condition 4 requirement) through the following mechanisms that have been deployed during 2020/21:

- The Board has maintained a strong emphasis on quality and safety in its meeting agendas to ensure that these remain the focus of decision making and planning
- The Board has an executive lead for quality and clear accountability structures are in place for a quality agenda that is integrated into all aspects of the organisation's work
- The Board has continued to undertake visits to wards to meet with staff and gain feedback on an intermittent basis where pandemic circumstances have allowed. Whilst Governors have not participated in these visits this year, they have continued to observe Board and committee meetings where feedback has been shared
- The Board has continued to deliver optimal elective, diagnostic and cancer care to patients as the pandemic has allowed

- The Board has maintained appropriate oversight of regulatory and compliance regimes through robust incident management arrangements in line with regional and national guidance and support

All staff within the Trust graded at Band 8a or above are required to declare any interests in line with national guidance, on an annual basis. The Register of Interests is reviewed by the Risk and Audit Committee and published on the Trust website. The Trust has implemented an automated process in year to seek appropriate declarations using the Electronic Staff Record.

The Trust involves its stakeholders in managing risk in the following ways:

- Regular reporting to the Council of Governors on quality, finance and performance, with an emphasis on the reporting of risks, current concerns and complaints
- Governors attendance by videoconference at key meetings including the Board of Directors, Quality Committee, Risk and Audit Committee, People and Culture Committee and Finance and Performance Committee; and stakeholder attendance at Patient Experience Group which reports to the Quality Committee
- Regular meetings with the Trust's principle commissioners and the Regional Office to benchmark quality performance against and risks relating to service delivery during the pandemic
- Consulting with its membership on key strategic direction decisions as part of the planned refresh of the Trust's strategy and progression of the Integrated Care System
- Joint working with local and regional healthcare providers to shape optimum care pathways and mitigate risks and with other system partners in the development of the Integrated Care System approach
- Membership and wider patient and public engagement strategies.

Workforce
As an employer of staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Delivery of the Workforce Race Equality Scheme plan for the Trust is monitored by the People and Culture Committee and escalated to the Board. Reporting requirements have been satisfied in respect of the Workforce Race Equality Standard, Workforce Disability Equality Standard and the Gender Pay Gap reporting.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff *(as defined by the Trust with reference to the guidance)* within the past twelve months as required by the *Managing Conflicts of Interest in the NHS guidance*. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme

records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with and has refreshed its Climate Change Adaption Plan 2020-25 in year.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income, expenditure and capital investments. The plan incorporates the Trust's plan for improving productivity and efficiency in order to minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. Financial plans are approved by the Board, having been previously assessed by the Finance and Performance Committee.

Trust plans for 2020/21 were overtaken by the pandemic and the introduction of a national funding regime in response to the crisis.

The Board and its committees received detailed reports covering finance, activity, capacity, workforce management, risk and performance.

The Board is provided with assurance on the use of resources through a regular performance, activity and expenditure reports. The Finance and Performance Committee also undertakes a detailed review on a monthly basis. External auditors review the use of resources each year as part of the annual audit programme. Internal audit resources are directed to areas where risk is attached or where issues have been identified although the programme of planned work in year has been somewhat impacted by the pandemic. Any concerns on the economy, efficiency and effectiveness of the use of resources are well monitored and addressed in a timely and appropriate manner.

Information Governance

The Trust operates under the guidelines and legislation which govern Information Governance within the NHS and have embedded the processes necessary to meet the standards required. Our Information Risk Management Policy and Risk Management structure is owned by the Trust's Senior Information Risk Owner and reviewed via the Information Governance Group, alongside Information Asset Assurance Reports from the Trust's Information Asset Owners and a rolling overview of all Information Security and Information Governance incidents at each bi-monthly meeting. The Trust's Information Risk Policy is aligned with the Trust's Information Security Policy, which details the security arrangements, is in place for systems and devices.

The Trust reported no serious incidents during the 2020/21 to the Office of the Information Commissioner and NHS Digital. The Risk and Audit Committee maintains oversight Information Governance.

Data Quality and Governance

Governance and Leadership

The Board is actively engaged in quality improvement and is assured that quality governance is subject to rigorous challenge through Non-Executive Director engagement and Chairmanship of the key board Committees. The Board membership includes the Executive role of Chief Information Officer and the Chief Finance Officer is the accountable Senior Information and Reporting Officer. The Trust appointed to the Information Governance Manager / Data Protection Officer post in year in order to lead the operational delivery of the Data Security and Protection Toolkit and other regulatory requirements across the Trust.

The role of policies and plans in ensuring quality data

The revised Information Strategy recognises data quality as one of the five core elements of the Information Maturity Model. As the Trust becomes increasingly paper light, information plays an integral part of the processes to deliver effective and timely healthcare across the organisation. Therefore, excellent data quality is pivotal in order to ensure that the data from different systems can be seamlessly joined together and provided to healthcare professionals in a timely, secure and accurate manner.

Systems and Processes

Specific actions have been taken to strengthen the existing processes around data quality over the last few months, building on the data quality processes and procedures that have been in place for some time the Trust. Current processes and procedures as well as recent initiatives to improve data quality include the following:

- **Information Assurance:** The Data Quality Management Group has provided a robust mechanism to monitor and control data quality measures for the clinical Information Systems. This group has been re-formed into an Information Assurance Group that will extend data quality assurance to cover all aspects of data quality within the Trust including the data items reported on the Trust dashboards. In addition a new Information Assurance Manager post has been created as part of the clinical systems restructure. This post will report to the Information Assurance Group and will work with divisional and change management teams to educate, reinforce and monitor data quality and information management processes across the Trust for all patient based applications.

- **Governance.** Governance improvements around the Information Assurance Group have been made in order to allow other Groups such as the Clinical Coding Task and Finish Group and the Digital Portfolio Group to escalate all data quality issues to Information Assurance Group. Finally, bi- monthly highlight reports to Digital Portfolio Group will provide appropriate visibility on any major data quality issues.

- **Information Dashboards.** The performance dashboards have been reviewed frequently and appropriate improvements have been implemented.

- **Ownership.** Improving ownership of data quality issues is a long term objective of the Information Strategy. The Information Assurance Group with its new governance structure ensures ownership and responsibilities are agreed and supported at

executive level and cascaded through divisional directors and managers who hold staff accountable. The two Divisional Information Analysts will be expected to work closely with the senior divisional management and clinical teams to identify and resolve any data quality issues that might arise.

- **Regular audit and external assurance**. Audits and in-depth analysis of data quality are conducted in a number of areas, including: mortality; specialist clinical coding areas (on a regular, randomly selected basis as per national best practice recommendations); in additional to departmental clinical audits. Key issues will be discussed at the Information Assurance Group to ensure a culture of continuous improvement on data quality. We have undertaken an interim review on our ISO27001 accreditation and retained the high standard for the Digital department. The Trust is continuing to migrate email services to ensure that they remain secure with a programme of work to deliver secure email accreditation due for completion by the end of the financial year.

- **Information Systems**. As more information is captured in our information systems and business processes change accordingly, it is important to understand the data quality implications from any systems change. The Information Assurance Group has been working closely with the system managers and the key business users to address any data quality issues. Of particular note has been the DCH contribution to the Dorset Care Record in sharing core clinical information with health and social care partners in Dorset. We now have greater visibility to data quality reporting across partner organisations which has shown good performance for DCH particularly with regard to accuracy of NHS numbers which is the key patient identifier in bringing records together from different care settings across Dorset. Where data quality issues are identified they are rectified quickly with feedback to users of source systems to reinforce importance of accuracy and completeness in recording of patient data.

Quality Account
Production of a Quality Report 2020/21 will not be subject to external audit due to the COVID-19 pandemic and there is no requirement for this report to be submitted with the Annual Report and Accounts for 2020/21.

Review of Effectiveness
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Risk and Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust continually seeks to improve the effectiveness of its systems of internal control and put action plans in place to meet any identified shortfalls. A review of committee effectiveness was undertaken in March 2021 and identified that Board oversight of strategic risk mitigation would be strengthened via review of the Board Assurance Framework by Board committees in addition to those undertaken by the Risk and Audit Committee. Trust Board meetings are open to members of the public and Board Committees are attended by nominated governor observers. The Board reporting cycle ensures that the Board receives regular reports from its Committees, operational reports from Executives, the Assurance Framework and Risk Register bimonthly and planned reports on business and other operational issues. The introduction of an Escalation Report from Board committees to board immediately following each meeting, has ensured timely escalation of risks and issues for the Board's attention.

The governance structure is as follows:

The Board: The powers reserved to the Board are, broadly, regulation and control; strategy; business plans and budgets; risk management; financial performance and reporting and audit arrangements.

Risk and Audit Committee: Provides assurance to the Board as to the effectiveness of the Trust's systems of governance and control across the full range of the Trust's responsibilities. It reviews the establishment and maintenance of an effective system of integrated governance, risk management, finance, counter fraud, security management, and internal control across the whole of the organisation's activities, both clinical and non-clinical. The committee utilises the assurance framework, risk register, internal and external audit reports, the work of the Quality Committee and the ability to question the Chief Executive regarding the Annual Governance Statement to support its work.

Finance and Performance Committee: provides assurance to the Board and does not remove the requirement for the Board to monitor financial and operational performance. The Committee provides scrutiny and makes recommendations to the Board to assist in decision making. Specific areas scrutinised by the Finance and Performance Committee include financial planning, operational performance, business case assessments and the delivery of efficiency and cost improvement programmes. The Finance and Performance Committee is able to approve business cases within delegated limits.

Quality Committee: provides assurance that the Trust has an effective framework within which it can work to improve and assure the quality and safety of services it provides in a timely, cost effective way. The committee assesses, reviews and monitors performance, including safer staffing and mortality data which is then published on the Trust's website, internal control, external validation and assessment, the annual quality report and plans and national guidance and policy.

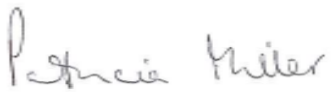
People and Culture Committee: The purpose of the committee is to be responsible for the consideration of matters relating to workforce planning and development, efficiency, human resources policy and the Trust's People Strategy. It also has responsibility for leadership development and talent management; recruitment and retention; education and training; people policies, processes and systems; diversity and inclusion and health and wellbeing. The committee ensures that workforce strategies and staffing systems are in place that assure the Board that staffing processes are safe, sustainable and effective.

The Committee acts as a means of internal assurance for compliance against the Care Quality Commission's fundamental standards of quality and safety and safe, caring, effective and well-led domains.

My view is further informed by:

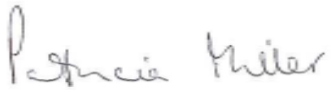
- Opinions and reports by Internal Audit, who work to a risk based annual plan. The Head of Internal Audit Opinion for 2020/21 was as follows: “Overall, we are able to provide **moderate** assurance that there is a sound system of internal control, designed to meet the Trust’s objectives and that controls are being applied consistently”.
- Opinion and reports from the Trust’s External Auditors
- Monthly reports to NHS Improvement
- Full compliance with the Care Quality Commission essential standard for quality and safety for all regulated activities across all locations
- Results of patient and staff surveys
- Investigation reports and action plans following serious incidents
- Council of Governors feedback
- Clinical audit reports
- Trust evaluations and responses to national peer review findings and reports

Conclusion
No significant internal control issues have been identified for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.



Patricia Miller
Chief Executive Officer
4 June 2021

The Accountability Report was approved by the Board of Directors on 26 May 2021 and signed on its behalf by



Patricia Miller
Chief Executive Officer
4 June 2021

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Dorset Country Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2021 and of the Group's and Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Group's and Trust's business model and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group and Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Risk and Audit Committee and internal audit and inspection of policy documentation as to the Group and Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Risk and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Group and Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account the current financial regime, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected account pairings, unexpected posters and seldom used accounts.
- Evaluating the business purpose of significant unusual transactions.
- Assessing significant estimates for bias.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify revenue had been recognised in the correct accounting period.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Group's and Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Group and Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Group and Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Group and Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 80, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve

the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

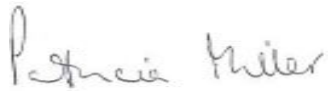
Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

4 June 2021

Foreword to the Accounts

These accounts for the year ended 31st March 2021 have been prepared by Dorset County Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and comply with the annual reporting guidance for NHS Foundation Trusts within the Department of Health and Social Care Group Accounting Manual 2020/21.

Dorset County Hospital NHS Foundation Trust's Annual Report and Accounts are presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006.



Patricia Miller
Chief Executive
4 June 2021

Statement of Comprehensive Income for the year ended 31st March 2021

		Group		Trust	
		2020/21	2019/20	**2020/21**	2019/20
	Note	**£000**	£000	**£000**	£000
Operating income from patient care activities	3	195,054	181,499	195,054	181,499
Other operating income	4	39,454	27,844	39,549	27,936
Operating expenses	5	(231,915)	(207,030)	(232,132)	(207,233)
Operating surplus/(deficit)		**2,593**	**2,313**	**2,471**	**2,202**
Finance costs:					
Finance income	10	-	114	-	113
Finance expenses	11	(223)	(168)	(224)	(168)
PDC dividends charge		(1,919)	(1,983)	(1,919)	(1,983)
Net finance costs		**(2,142)**	**(2,037)**	**(2,143)**	**(2,038)**
Losses on disposal of assets	12	(41)	(50)	(41)	(50)
Corporation tax expense		(23)	(21)	-	-
Surplus/(Deficit) for the year		**387**	**205**	**287**	**114**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairment of property, plant and equipment		-	-	-	-
Revaluation gains on property, plant & equipment		-	-	-	-
Total comprehensive income/(expense) for the year		**387**	**205**	**287**	**114**

The notes on pages 102 to 138 form part of these accounts.

Statement of Financial Position as at 31st March 2021

		Group		Trust	
		31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	14	8,424	5,455	8,424	5,455
Property, plant and equipment	15.4	101,717	90,102	101,713	90,097
Trade and other receivables	18.1	908	817	908	817
Total non-current assets		**111,049**	**96,374**	**111,045**	**96,369**
Current assets					
Inventories	17	2,610	2,992	2,456	2,783
Trade and other receivables	18.1	6,177	10,714	6,073	10,631
Cash and cash equivalents	19	17,698	7,335	17,648	7,310
Total current assets		**26,485**	**21,041**	**26,177**	**20,724**
Current liabilities					
Trade and other payables	20	(29,512)	(25,461)	(29,477)	(25,316)
Borrowings	21	(190)	(262)	(190)	(262)
Provisions	22	(50)	(50)	(50)	(50)
Other liabilities	23	(2,065)	(1,802)	(2,065)	(1,802)
Total current liabilities		**(31,817)**	**(27,575)**	**(31,782)**	**(27,430)**
Total assets less current liabilities		**105,717**	**89,840**	**105,440**	**89,663**
Non-current liabilities					
Borrowings	21	(7,022)	(7,095)	(7,022)	(7,095)
Provisions	22	(792)	(730)	(792)	(730)
Total non-current liabilities		**(7,814)**	**(7,825)**	**(7,814)**	**(7,825)**
Total assets employed		**97,903**	**82,015**	**97,626**	**81,838**
Financed by taxpayers' equity:					
Public dividend capital		103,283	87,782	103,283	87,782
Revaluation reserve		25,982	25,983	25,982	25,983
Income and expenditure reserve		(31,362)	(31,750)	(31,639)	(31,927)
Total taxpayers' equity:		**97,903**	**82,015**	**97,626**	**81,838**

The financial statements on pages 98 to 138 were approved by the Board on 26 May 2021 and signed on its behalf by:

Patricia Miller
Chief Executive
4 June 2021

Statement of Changes in Taxpayers' Equity

Group	**Total**	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2020	**82,015**	**87,782**	**25,983**	**(31,750)**
Surplus for the year	**387**	-	-	387
Transfers between reserves	**-**	-	(1)	1
Public Dividend Capital	**15,501**	15,501	-	-
Taxpayers' equity at 31 March 2021	**97,903**	**103,283**	**25,982**	**(31,362)**
Taxpayers' equity at 1 April 2019	**80,082**	86,054	25,984	(31,956)
Surplus for the year	**205**	-	-	205
Transfers between reserves	**-**	-	(1)	1
Public Dividend Capital	**1,728**	1,728	-	-
Taxpayers' equity at 31 March 2020	**82,015**	**87,782**	**25,983**	**(31,750)**

Trust	**Total**	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2020	**81,838**	**87,782**	**25,983**	**(31,927)**
Surplus for the year	**287**	-	-	287
Transfers between reserves	**-**	-	(1)	1
Public Dividend Capital	**15,501**	15,501	-	-
Taxpayers' equity at 31 March 2021	**97,626**	**103,283**	**25,982**	**(31,639)**
Taxpayers' equity at 1 April 2019	**79,996**	86,054	25,984	(32,042)
Surplus for the year	**114**	-	-	114
Transfers between reserves	**-**	-	(1)	1
Public Dividend Capital	**1,728**	1,728	-	-
Taxpayers' equity at 31 March 2020	**81,838**	**87,782**	**25,983**	**(31,927)**

The Revaluation Reserve consists of £25,982k (£25,983k at 31 March 2020) relating to property, plant and equipment.

Statement of Cash Flows for the year ended 31st March 2021

	Group		Trust	
	2020/21	2019/20	**2020/21**	2019/20
	£000	£000	**£000**	£000
Cash flows from operating activities				
Operating surplus/(deficit)	2,593	2,313	2,471	2,202
Depreciation and amortisation	5,917	5,280	5,915	5,279
Income recognised in respect of capital donations (cash and non-cash)	(653)	(206)	(653)	(206)
Decrease/(Increase) in trade and other receivables	4,459	(2,395)	4,480	(2,353)
Decrease in inventories	382	36	327	70
(Decrease)Increase in trade and other payables	(16)	5,143	95	5,224
Increase in other liabilities	263	111	263	111
Increase in provisions	64	492	64	492
Corporation tax paid	(22)	(19)	-	-
Net cash generated from operations	**12,987**	**10,755**	**12,962**	**10,819**
Cash flows from investing activities				
Interest received	4	116	4	115
Purchase of intangible assets	(1,756)	(824)	(1,756)	(824)
Purchase of property, plant and equipment	(14,111)	(6,116)	(14,111)	(6,116)
Sales of property, plant and equipment	31	10	31	10
Receipt of cash donations to purchase capital assets	100	201	100	201
Net cash used in investing activities	**(15,732)**	**(6,613)**	**(15,732)**	**(6,614)**
Cash flows from financing activities				
Public dividend capital received	15,501	1,728	15,501	1,728
Capital element of finance lease obligations	(199)	(119)	(199)	(119)
Interest Paid	(97)	(98)	(97)	(98)
Interest element of finance lease obligations	(161)	(59)	(161)	(59)
PDC dividends paid	(1,936)	(1,795)	(1,936)	(1,795)
Net cash used in financing activities	**13,108**	**(343)**	**13,108**	**(343)**
Increase in cash and cash equivalents	**10,363**	**3,799**	**10,338**	**3,862**
Cash and cash equivalents at 1 April	7,335	3,536	7,310	3,448
Cash and cash equivalents at 31 March	**17,698**	**7,335**	**17,648**	**7,310**

Notes to the Financial Statements

1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2020/21 issued by the DHSC. The accounting policies contained in the DHSC GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be the most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below.

The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Critical accounting judgements and key sources of estimation uncertainty

In the preparation of the financial statements, the Trust is required to make estimates and assumptions that affect the application of accounting policies and the carrying amounts of assets and liabilities. These estimates and assumptions are based on historical experience and other factors that are considered to be relevant. Actual outcomes may differ from prior estimates and the estimates and underlying assumptions are continually reviewed.

The key sources of estimation uncertainty which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities are:

Valuation of land and buildings

Land and buildings are included in the Trust's Statement of Financial Position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology and market value for existing use for non-specialised buildings.

The Trust has assessed the change in Building Cost Information Service (BCIS) indices, from the last full land and buildings valuation undertaken by Avison Young (external valuers) as at 31 March 2019 as set out in accounting policy note 1.6.2. It is not deemed to be significant and the Trust has not obtained an external valuation in 2020/21.

A 5% change in the valuation would have £3.7 million impact on the Statement of Financial Position with a £0.06 million impact on the PDC dividend due to be paid next year and accrued in these financial statements.

Of the £74.9 million net book value of land and buildings subject to valuation, £69.2 million relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient information to indicate what the impact of this will be.

Depreciation of property, plant and equipment and amortisation of computer software
The Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

1.2 Consolidation

1.2.1 Subsidiaries
Entities over which the Trust has power to exercise control are classified as subsidiaries. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves of the subsidiary are included as a separate item in the Statement of Financial Position.

Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust (including where they report under UK FRS 102) or where the subsidiary's accounting date is not coterminous. The amounts consolidated are drawn from the financial statements of DCH SubCo Ltd. Intra-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust wholly owns DCH SubCo Ltd which forms part of the consolidated accounts. DCH SubCo Ltd provides outpatient pharmacy services. Its turnover for the year ended 31st March 2021 was £5.3 million and its gross assets at 31 March 2021 totalled £0.6 million.

The Trust has established that, as it is the corporate trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund, it effectively has the power to exercise control of this charity so as to obtain economic benefits. However the assets, liabilities and transactions are immaterial in the context of the Trust and therefore it has not been consolidated. Details of balances and transactions between the Trust and the charity are included in the related parties' notes.

1.2.2 Joint Ventures
Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

The Trust has one joint venture DCH Estates Partnership LLP OC418519, which is a commercial partnership with Partnering Solutions (Dorset) Ltd (Interserve Prime) creating a Strategic Estates Partnership. No assets or transactions have taken place during 2020/21.

1.3 Income
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2 Pension costs

Payments to defined contribution pension schemes (including defined benefit schemes that are accounted for as if they were a defined contribution scheme) are recognised as an expense as they fall due.

NHS Pension Scheme: Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs are charged to operating expenses at the time the Trust commits itself to the retirement regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

The Foundation Trust does not have any employees that are members of the Local Government Superannuation Scheme and therefore, does not pay employer contributions into this scheme.

1.4.3 Termination Benefits

Staff termination benefits are provided for in full when there is a detailed formal termination plan and there is no realistic possibility of withdrawal by either party.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except when it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually it cost at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;
- the assets are functionally interdependent, with broadly simultaneous purchase dates, which are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building includes a number of components with significantly different asset lives, e.g. hospital wings, then these components are treated as separate assets and depreciated over their own useful economic lives (UEL).

The component parts of each significant Trust building are depreciated as a group, as permitted by IAS 16, unless a component has a significantly different UEL and is deemed by the Trust to be significant, in which case it is depreciated separately over its own economic useful life.

1.6.2 Measurement

Valuation: All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Non-specialised buildings – market value for existing use
- land and specialised buildings – Modern equivalent asset value

All land and buildings are revalued using professional valuations in accordance with accounting standard IAS 16 Property, Plant and Equipment every five years. A three year interim valuation is also carried out. Additional valuations are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period.

Professional valuations are carried out by the Trust's external valuer (Avison Young). The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Until 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. Indexation ceased from 1st April 2008. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment, which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

The last full valuation survey was assessed by the valuer of Avison Young at 31st March 2019.

Revaluation gains and losses: Revaluation gains are recognised in the revaluation reserve, except where; and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned; and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments: In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits, or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) impairment charged to operating expenses; (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment that arises from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

1.6.3 Subsequent expenditure Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that the future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred

1.7 Intangible assets

1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; and where the cost of the asset can be measured reliably.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Expenditure on development is capitalised only where all of the following have been demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset is identified;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 Investment Properties or IFRS 5 Assets Held for Sale.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

1.8 Depreciation and amortisation

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction are not depreciated until brought into use.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

The following table details the useful economic lives currently used for the main classes of assets:

Asset class	Min Life Years	Max Life Years
Buildings exc. dwellings	10	66
Dwellings	44	79
Plant & machinery	3	15
Information technology	3	15
Furniture & fittings	5	15
Intangible assets	3	19

Property, plant and equipment which have been re-classified as 'held for sale' cease to be depreciated upon the re-classification.

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.9 Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the COVID-19 pandemic. As defined in the DHSC GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

1.10 De-recognition

Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.11.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.11.3 Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the 'first-in first-out' formula. These are considered to be a reasonable approximation to fair value due to the high turnover of stocks.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the DHSC GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.14 Provisions

The Trust recognises a provision where is has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of that amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 0.7% in real terms, except for post-employment benefits provisions which use the HM Treasury's pension discount rate of -0.95% in real terms.

1.15 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 22.2 but is not recognised in the Trust's accounts.

1.16 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of any claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, these are disclosed where an inflow of economic benefits is probable. The Trust currently has no contingent assets to disclose.

Contingent liabilities are not recognised, but are disclosed in note 25 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

Where additional assets are purchased relating to the COVID-19 pandemic, the value of these assets will be excluded from average relevant net assets for PDC Dividend calculations, in the same manner as donated and grant funded assets. Such assets will therefore not attract a PDC dividend charge.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS)

and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) approved expenditure on COVID-19 capital assets, (iv) assets under construction for nationally directed schemes and (v) any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing net relevant assets.

In accordance with the requirement laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Financial instruments and financial liabilities

1.19.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The DHSC GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

1.19.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets/liabilities are classified as subsequently measured at amortised cost.

1.19.3 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

1.19.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.19.5 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.20 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation Tax

Section 148 of the Finance Act in 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trusts activities are related to core healthcare and are not subject to tax.

Private patient activities are covered by section 14(1) of the Health and Social Care (Community Health and Standards) Act 2003 and not treated as a commercial activity and are therefore tax exempt; and
Other trading activities (including car parking and staff canteens) are ancillary to the core activities and are not deemed to be entrepreneurial in nature.

However, the Trust's commercial subsidiary is subject to corporation tax, and this has been included in the group accounts.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of transaction.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However they are disclosed in Note 29 to the accounts in accordance with the requirements of the HM Treasury's Financial Reporting Manual.

1.24 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following standards and interpretations to be applied in 2020/21. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23:

IFRS 14 Regulatory Deferral Account – Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC Bodies.

IFRS 16 Leases – Standard is effective at 1 April 2022 as per the FReM but HM Treasury have revised the implementation date to 1 April 2022.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, Standard is not yet adopted but the FReM which is expected to be from 2023: early adoption is not therefore permitted

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations, which is in line with guidance contained in the DHSC GAM 2020/21.

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the Statement of Financial Position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the Statement of Financial Position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying assets value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and the adoption of the standard. The related right of use asset will be measured equal to liability adjusted for any prepaid or accrued lease payments.

For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected impact of applying the standard in 2022/23 is currently impracticable. However the Trust does expect this standard to have a material impact on non-current assets, liabilities and deprecation.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with general payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.26 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.27 Going concern

International Accounting Standard 1 requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust recorded an operating surplus of £0.4 million for the year ended 31 March 2021, with a cash balance of £17.7 million. The Trust has operated throughout the entire 2020/21 year under a fixed income financial regime. It was been confirmed that this arrangement will operate until at least 30th September 2021. The Trust is awaiting further guidance on planning for the remainder of the financial year, however, the current cash position, future funding and potential borrowing is expected to be sufficient to cover cash requirements for the remainder of the going concern period.

It is also noted that the cash regime within the NHS for new financial revenue support will be in the form of non-repayable Public Dividend Capital, rather than interest bearing loans. Therefore, should the Trust be in need of cash support it will not be in the form of repayable debt.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the going concern period, being 12 months from the date of signing this Annual Report. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

2. Segment analysis

The Trust has considered the requirements in IFRS 8 for segmental analysis. Having reviewed the operating segments reported internally to the Board, the Trust is satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- The nature of the products and services;
- The nature of the production processes;
- The type of customer for their products and services;
- The methods used to distribute their products or provide their services; and
- The nature of the regulatory environment.

The Trust therefore has just one segment, “healthcare”. Analysis of income by different activity types and sources is provided in note 3.

3. Income from patient care activities

Analysis by activity	**Group**		**Trust**	
	Year ended 31 March 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000
Block contract/system envelope income	168,913	157,365	168,913	157,365
High costs drugs income from commissioners	15,213	13,957	15,213	13,957
Other NHS clinical income	4,167	2,652	4,167	2,652
Private patient income	617	819	617	819
Additional pension contribution central funding*	5,765	5,258	5,765	5,258
Other clinical income	379	1,448	379	1,448
Total	**195,054**	181,499	**195,054**	181,499
Income from Commissioner Requested Services	194,058	180,228	194,058	180,228
Income from non-Commissioner Requested Services	996	1,271	996	1,271
Total	**195,054**	181,499	**195,054**	181,499

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2020/21, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Commissioner-requested services are services which local commissioners believe should continue to be provided locally if any individual provider is at risk of failing financially. Any organisation providing a commissioner-requested service has to continue offering the service unless it can obtain agreement from NHS Improvement and the commissioners to stop. It cannot dispose of relevant assets used to provide the service without NHS Improvement consent and it must pay into a risk pool that will fund services in the event of financial failure.

Analysis by source	Group		Trust	
	Year ended	Year ended	**Year ended**	Year ended
	31 March	31 March	**31 March**	31 March
	2021	2020	**2021**	2020
	£000	£000	**£000**	£000
NHS - Foundation Trusts	2,063	2,544	2,063	2,544
NHS - Trusts	1	5	1	5
NHS - NHS England	40,503	37,432	40,503	37,432
NHS - CCGs	151,445	140,155	151,445	140,155
Local Authorities	19	40	19	40
NHS - Other	27	53	27	53
Non NHS - Private patients	617	819	617	819
Non NHS - Overseas patients	22	37	22	37
NHS Injury Scheme	292	366	292	366
Non NHS - Other	65	48	65	48
Total	**195,054**	181,499	**195,054**	181,499

NHS Injury Scheme income relating to the 2020/21 financial year is subject to a provision for doubtful debts of 22.43% (2019/20: 21.79%) to reflect expected rates of collection.

The Group and Trust overseas patient income for the year amounted to £22k (2019/20 £37k). Cash received amounted to £12k (2019/20 £35k) in respect of current and previous years' income. The amounts written off in respect of current and prior years amounted to £nil (2019/20 £nil).

4. Other operating income

	Note	Group Year ended 31 March 2021 £000	Group Year ended 31 March 2020 £000	Trust Year ended 31 March 2021 £000	Trust Year ended 31 March 2020 £000
Research and development		673	712	673	712
Education and training		8,853	6,728	8,853	6,728
Education and training - notional income from apprenticeship fund		363	258	363	258
Received from NHS Charities: Physical assets		-	5	-	5
Received from NHS Charities: Cash donations		100	201	100	201
Received from NHS Charities: Contributions to expenditure		47	16	47	16
Donated equipment from DHSC for COVID response (non-cash)		553	-	553	-
Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold		59	-	59	-
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response		3,269	-	3,269	-
Non-patient care services to other bodies		7,859	7,819	7,946	7,903
Reimbursement and top up funding		15,910	-	15,910	-
Provider sustainability fund/Financial recovery fund/Marginal rate emergency tariff funding		-	9,256	-	9,256
Staff recharges		470	499	478	499
Rental revenue from operating leases	6.2	53	87	53	94
Car parking		124	725	124	725
Catering		366	571	366	571
Pharmacy sales		38	41	38	42
Staff accommodation rentals		402	375	402	375
Estates recharges		40	44	40	44
IT recharges		4	7	4	7
Clinical excellence awards		44	107	44	107
Other income generation schemes		36	42	36	42
Other income		191	351	191	351
Total		**39,454**	27,844	**39,549**	27,936

5. Operating expenses

	Note	Group Year ended 31 March 2021 £000	Group Year ended 31 March 2020 £000	Trust Year ended 31 March 2021 £000	Trust Year ended 31 March 2020 £000
Employee expenses	7.1	154,859	135,449	154,794	135,384
Employee expenses - Non-executive directors		127	122	127	122
Purchase of healthcare from NHS and DHSC bodies		7,042	8,131	7,042	8,131
Purchase of healthcare from non-NHS and non-DHSC bodies		4,191	4,206	9,476	8,046
Supplies and services - clinical (excluding drug costs)		15,702	16,513	15,702	16,512
Supplies and services - clinical utilsation of consumables donated from DHSC for COVID response		3,269	-	3,269	-
Supplies and services - general		1,763	1,635	1,763	1,635
Supplies and services - general notional cost of equipment donated from DHSC for COVID response below capitalisation threshold		59	-	59	-
Drug costs		18,456	18,482	13,469	14,926
Inventories written down (net, including drugs)		18	35	18	35
Consultancy costs		325	312	318	307
Establishment		1,307	1,159	1,306	1,158
Premises - Business rates payable to Local Authorities		692	1,084	692	1,084
Premises - Other		7,569	6,201	7,569	6,200
Transport (business travel only)		355	492	355	492
Transport (other)		251	266	251	266
Depreciation on property, plant and equipment		5,283	4,730	5,281	4,729
Amortisation on intangible assets		634	550	634	550
Movement in credit loss allowance		(14)	4	(14)	4
Change in provisions discount rate		94	10	94	10
External audit - statutory audit services*		54	46	50	42
External audit - audit assurance services*		-	1	-	1
Internal Audit Costs - (not included in employee expenses)		75	69	75	69
Clinical negligence - NHS Resolution (premium)		5,580	5,244	5,580	5,244
Legal fees		175	22	175	22
Insurance		119	113	119	113
Research and Development		9	25	9	25
Training courses and conferences		1,441	467	1,441	467
Education and training - notional expenditure funded from apprenticeship fund		363	258	363	258
Rentals under operating leases - minimum lease payments	6.1	116	119	116	119
Car parking and security		898	190	898	190
Losses, ex gratia & special payments		3	5	3	5
Other services		561	603	561	603
Other		539	487	537	484
Total		**231,915**	207,030	**232,132**	207,233

*no other remuneration was paid to the auditor, except for the amounts disclosed above

6. Operating leases

6.1 As lessee

Payments recognised as an expense	Group		Trust	
	Year ended 31 March 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000
Minimum lease payments:				
Buildings	50	51	50	51
Other	66	68	66	68
Total minimum lease payments	**116**	119	**116**	119

Future minimum lease payments on buildings leases due:	Year ended 31 March 2021	Year ended 31 March 2020	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000	**£000**	£000
Not later than one year	50	50	50	50
Later than one year and not later than five years	202	202	202	202
Later than five years	152	202	152	202
Total	**404**	454	**404**	454

Future minimum lease payments on other leases due:	Year ended 31 March 2021	Year ended 31 March 2020	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000	**£000**	£000
Not later than one year	26	38	26	38
Later than one year and not later than five years	43	19	43	19
Total	**69**	57	**69**	57

6.2 As lessor

Rental recognised as an income	Group		Trust	
	Year ended 31 March 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000
Minimum lease payments: Land	53	87	60	94
Total minimum lease payments	**53**	87	**60**	94

Future minimum lease payments on Buildings leases due:	Year ended 31 March 2021	Year ended 31 March 2020	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000	**£000**	£000
Not later than one year	88	87	95	94
Later than one year and not later than five years	344	341	358	362
Later than five years	86	170	86	170
Total	**518**	598	**539**	626

7. Employee expenses and numbers

7.1 Employee expenses

	Group		Trust	
	Year ended 31 March 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000
Staff & executive directors	152,996	133,726	152,931	133,661
Research and development staff	760	737	760	737
Education and training staff	1,055	979	1,055	979
Redundancy	47	-	47	-
Early retirements	(4)	7	(4)	7
Special payments	5	-	5	-
	154,859	135,449	**154,794**	135,384
Salaries and wages	115,262	100,724	115,205	100,667
Social security costs	10,688	9,566	10,682	9,560
Apprenticeship levy	551	485	551	485
Employer contributions to NHS Pension scheme	13,227	12,052	13,227	12,052
Employer contributions paid by NHSE on provider's behalf (6.3%)	5,765	5,258	5,765	5,258
Pension cost - other	48	38	46	36
Agency and contract staff	10,383	7,837	10,383	7,837
Termination benefits	169	96	169	96
Less: Staff costs capitalised as part of assets	(1,234)	(607)	(1,234)	(607)
Employee benefits expense	**154,859**	135,449	**154,794**	135,384

Salaries and wages include the cost of amounts accrued in respect of holiday earned by employees due to their service, but not taken, as required under IAS 19.

The amount of Employer's pension contributions payable in the year ended 31 March 2021 was £19,040k (2019/20: £17,348k), £5,765k of this figure is paid by NHSE on behalf of the Trust. Of this total, an amount of £1,023k (2019/20: £1,034k) was unpaid at the reporting date.

7.2 Retirement benefits

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

8. Retirements due to ill-health

During 2020/21 there were two cases (2019/20: one case) of early retirement from the Trust agreed on grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £25k (2019/20: £62k). The cost of ill-health retirements is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

9. Salary and pension entitlement of directors and senior managers

9.1 Directors remuneration

	Group		Trust	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Directors remuneration - Salaries and wages	1,018	978	1,018	978
Employers pension contributions in respect of directors	132	141	132	141
	1,150	1,119	**1,150**	1,119
	Number	Number	**Number**	Number
The total number of directors to whom retirement benefits were accruing under:				
Defined benefit schemes	6	7	6	7

Detailed disclosures of the remuneration and pension entitlements of each director are set out on pages 30 to 40 of the Remuneration Report.

10. Finance income

	Group		Trust	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Interest on bank accounts	-	114	-	113
Total	**-**	114	**-**	113

11. Finance expenses

	Group		Trust	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Loans from the Department of Health	97	98	97	98
Finance Leases	128	69	129	69
Total interest expense	225	167	226	167
Unwinding of discount on provisions	(2)	1	(2)	1
Total finance expenses	**223**	168	**224**	168

12. Gains/(losses) on disposals

	Group		Trust	
	Year ended 31 March 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000
Gains on disposal of other property, plant and equipment	25	7	25	7
Losses on disposal of other property, plant and equipment	(66)	(57)	(66)	(57)
Total (losses) on disposal of assets	**(41)**	(50)	**(41)**	(50)

13. Other Financial Commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2021	3 1 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
not later than 1 year	2,099	1,745	2,099	1,745
after 1 year and not later than 5 years	2,664	2,457	2,664	2,457
Total	**4,763**	4,202	**4,763**	4,202

14. Intangible assets

	Group and Trust	
	Software licences 2020/21	**Software licences** 2019/20
	£000	£000
Cost or valuation at 1 April	10,237	9,743
Additions - purchased	3,603	789
Disposals	(5)	(295)
Cost or valuation at 31 March	**13,835**	10,237
Amortisation at 1 April	4,782	4,527
Provided in the year	634	550
Impairments charged to operating expenses	-	-
Disposals	(5)	(295)
Amortisation at 31 March	**5,411**	4,782
Net book value		
Purchased	8,420	5,447
Donated	4	8
Net book value total at 31 March	**8,424**	5,455

Software licences have been assigned asset lives of between 3 and 19 years. The total reported includes £3,261k (2020: £33k) of software under construction.

15. Property, plant and equipment

Assets utilised by the Trust under Finance leases arrangements are capitalised as part of property, plant and equipment under IFRS. The net book value of fixed assets held at the balance sheet date that were subject to a finance lease was £2,359k (2020: £2,526k).

15.1 Property, plant and equipment, current year 2020/21

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
Group	**£000**	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	**116,584**	5,050	67,578	4,530	2,087	28,462	8,286	591
Additions - purchased	**16,230**	-	1,929	-	7,737	4,122	2,362	80
Additions - leased	**87**	-	-	-	-	-	87	-
Additions - equipment donated from DHSC for COVID response (non-cash)	**553**	-	-	-	-	553	-	-
Additions - assets purchased from cash donations/grants	**100**	-	59	-	-	35	6	-
Reclassification	**-**	-	499	-	(1,744)	1,245	-	-
Disposals	**(1,660)**	-	-	-	(7)	(1,616)	(4)	(33)
Cost or valuation at 31 March 2021	**131,894**	**5,050**	**70,065**	**4,530**	**8,073**	**32,801**	**10,737**	**638**
Depreciation at 1 April 2020	**26,482**	-	2,206	132	-	18,505	5,411	228
Provided in the year	**5,283**	-	2,242	133	-	1,962	921	25
Disposals	**(1,588)**	-	-	-	-	(1,551)	(4)	(33)
Depreciation at 31 March 2021	**30,177**	**-**	**4,448**	**265**	**-**	**18,916**	**6,328**	**220**

15.2 Property, plant and equipment, prior year 2019/20

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
Group	**£000**	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2019	**111,547**	5,050	66,218	4,530	222	27,701	7,216	610
Additions - purchased	**6,242**	-	1,301	-	1,977	1,563	1,401	
Additions - donations of physical assets	**5**	-	-	-	-	5	-	-
Additions - assets purchased from cash donations/grants	**201**	-	35	-	-	166	-	-
Reclassification	**-**	-	24	-	(112)	87	1	-
Revaluation surpluses	**12**	-	-	-	-	-	-	12
Disposals	**(1,423)**	-	-	-	-	(1,060)	(332)	(31)
Cost or valuation at 31 March 2020	**116,584**	**5,050**	**67,578**	**4,530**	**2,087**	**28,462**	**8,286**	**591**
Depreciation at 1 April 2019	**23,103**	-	-	-	-	17,977	4,903	223
Provided in the year	**4,730**	-	2,206	132	-	1,528	840	24
Revaluation surpluses	**12**	-	-	-	-	-	-	12
Disposals	**(1,363)**	-	-	-	-	(1,000)	(332)	(31)
Depreciation at 31 March 2020	**26,482**	**-**	**2,206**	**132**	**-**	**18,505**	**5,411**	**228**

15.3 Property, plant and equipment DCH Subco Ltd

Note 15.1 contains £3,000(15.2 contains £5,000) of Information technology assets relating to DCH Subco Ltd.

15.4 Property, plant and equipment financing

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2021								
Owned assets	**94,606**	5,050	60,453	4,265	8,073	12,365	4,282	118
Finance lease	**2,359**	-	2,225	-	-	17	117	-
Donated assets	**4,219**	-	2,939	-	-	970	10	300
Donated assets from DHSC for Covid response	**533**	-	-	-	-	533	-	-
Total at 31 March 2021	**101,717**	**5,050**	**65,617**	**4,265**	**8,073**	**13,885**	**4,409**	**418**
Net book value as at 31 March 2020								
Owned assets	**83,157**	5,050	60,010	4,398	2,087	8,780	2,776	56
Finance lease	**2,526**	-	2,395	-	-	40	91	-
Donated assets	**4,419**	-	2,967	-	-	1,137	8	307
Total at 31 March 2020	**90,102**	**5,050**	**65,372**	**4,398**	**2,087**	**9,957**	**2,875**	**363**

16. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements comprise:

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Property, plant and equipment	3,476	567	3,476	567
Intangible assets	65	-	65	-
Total	**3,541**	567	**3,541**	567

17. Inventories

Current year 2020/21	Group			
	Drugs	**Consumables**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Balance at 1 April	1,002	1,872	118	**2,992**
Additions	18,205	6,380	360	**24,945**
Inventories recognised as an expense in the period	(18,440)	(6,505)	(364)	**(25,309)**
Write-down of inventories recognised as an expense	(18)	-	-	**(18)**
Balance at 31 March	**749**	**1,747**	**114**	**2,610**

Current year 2020/21	Trust			
	Drugs	**Consumables**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Balance at 1 April	793	1,872	118	**2,783**
Additions	13,180	6,380	360	**19,920**
Inventories recognised as an expense in the period	(13,360)	(6,505)	(364)	**(20,229)**
Write-down of inventories recognised as an expense	(18)	-	-	**(18)**
Balance at 31 March	**595**	**1,747**	**114**	**2,456**

The Trust does not currently operate a complete inventory management control system and is therefore, not able to separately evaluate any amount arising, from write-downs or losses, for inventories other than drugs.

18. Trade and other receivables

18.1 Trade and other receivables

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
Current	**£000**	£000	**£000**	£000
Contract receivables (IFRS 15): invoiced	1,801	2,522	1,801	2,522
Contract receivables (IFRS 15): not yet invoiced/ non-invoiced	1,215	5,126	1,215	5,126
Allowance for impaired contract receivables	(79)	(93)	(79)	(93)
Prepayments	2,200	2,299	2,198	2,297
Interest receivable	-	4	-	4
PDC dividend receivable	29	12	29	12
VAT receivables	772	461	670	381
Other receivables	239	383	239	382
Total	**6,177**	10,714	**6,073**	10,631
Non-current				
Prepayments	62	38	62	38
Contract receivables (IFRS 15): not yet invoiced/ non-invoiced	245	267	245	267
Clinician pension tax provision	601	512	601	512
Total	**908**	817	**908**	817
Grand Total	**7,085**	11,531	**6,981**	11,448

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by central government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Receivables past their due date but not impaired

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
By one to two months	215	694	215	694
By two to three months	152	59	152	59
By three to six months	21	182	21	182
By more than six months	36	354	36	354
Total	**424**	1,289	**424**	1,289

18.3 Receivables past their due date and impaired

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
By up to one month	1	1	1	1
By one to two months	2	11	2	11
By two to three months	7	7	7	7
By three to six months	26	32	26	32
By more than six months	319	393	319	393
Total	**355**	444	**355**	444

18.4 Allowances for credit losses (doubtful debts)

Contract receivables and contract assets	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Balance at 1 April	93	89	93	89
New allowances arising	29	40	29	40
Reversals of allowances	(43)	(36)	(43)	(36)
Balance at 31 March	**79**	93	**79**	93

19. Cash and cash equivalents

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Balance at 1 April	7,335	3,536	7,310	3,448
Net change in year	10,363	3,799	10,338	3,862
Balance at 31 March	**17,698**	7,335	**17,648**	7,310
Made up of				
Commercial banks and cash in hand	5	5	5	5
Cash with Government Banking Service	17,693	7,330	17,643	7,305
Cash and cash equivalents	**17,698**	7,335	**17,648**	7,310

20. Trade and other payables

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
Current	**£000**	£000	**£000**	£000
Trade payables*	9,119	15,246	8,810	14,788
Capital payables	6,039	1,973	6,039	1,973
Accruals	11,237	5,501	11,537	5,839
Other taxes payable	3,117	2,741	3,091	2,716
Total	**29,512**	25,461	**29,477**	25,316

* Trade Payables includes outstanding pension contributions of £1,886k (2020 £1,724k).

21. Borrowings

	Group Current		Trust Current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Loans from Department of Health and Social Care	4	4	4	4
Obligations under finance leases	186	258	186	258
Total	**190**	262	**190**	262

	Non-current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Loans from Department of Health and Social Care	4,600	4,600	4,600	4,600
Obligations under finance leases	2,422	2,495	2,422	2,495
Total	**7,022**	7,095	**7,022**	7,095

The Trust drew down a capital loan from the Department of Health against the receipt of future asset sales at an annual interest rate of 2.11%. The loan repayment date has been extended by the Department of Health and Social Care in a letter dated 4th May 2020 to 15th March 2026.

21.1 Reconciliation of liabilities current year 2020/21

	Total	**DHSC loans 2020/21**	**Finance leases 2020/21**
Group and Trust	**£000**	**£000**	**£000**
At 1 April 2020	**7,357**	4,604	2,753
Cash movements:			
Financing cash flows - principle	**(199)**	-	(199)
Financing cash flows - interest	**(258)**	(97)	(161)
Non-cash movements:			
Additions	**87**	-	87
Interest charge arising in year	**225**	97	128
At 31 March 2021	**7,212**	4,604	2,608

Reconciliation of liabilities prior year 2019/20

	Total	**DHSC loans 2019/20**	**Finance leases 2019/20**
Group and Trust	**£000**	**£000**	**£000**
At 1 April 2019	**7,466**	4,604	2,862
Cash movements:			
Financing cash flows - principle	**(119)**	-	(119)
Financing cash flows - interest	**(157)**	(98)	(59)
Non-cash movements:			
Additions	**-**	-	-
Interest charge arising in year	**167**	98	69
At 31 March 2020	**7,357**	4,604	2,753

22. Provisions

	Group and Trust Current	
	31 March 2021	31 March 2020
	£000	£000
Pensions early departure costs	20	22
Pensions injury benefits	13	13
Other legal claims	17	15
Total	**50**	50

	Non-current	
	31 March 2021	31 March 2020
	£000	£000
Pensions early departure costs	75	95
Pensions injury benefits	116	123
Clinician pension tax reimbursement	601	512
Total	**792**	730

22.1 Provisions movement

Group and Trust	**Total** £000	**Pensions early departure costs** £000	**Pensions Injury benefits** £000	**Legal and other claims** £000	**Clinician pension tax** £000
At 1 April 2020	**780**	117	136	15	512
Change in discount rate	**94**	1	4	-	89
Arising during the year	**16**	6	3	7	-
Utilised during the year - accruals	**(9)**	(6)	(3)	-	-
Utilised during the year - cash	**(28)**	(18)	(10)	-	-
Reversed unused	**(9)**	(4)	-	(5)	-
Unwinding of discount	**(2)**	(1)	(1)	-	-
At 31 March 2021	**842**	95	129	17	601
Expected timing of cash flows:					
Within one year	**50**	20	13	17	-
Between one and five years	**711**	59	51	-	601
After 5 years	**81**	16	65	-	-
Total	**842**	95	129	17	601

Provisions that are not expected to become due for several years are shown at a reduced value to take account of inflation.

Provisions shown under the heading ‘Pensions early departure costs’ have been calculated using figures provided by the NHS Pension Agency. They assume certain life expectancies. Provisions shown under the heading ‘Legal claims’ relate to public and employer liability claims. The liability claims amounts have been calculated using information provided by NHS Resolution and are based on the best information available at the balance sheet date.

22.2 Clinical negligence liabilities	31 March 2021	31 March 2020
Group and Trust	**£000**	£000
Amount included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust	114,295	113,086

23. Other liabilities	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Deferred income - goods and services	2,065	1,802	2,065	1,802
Total	**2,065**	1,802	**2,065**	1,802

24. Finance lease obligations	Minimum lease payments		Present value of minimum lease payments	
Group and Trust	**31 March 2021**	31 March 2020	**31 March 2021**	31 March 2020
	£'000	£'000	**£'000**	£'000
Gross lease liabilities	**3,600**	3,895	**2,654**	2,956
of which liabilities are due				
not later than one year	325	427	302	416
later than one year and not later than five years	1,008	955	857	850
later than five years	2,267	2,513	1,495	1,690
Finance charges allocated to future periods	(992)	(1,142)	(794)	(944)
Net lease liabilities	**2,608**	**2,753**	**1,860**	**2,012**
of which liabilities are due				
not later than one year	186	258	172	247
later than one year and not later than five years	580	505	490	448
later than five years	1,842	1,990	1,198	1,317
	2,608	**2,753**	**1,860**	**2,012**

All finance lease obligations disclosed above relate to plant and machinery and buildings.

25. Contingencies

Contingent liabilities	31 March 2021	31 March 2020
Group and Trust	**£000**	£000
Risk pooling*	3	5
Total	**3**	5

* Risk pooling is in respect of employer and public liability incidents for which claims have been made against the Trust. The contingent liabilities have been calculated using information provided by NHS Resolution. Provisions relating to these cases are included in Note 22.

26. Financial instruments

26.1 Financial assets

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
Loans and receivables	**£000**	£000	**£000**	£000
Trade and other receivables with NHS and DH bodies	3,430	7,204	3,430	7,204
Trade and other receivables with other bodies	592	1,516	592	1,516
Cash and cash equivalents at bank and in hand	17,698	7,335	17,698	7,310
Total at 31 March	**21,720**	16,055	**21,720**	16,030

The financial assets consist of the financial element of trade and other receivables (Note 18.1) and cash and cash equivalents at bank and in hand (Note 19).

26.2 Financial liabilities

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	**£000**	£000
Borrowing excluding finance lease and PFI contract	4,604	4,604	4,604	4,604
Obligations under finance lease	2,608	2,753	2,608	2,753
Trade and other payables with NHS and DH bodies	1,535	7,664	1,535	7,664
Trade and other payables with other bodies	21,448	12,823	21,439	12,702
Provisions under contract	842	780	842	780
Total at 31 March	**31,037**	28,624	**31,028**	28,503

The financial liabilities consist of the financial element of trade and other payables (Note 20), plus current and non-current borrowings (Note 21) and provisions (Note 22.1) excluding legal costs.

Maturity of financial liabilities	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Finance leases				
In one year or less	325	427	325	427
In more than one year but not more than five years	1,008	955	1,008	955
In more than five years	2,267	2,513	2,267	2,513
	3,600	3,895	**3,600**	3,895
DHSC loans				
In one year or less	97	98	97	98
In more than one year but not more than five years	4,891	4,988	4,891	4,988
	4,988	5,086	**4,988**	5,086
Trade & Payables: DHSC group bodies				
In one year or less	1,535	7,664	1,535	7,664
	1,535	7,664	**1,535**	7,664
Trade & Payables: other bodies				
In one year or less	21,448	12,823	21,439	12,702
	21,448	12,823	**21,439**	12,702
Provisions				
In one year or less	49	49	49	49
In more than one year but not more than five years	708	632	708	632
In more than five years	75	93	75	93
	832	774	**832**	774
Total				
In one year or less	23,454	21,061	23,445	20,940
In more than one year but not more than five years	6,607	6,575	6,607	6,575
In more than five years	2,342	2,606	2,342	2,606
	32,403	30,242	**32,394**	30,121

The figures above are based on undiscounted future contractual cash flow as per IFRS 7 Financial Instruments.

26.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and Policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

26.3.1 Currency risk

The Trust is a UK based organisation with no overseas operations. The vast majority of its income, expenses, assets and liabilities are denominated in sterling, and therefore it has low exposure to currency risk.

26.3.2 Interest rate risk

The Trust's exposure to interest rate risk is limited to the rate of interest it earns on short-term cash deposits placed with the National Loans Fund and its cash balances with the Government Banking Service. All of the borrowings of the Trust are at fixed rates of interest.

The Trust earned interest of £nil (at an average rate of approximately 0%) during 2020/21. An increase in interest rates of 0.5% would increase interest earned by approximately £159,600.

26.3.3 Credit risk

The majority of the Trust's trade and other receivables are due from other NHS bodies that are funded by central government. As a result, the Trust has a low credit risk profile. Exposures as at 31 March are disclosed in the Trade and other receivables note.

The Trust has a credit control policy and actively pursues unpaid debts, utilising the services of a debt collection agency for certain older debts. The Trust does not enter into derivative contracts.

With the COVID-19 pandemic it is determined that the Trust continues to have a low credit risk profile as the Trust's trade and other receivables are due from other NHS Bodies which are funded by central government.

26.3.4 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from internally generated funds, or from facilities made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has a surplus of £0.4m in the current financial year and has a cash balance of £17.7m. Therefore, there is minimal risk to payables.

27. Events after the reporting period

There have been no significant post balance sheet events requiring disclosure.

28. Related party transactions

Dorset County Hospital NHS Foundation Trust is an independent public benefit corporation as authorised by NHS Improvement in their Terms of Authorisation. None of the Trust's Directors, senior managers, or parties deemed to be related to them, has undertaken any material transactions with Dorset County Hospital NHS Foundation Trust.

The Department of Health and Social Care is regarded as the ultimate parent of the Trust. During the year the Foundation Trust has had a significant number of transactions with entities for which the Department of Health is regarded as the ultimate parent. Central and Local Government and NHS entities, with which the Foundation Trust had transaction totals exceeding £500,000 for the year, are listed in the following table.

	Income in year to 31 March 2021	Expenditure in year to 31 March 2021	Receivables at 31 March 2021	Payables at 31 March 2021
	£000	£000	£000	£000
Department of Health and Social Care	43	-	-	4,606
Dorset Healthcare NHS Foundation Trust	4,472	4,613	922	462
Health Education England	8,862	24	41	85
HM Revenue and Customs - Tax & NI	-	11,262	-	3,117
NHS Blood and Transplant	-	857	-	12
NHS Dorset Clinical Commissioning Group	149,660	814	185	615
NHS England - Core	18,574	-	1,025	-
South West Regional Office	30,089	-	9	-
NHS Somerset CCG	2,343	-	-	-
NHS Resolution	-	5,697	-	-
NHS Pension Scheme	-	18,992	-	1,877
University Hospital Southampton NHS Foundation Trust	719	214	146	13
Poole Hospital NHS Foundation Trust	233	546	-	-
University Hospitals Dorset NHS Foundation Trust	776	1,165	327	206
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	392	306	-	-
DCH Subco Ltd	5,286	94	300	-

The payables included above in respect of HM Revenue and Customs and NHS Pension Scheme include both employee and employer contributions. The expenditure figures for these organisations are only in respect of employer contributions.

Poole Hospital NHS Foundation and The Royal Bournemouth and Christchurch Hospitals Foundation Trust merged to form University Hospitals Dorset NHS Foundation Trust on 1st October 2020.

The Trust receives revenue payments and contributions to the cost of non-current assets from the Dorset County Hospital NHS Foundation Trust Charitable Fund, of which the Foundation Trust is the corporate trustee.

Transactions with Dorset County Hospital NHS Foundation Trust Charitable Fund:	**31 March 2021**	31 March 2020
	£000	£000
Contributions from the Charity to non-current assets	100	206
Contributions from the Charity to expenditure	47	36
Administration costs charged to the Charity	-	22

29. Third Party Assets

The Trust did not hold cash and cash equivalents which relate to monies held on behalf of patients (2019/20 £nil).

30. Losses and special payments

The total costs included in this note are on a cash basis and may not reconcile to the amounts in the notes to the accounts, which are prepared on an accruals basis.

Group and Trust	**Number of cases**		**Total value of cases**	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Number	Number	**£'000**	£'000
Losses;				
Losses of cash due to:				
overpayment of salaries etc	**3**	-	**5**	-
Damage to buildings and property due to:				
stores losses	**1**	1	**18**	35
Special Payments;				
Compensation under court order or legally biniding arbitration award	**-**	1	**-**	1
Ex-gratia payments in respect of:				
loss of personal effects	**6**	5	**2**	3
other	**2**	4	**1**	1
	12	11	**26**	40

31. Limitation on auditor's liability

The limitation on the Trust's auditor's liability is £1.0million (2019/20: £1.0million).

32. Pooled Budget – Equipment for Living Partnership

The Trust, via Dorset CCG, contributes towards a pooled budget arrangement which started on the 1st April 2015. This is hosted by BCP Council to provide equipment for Living Partnership.

Payments are included in note 5 – Operating expenses under heading Purchase of healthcare from NHS and DHSC bodies. The Trust contributed £198k in 2020/21 (£194k 2019/20). This forms part of the Dorset CCG total included in the table below.

The below disclosure is based on month 12 information provided by Dorset CCG and it should be noted that these figures are un-audited.

Group and Trust	**Year ended 31 March 2021**	Year ended 31 March 2020
Funding	**£000**	£000
BCP Council	1,410	1,410
Dorset Council	1,232	1,232
Dorset CCG	5,657	5,508
Partner Contributions (excluding management costs)	8,299	8,150
Partner Allocation: Local Authority	-	245
Partner Allocation: CCG	-	498
COVID-19 Funding (Unpooled)	1,500	56
Total Funding	**9,799**	8,949
Expenditure		
Integrated Community Equipment Store		
Actual Spend to March	(9,799)	(8,949)
Total Expenditure	**(9,799)**	(8,949)
Total Surplus at 31 March	**-**	-