University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 27 July 2022

13:15 – 15:15

For members of the Board: Boardroom, Poole Hospital

For members of the public: Via Microsoft Teams

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

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 13:15 on Wednesday 27 July 2022 in the Boardroom at Poole Hospital and via Microsoft Teams.

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

Rob Whiteman
Chairman

AGENDA – PART 1 PUBLIC MEETING

13:15 on Wednesday 27 July 2022

Time	Item		Method	Purpose	Lead
13:15	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	2	Declarations of Interest	**Verbal**		**Chair**
	3	Patient Story	**Verbal**	**Noting**	**CNO**
13:25	**4**	**MINUTES AND ACTIONS**			
	4.1	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 25 May 2022	**Paper**	**Approval**	**Chair**
	4.2	Matters Arising - Action List	**Paper**	**Review**	**Chair**
	5	Chief Executive Officer's Report	**Paper**	**Noting**	**CEO**
13:40	**6**	**QUALITY AND PERFORMANCE**			
	6.1	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Noting**	**EDs**
14:10	**7**	**GOVERNANCE**			
	7.1	Quality Impact Assessment Overview Report	**Paper**	**Noting**	**DCMO/ CNO**
	7.2	Guardian of Safe Hours Report	**Paper**	**Noting**	**DCMO**
	7.3	Quality Assurance for Responsible Officers and Revalidation and Annual Organisational Audit Report	**Paper**	**Assurance**	**DCMO**
	7.4	Board Assurance Framework (coming year)	**Paper**	**Approval**	**CNO**
	7.5	Annual Complaints & Patient Experience Report	**Paper**	**Noting**	**CNO**
	7.6	Mixed Sex Accommodation Declaration	**Paper**	**Approval**	**CNO**

	7.7	Quality Strategy	**Paper**	**Approval**	**CNO**
	7.8	Risk Management Strategy	**Paper**	**Approval**	**CNO**
	7.9	Annual Security Report	**Paper**	**Noting**	**COO**
	7.10	Committee Annual Reports • Audit Committee • Charitable Funds Committee • Finance and Performance Committee • Quality Committee • Private Patient Strategy Committee • Sustainability Committee • Transformation Committee • Workforce Strategy Committee	**Paper**	**Noting**	**Committee Chairs**
14:40	**8**	**STRATEGY AND TRANSFORMATION**			
	8.1	Benefits Realisation Update	**Paper**	**Noting**	**CSTO**
15:05	**9**	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 24 July 2022 to company.secretary-team@uhd.nhs.uk		**Receive**	**Chair**
	10	Any Other Business	**Verbal**		**Chair**
	11	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 28 September 2022 at 13:15 via Microsoft Teams Future Meeting Dates: 30 November 2022			
	12	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
15:15	**13**	**Close**	**Verbal**		**Chair**

* late paper

This meeting is being recorded in order for minutes or notes of the meeting to be produced. The recording will be deleted once the minutes or notes of the meeting have been approved.

Items for Next Board Part 1 Agenda

Standing Reports

- Patient Story
- CEO Report
- Integrated Performance Report
- Benefits Realisation Update

Quarterly Reports

- Mortality Report Q1

Bi-Annual Reports

- Nursing Establishment Report
- Freedom to Speak Up Guardian Report

Annual Reports

- Annual Safeguarding Report and Statement of Commitment
- Workforce Race Equality Standards (WRES) Action Plan
- Emergency Preparedness Resilience and Response (EPRR) Assurance
- Annual Infection Prevention and Control Report
- Annual Health and Safety Report
- Annual CQC Report
- Workforce Race Equality Standards (WRES) Report

Ad-hoc Reports

- Social Value Action Plan

List of abbreviations:

CEO – Chief Executive Officer
COO – Chief Operating Officer
DCMO – Deputy Chief Medical Officer
CNO – Chief Nursing Officer
CSTO – Chief Strategy and Transformation Officer
EDs – Executive Directors

AGENDA – PART 2 PRIVATE MEETING

15:30 on Wednesday 27 July 2022

Time	Item		Method	Purpose	Lead
15:30	**14**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	15	Declarations of Interest	**Verbal**		**Chair**
15:35	**16**	**MINUTES AND ACTIONS**			
	16.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 25 May 2022	**Paper**	**Approval**	**Chair**
	16.2	For Accuracy and to Agree: Extraordinary Part 2 Minutes of meeting held on 16 June 2022	**Paper**	**Approval**	**Chair**
	16.3	For Accuracy and to Agree: Part 2 Minutes of meeting held on 29 June 2022	**Paper**	**Approval**	**Chair**
	16.4	For Accuracy and to Agree: Extraordinary Part 2 Minutes of meeting held on 6 July 2022	**Paper**	**Approval**	**Chair**
	16.5	Matters Arising – Action List	**Paper**	**Review**	**Chair**
15:45	**17**	**QUALITY, PERFORMANCE & RISK**			
	17.1	Risk Register Report	**Paper**	**Approval**	**CNO**
	17.2	Serious Incident Report	**Paper**	**Noting**	**DCMO**
16:05	**18**	**STRATEGY AND TRANSFORMATION**			
	18.1	Christchurch Phase II Business Case Update	**Paper**	**Approval**	**CFO**
16:20	**19**	**GOVERNANCE**			
	19.1	Domestic Services at Poole Hospital	**Paper**	**Approval**	**CFO**
	19.2	Orthopaedic Products	**Paper**	**Approval**	**CFO**
	19.3	Escalations from Board Committees: Audit Committee Finance and Performance Committee Private Patients Strategy Quality Committee	**Verbal**	**Noting**	**Committee Chairs**
16:55	**20**	Any Other Business	**Verbal**		**Chair**

	21	Reflections on the Board Meeting	**Verbal**		**Chair**
	22	**Date and Time of Next Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 24 August 2022 via Microsoft Teams. Future Meetings: Wednesday 28 September 2022, 26 October 2022 and 30 November 2022.			
17:00		**Close**	**Verbal**		**Chair**

* late paper

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Items for Next Board Part 2 Agenda

- Integrated Performance Report Summary

List of abbreviations:

CFO – Chief Finance Officer
DCMO – Deputy Chief Medical Officer
CNO – Chief Nursing Officer

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Board of Directors Part 1 meeting held on Wednesday 25 May 2022 at 13:15 via Microsoft Teams.

Present:	Philip Green	Acting Trust Chairman *(Chair)*
	Karen Allman	Chief People Officer
	Pankaj Davé	Non-Executive Director
	Peter Gill	Chief Informatics Officer
	John Lelliott	Non-Executive Director
	Stephen Mount	Non-Executive Director
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy & Transformation Officer
	Cliff Shearman	Non-Executive Director
	Paula Shobbrook	Acting Chief Executive
	Caroline Tapster	Non-Executive Director
In attendance:	Yasmin Dossabhoy	Associate Director of Corporate Governance
	Fiona Hoskins	Acting Chief Nursing Officer
	Helen Martin	Freedom to Speak Up Guardian *(for item 8.1)*
	Deb Matthews	Director of Organisational Development *(for item 7.6)*
	Judith May	Deputy Chief Operating Officer
	Penny Scott	Clinical Lead Speech and Language Therapist ENT/Head and Neck Oncology
	Matt Thomas	Deputy Chief Medical Officer
	Sarah Locke	Deputy Company Secretary *(minutes)*

BoD 114/22	**Welcome, Introductions, Apologies & Quorum** The Chair welcomed everyone to the meeting. Apologies were received from: • Mark Mould, Chief Operating Officer *(represented by Judith May)* • Alyson O'Donnell, Chief Medical Officer *(represented by Matt Thomas)* The meeting was declared quorate.
BoD 115/22	**Declarations of Interest** No further interests were declared.
BoD 116/22	**Patient Story** Fiona Hoskins introduced Penny Scott, Clinical Lead for Speech and Language Therapy Services to present the patient story (which was played on a video by the patient, Deborah Thomas) following her care under the cancer services in the Speech and Language Service. The team applied for an innovation fund to increase community support for Head and Neck Services and the project was part of the Community Outreach Project that optimises patient's surgery both reducing the number of outpatient visits and length of stay. The patient was treated for an early cancer at the base of her tongue and received six weeks of intensive chemotherapy and radiotherapy. Although cured of cancer, unfortunately her airway was not functioning, her vocal

	cords were semi paralysed, she was unable to swallow and she had several readmissions for chest infections. The decision was taken to remove the patient's voice box and a speaking valve was fitted. Historically patients would have been required to attend several sessions of preoperative counselling, been admitted to hospital for two to three weeks followed by intensive sessions in hospital for two to three times a week for six weeks and often have radiotherapy that would be required daily. Following the successful bid to the Wessex Cancer Alliance, funding was allocated to develop the Outreach Service. Patients came into hospital once for their diagnosis and then the pre-operative and non-medical work up could be done in the patients' home. Social services and support services could be involved much earlier and often in place before surgery. A pathway was developed with a small group of existing laryngectomy patients to enable patients to look after their airway and stomach, the breathing hole in their neck and secretions associated with surgery, learning how to use equipment appropriately which really helped patients. The length of stay for many of the patients reduced from three weeks to ten days. It was a very difficult time for Head and Neck cancer patients during the Covid pandemic but being able to take the opportunity to review the pathway to make the care patients receive much more personalised and functional had been immensely successful. Pankaj Davé asked if this service was specific to the Trust or if it was available across Dorset. Penny Scott explained that as all of the major Head and Neck surgery was carried out in Poole Hospital, it was a specific service, however contact had been established with patients in West Dorset so the service would be expanding across Dorset. Fiona Hoskins expressed her thanks to Penny Scott for providing a patient story that demonstrated an excellent example of co-design of services with patients. The Board extended their thanks to Deborah Thomas, Penny Scott and her team. The Board NOTED the patient story.
BoD 117/22	**For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 30 March 2022** The minutes of the meeting held on 30 March 2022 were APPROVED as an accurate record. The Chair highlighted that previous minutes identified those raising questions by job title only. Future minutes would identify individuals using full names, but historical minutes would not be amended.
BoD 118/22	**Matters Arising – Action List** **BoD 178/21** – The Quality Impact Assessment Policy was scheduled for the May 2022 agenda. Action CLOSED. **BoD 073/22** –The Board Committee reviews would be scheduled for presentation at the Board on 27 July 2022 and the Annual Board Effectiveness Report would be scheduled for the September 2022 meeting. Action to remain OPEN. The NHS Improvement's Terms of Licence – Code of Governance Report was scheduled for the May 2022 agenda. Action CLOSED. Action to be amended with the status reflected accordingly.

BoD 119/22	**Chief Executive Officer's Report** Paula Shobbrook presented the Chief Executive Officer's Report, highlighting the following key points: • Infection Prevention Controls (IPC) remained across services, but rates had reduced, although caveated by the fact that national testing had also reduced. • There had been some working on the recovery of services which had meant that more patients were being seen in hospital. • The requirements set out by NHSE/I for returning to pre-pandemic levels of service and how this would be managed had been received. • Some work had already been completed, as demonstrated in the patient story, on working with patients to ensure resources were more effective. • The Trust remained incredibly busy across both sites and there had been extreme pressures in the Emergency department (ED), with a focus on the ambulance delays. • Paula Shobbrook and Philip Green had met with Chief Executives and Chairs across Dorset to discuss how the ambulance service risk would be managed as a system. • The hospital transformation continued with the topping out of the building at Poole Hospital. • Professional celebrations were highlighted with National Nurses Week and some notable visits including from His Royal Highness Prince of Wales. • The first ICS Shadow Board was held on 20 May 2022. • On 1 June 2022 Siobhan Harrington would be starting as Chief Executive and from 1 July 2022 Rob Whiteman would be starting as Trust Chairman. The Board NOTED the Chief Executive's report.
BoD 120/22	**Update on Covid** Fiona Hoskins presented the Update on Covid, highlighting the following key points: • There was an improving position with 42 inpatients across both sites with Covid. There were two patients in ICU with Covid and although there had been periods of having no patients in ITU with Covid, this was a stronger position than during previous waves. • Community rates across Dorset, and nationally were reducing but again, with a caveat that all national requirements for testing had been reduced. • There were no current outbreaks on any wards and all previous outbreaks were being reviewed to identify learning. • The numbers of Covid related staff absence had reduced to pre-wave 3 levels, which had made a positive impact on staff morale. • Lateral flow testing had been introduced for planned and elective surgery with a plan to implement this for inpatients as well. • In line with national guidance, 2 metre distancing had been removed and in all non-health care environments, such as offsite offices, masks had been removed. • Visiting restrictions remained in place for individual areas based on the speciality of the service. The Covid update was NOTED by the Board.

BoD 121/22	**Covid Inquiry** Fiona Hoskins presented the Trust's internal review in response to the Covid Inquiry, highlighting the following key points: • This had been previously presented at the Quality Committee and the Trust Management Group (TMG). • Following the announcement of the Covid Inquiry a Steering Group was set up with the aim to collate and scrutinise all relevant information and data to identify key learning opportunities on the Trust's response to the pandemic. • Overview of Findings: o Both sites, Royal Bournemouth Hospital (RBH) and Poole Hospital, had major incident teams, clinical decision-making groups and a dedicated email for Covid guidance. o A toolkit that commenced at Poole Hospital was subsequently shared at RBH and was fully embedded following the merger. o During heightened periods of the pandemic and with limited resources, actions were taken but not logged in an efficient manner. o The IPC Team helped make risk-based decisions around best practice. o Logistics Teams ensured the supply of PPE (Personal Protective Equipment) on both sites. o Communication briefings were being sent out to all staff daily. • Challenges: o There were opportunities to implement national advice for specific staff groups more promptly. o There was reduced visibility of the Executive Team which staff had reported made them feel isolated. o Although counselling support was implemented early on in the pandemic, the service became quickly overwhelmed. o Staffing levels were a challenge in all areas and not only due to vacancies but also due to increased acuity, adjusting to practice of using PPE and increased staff sickness levels. o There were periods of outbreaks between October 2020 and March 2021. All outbreak policies, practices and review Committees were put in place following good practice guidelines. o A reduction in flow through the Integrated Care System was noted which remained a challenge. o Estates issues in the Maternity Unit impacted on visitors not being able to return which did not align with the rest of the Trust. • Areas for future explanation: o All actions taken during the pandemic were to be collated. o Good evidence of learning across the Trust to be identified. o Actions specifically from the IPC Team, looking at how the workforce was redeployed and how they were supported and understanding lived experience of the pandemic from staff. o Pre-merger actions plans would be reviewed. • Next Steps: o An ongoing focus on the key lines of enquiry and identify staff groups to participate in that exercise. o A toolkit would be developed to prepare staff for what to expect at the inquiry.

	○ Review the ongoing impact of Covid on all services. ○ Maximum support for all staff to be continued. ○ Alignment with the Organisational Development Programme. • Staff worked hard throughout the pandemic and continue to do so. • The Trust implemented all national guidance that was released, even when the guidance was changing rapidly, and implementation of guidelines was expected to be very fast. The Chair and the Board recognised the hard work from the staff all over the Trust, including support staff, throughout the pandemic. Paula Shobbrook added that this had been an important piece of work which had enabled a review of the processes from legacy trusts and then as UHD. Whilst the review had been in preparation for the national inquiry, the important part had been to highlight the learning and understanding that had been delivered against the national requirements. Staff have been able to reflect what they had been through which would be built on through the organisational development. Peter Gill wanted to highlight that senior leaders were actively stopped from entering clinical areas and asked what would be done differently with regards to visibility of senior leaders. Fiona Hoskins commented that whilst at the beginning of the pandemic it was appropriate to not have senior leaders in clinical areas, there was an opportunity to have allowed that practice to have been restarted earlier. Paula Shobbrook also added that individual line managers were changed for some staff and this had impact on the team that they worked in. Cliff Shearman commented that the crisis support that was put in place to support colleagues was paramount and praised the Wellbeing work to support staff during the pandemic and the importance of that continuing. John Lelliott commented that it was important to identify the lessons learned and how the benefit from that could be used going forward. Stephen Mount asked if there had been any claims received with regard to patient discharges to care homes without testing in the early stages of the pandemic. Matt Thomas replied that there were none that the Trust was aware of. The Covid Inquiry presentation was NOTED by the Board.
BoD 122/22	**Integrated Quality, Performance, Workforce, Finance and Informatics Report** Judith May presented the next steps on transitioning from Covid to recovery and the Operational data, highlighting the following key points: • The Trust had received a letter outlining the national step down from a level 4 national incident to a level 3 regional incident with four key messages: ○ Operational time and resource to focus on recovery of services. ○ There would be no additional expectations or priorities on local systems beyond those set out in the 2022/23 priorities and operational planning guidance. ○ Immediate focus on delivering timely urgent and emergency care and discharge, providing more routine elective and cancer tests and treatments and improving patient experience. ○ Legal creation of the Integrated Care Boards from 1 July 2022.

	• The five key operational issues:
	  ○ The number of patients in hospital with Covid.
	  ○ Staff absences remained high, although was improving.
	  ○ Elective recovery: focus on patients that have waited more than 104 weeks and a regional focus on patients waiting over 78 weeks.
	  ○ Wider pressures in the health care system; busy emergency care pathway, continuing pressure on social care and reduced capacity in the community.
	  ○ Limited number of Medically Ready To Leave (MRTL) patients leaving the Trust.
	
	Fiona Hoskins presented the Quality Section of the IPR, highlighting the following key points:
	
	• There were three moderate incidents relating to falls.
	• Section 42 data identified no themes although these were usually related to discharges which also linked with the challenges of discharging the MRTL patients.
	• Core skills training continued to be delivered but some challenges remained around access to moving and handling training.
	• There was a slight deterioration in FFT (Friends and Family Test) responses. The Trust were looking to reintroduce the paper cards for FFT alongside retaining the text message for FFT.
	• 26 formal complaints had been received and 25 early resolutions resolved. Early resolutions were complaints that had been raised but resolved quickly which had been led by the Patient Engagement Team and had proved to be very successful.
	• April 2022 had fewer critical shifts recorded which helped with staff morale.
	
	Matt Thomas presented a Quality Section of the IPR, highlighting the following key points:
	
	• Mortality – the numbers were reducing to expected levels although there were still discrepancies between Poole and Bournemouth Hospitals and this would be reviewed. The reduction in numbers was partly due to the decrease of patients with acute Covid.
	• Themes had been identified following a review of fractured neck of femur. The findings had been shared with the relevant staff groups. The fractured neck of femur service was noted to be the busiest in the country.
	• The 7 day audit was being analysed. There was a weekday/weekend gap identified and this would be analysed further.
	• There were two serious incidents reported with regard to delayed treatment. One never event was reported in May 2022 which was being scoped. The never event was a wrong site of surgery.
	• There was a new policy alignment for IV fluids across both sites and there was a continued alignment of death in hospital review.
	
	Workforce:
	
	• The turnover and vacancy rates had increased. There were 240 new starters in April 2022 with the majority of these being nurses, including overseas nurses.
	• The Trust were applying for the armed forces silver award and looking to apply for the gold award in early 2023.
	• Overall sickness levels and referrals into Occupational Health had increased.

- There was more work to do on improving the uptake of statutory and mandatory training.
- There was a focus on reducing agency expenditure.
- Karen Allman thanked Carla Jones who had developed the Medical agency locum rate.

Peter Gill presented the Informatics Section of the IPR, highlighting the following key points:

- Uptime of more than 99.9% had been maintained since September 2021.
- There was a considerable amount of work to do to ensure that over 200 information assets, that contain personal identifiable data, are being governed properly. The annual return was due at the end of June 2022 and the Trust were considerably lower than the threshold.
- 80.8% of computers were not running on supportive software due to a Microsoft change. A warning of the change had been provided but there had not been time to test the systems and therefore could not be assured that software applications would work.
- The inpatient transition went live on 17 May 2022, which was launched very successfully, and Peter Gill thanked Judith May for leading the operational services for this.
- The first summit for Dorset to look at electronic patient records was being held on 30 June 2022.

Pete Papworth presented the Finance section of the IPR, highlighting the following key points:

- Due to the significant economic challenges and considerable level of inflation, the Board approved a deficit of £32.2m for the year.
- There were also deficits across the Dorset ICS, the south west region and an aggregated national deficit across the NHS.
- Additional funding of £20m for Dorset was announced, together with additional funds for the ambulance Trusts. The allocations were being finalised and financial plans would be revisited with a resubmission due on 20 June 2022.
- There was a significant adverse variance in month 1 of £1.7m primarily due to non-delivery of CIP (Cost Improvement Plan) and Covid expenditure costs that had been continued but would come to an end during quarter 1.
- There had been a reduction in agency spending and this also mitigated the financial risk in the budget.
- There was an underspend on the capital programme of £2.7m which related to timing of expenditure, particularly the One Dorset Pathology Hub, IT schemes and the New Hospitals Programme.
- The considerable risk to the Capital Programme remained.
- There was a cash position of £86.4m which had been fully committed over the medium term to the capital reconfiguration. The risk of continuing at the same level of in month deficit, would result in the cash balance not being available for the capital reconfiguration.
- Better Payment Performance had improved and on target for 95%.
- The Board Seminar had a particular focus on the financial challenges and the options to secure CIP delivery.

Cliff Shearman said that the Quality Committee had a particular interest in fractured neck of femur, noting that the Trust were the busiest unit in the country and yet other units were performing better and assured the Board

	that this would continue to be reviewed and monitored through the Quality Committee. Cliff Shearman asked how many of the MRTL patients were planned admissions. Matt Thomas responded that he would need to review the data, but planned admissions were assessed prior to admission to mitigate against the issues known on discharge from hospital. Care homes remained extremely cautious in accepting patients that have had Covid or been in contact with another patient with Covid. **ACTION:** Matt Thomas to review the proportion of medically ready to leave patients that are planned admission/emergency admission. **Matt Thomas** Caroline Tapster observed that it was very positive to see such an improvement in the early resolution of complaints and asked if the ages of the MRTL patients were higher and whether the changes to Continuing Health Care funding would have an impact. Matt Thomas confirmed that it was having an impact and advised that the majority of MRTL patients are older as they tend to have more complex needs, but it was not exclusive. There were a small percentage of mental health patients and children requiring T4 speciality beds going out of the county. Paula Shobbrook added that the numbers of patients MRTL is a constraint to the organisation. There are a number of discussions ongoing across the system on how the situation can be improved. There was a Chair and Chief Executive meeting being held on 27 May 2022 for this to be discussed further. The Integrated Performance Report was NOTED by the Board.
BoD 123/22	**Mortality Report** Matt Thomas said that there had been nothing further to add from the information presented under the Integrated Performance Report. Cliff Shearman added that assurance had been provided at the Quality Committee that the mortality rate had decreased and that it had been valuable to understand the work that the Trust had completed to be able to achieve this. The Mortality Report was NOTED by the Board.
BoD 124/22	**Ockenden Review** Fiona Hoskins presented the Ockenden Review, highlighting the following key points: • The final Ockenden review into maternity services at Shrewsbury and Telford NHS Trusts, was published on 30 March 2022. • There were four key pillars for organisations to review which were around staffing levels, trained workforce, learning from incidents and listening to families. • All NHS staff were encouraged to read the full report as there was clear and transferrable learning across all services. • A high-level overview and recommendations were presented to TMG in April 2022 and there were 15 immediate essential actions that have been outlined which related to workforce, governance, escalations, accountability, bereavement and patient care. • Following the publication, there were a further 92 actions. Those actions had been placed on hold nationally to further clarify the level of action that would be required and whether there were any financial implications.

	• The final report was submitted to the NHSE public board on 19 May 2022. • Within the report there were references to safe staffing and the maternity continuity of care programme. The Trust are continuing with that practice and ensuring that the programme would be safe based on staffing levels. Pankaj Davé asked if the report had included any recommendations in breakdown of governance and escalations to the Board. Fiona Hoskins advised that there were but that the actions were primarily around listening to families and concerns and also the robustness of serious incidents and identifying and sharing learning across the organisation. The Ockenden Review was NOTED by the Board.
BoD 125/22	**Reviewing Gender Pay** Deb Matthews presented the Review of the Gender Pay, highlighting the following key points: • The Gender Pay report had previously been presented at the Workforce Committee. • As part of the Equality Act 2010, the Gender Pay report was a mandatory requirement. • The data within the report was as of March 2021 and detailed the difference between the male and female average pay within the Trust which was distinct from the equal pay for work of equal value. • Gender pay gap was 6.62% median hourly pay rate, which was a decrease from 6.67% last year. This equated to a female employee earning 93p for every £1 that a male employee earned in 2020/21. • The table on page 60 of the meeting materials, showed that 76% of the total workforce was female but the majority of those were in bands 2-7. This was an improving position and expected to be improved further within the report for 2021/22. • The Consultant medical staff which was detailed on page 61 of the meeting materials under 5.1, showed that when medical and dental workforce were excluded from the gender pay calculations, the mean average pay would drop significantly to 0.65%. • The bonus pay gap for clinical excellence awards, as was detailed on page 62 of the meeting materials under 5.2, showed that 20.7% of male medical employees received a clinical excellence award compared to 10.5% of female medical employees. The average amount payable from the clinical excellence award was also different between male and female medical employees. • Over the previous two years the clinical excellence awards had been on a pro-rata allocation and in future years the national clinical impact award scheme would be transparent, simpler, fairer and more inclusive. • Next steps: o The report would be shared and published on the Trust internet. o There would be further analysis to understand roles where the gender pay gap was most apparent. o Encourage flexible working hours as this could often hinder employees when transitioning into higher banded roles. o Accessible online training availability to ensure fair career progression. o Consideration being given to adding an International Women's Network to the staff networks.

	○ The Clinical Excellence Awards changes as discussed. • The Gender Pay report would be shared with the Equality, Diversity and Inclusion Group (EDIG) and progress would be monitored through the Workforce Committee. The Chair asked for the applications process for clinical excellence awards to be explained. Matt Thomas explained that the process would be changing. Prior to Covid, an application form would be submitted and judged by a committee; female employees were undoubtedly underrepresented in those applications. The new national process had not been agreed but it was hoped that it would encourage more people to apply. The gender pay gap would remain as there was a historic imbalance which would be re-dressed as staff retired. Cliff Shearman also added that staff members would need to be supported by their Trust before they would be considered for a national award. Matt Thomas also said that the current allocation was a single payment. The Chair also asked if the new scheme would ensure inclusion in a wider setting. Matt Thomas replied that the format scheme for the coming year had not been approved so whilst that would be what was expected, it would not be known until the parameters had been announced. Pankaj Davé asked if the pay gap improved over time. Karen Allman advised that when compared to other trusts, the pay gap was better and had improved over time although there was almost no difference seen in the last year. The Board NOTED the Review of the Gender Pay.
BoD 126/22	**Freedom to Speak Up Guardian Report** Helen Martin presented the Freedom to Speak Up (FTSU) Guardian Report, highlighting the following key points: • The report had previously been presented to the Workforce Committee. • Data presented was for 2021/22 and outlined key themes, understanding why staff raised concerns through this route and to share the learning that had been identified. • The FTSU process is well governed and monitored through the Workforce Committee. • Within the staff survey, the responses to the questions about raising concerns had a higher-than-average score than in 2021 with a significant improvement on the question about feeling secure to raise a concern. • Questions related to being confident to raise a concern would continue to be monitored. • A new question was added for 2021 about feeling if the Trust would resolve a concern if raised. The Trust scored 50% and whilst this was higher than average, this needed to be improved. • Following a number of year on year increases in FTSU referrals, the activity for 2021/22 was similar to that of 2020/21. • The FTSU Guardian was a reactive role and the National Guardian Office (NGO) wanted that to be addressed nationally. • Themes for 2021/22: ○ 47% of referrals were related to attitudes and behaviours which increased for staff with a Black, Asian and Minority Ethnic (BAME) background.

	○ 33% related to process, such as rota, HR policy, return to work following sickness. ○ 12% related specifically to workload and the feeling of hopelessness and burnout. ○ There had been an increase in anonymous referrals. The UHD app had a new way to report anonymously. ○ Nurses are the greatest referrers followed by administrative staff and then Allied Health Professionals. • 75% of referrals were raised about the staff members line manager or the line manager being aware of an issue, but not addressing it. • Referrers also reported that their line manager had no time to speak to them. • There are a number of teams that were only just starting to integrate, and this was causing anxiety for some. • Regulators would be expecting senior managers to have completed the FTSU follow up module which was an e-learning tool. • The FTSU policy required approval but noted the national policy was due imminently and would be reflected in the Trust policy. • The focus for 2022/23 was to continue supporting the EDI Equality Diversity and Inclusion strategy, the FTSU team and key themes. Yasmin Dossabhoy referenced page 94 of the meeting materials and asked if the breakdown of data was available for male/female and other minority groups or if it was a specific issue with BAME. Helen Martin said that this would be taken forward but highlighted that it was very difficult to breakdown data for other minority backgrounds, and this was something that had been raised to the NGO for guidance. John Lelliott asked how referrals were dealt with when the concern related to the line manager, senior manager or even a Director. Helen Martin said that these were often addressed on case-by-case basis, and often completed in a coaching and supportive style. Following this, the situation would be discussed with the next line manager. Karen Allman reassured the Board that Helen Martin supported individuals, always worked to achieve a conclusion and was very pragmatic. Karen Allman clarified that of the FTSU concerns raised, 75% of these related to concerns with line managers and not that there was an issue with 75% of the line managers in the Trust. There was a programme of good people management training being launched to provide staff with the techniques to support their staff. Paula Shobbrook supported that the Board would agree to undertake the FTSU follow up module training. The findings in the report with regards to line managers was a reflection of the numbers of changes to line managers across the Trust. Paula Shobbrook also re-assured the Board that senior managers meet with Helen Martin when there are situations that need escalation and provided the FTSU Team with the support in order to achieve a successful outcome. **ACTION**: Helen Martin to forward the FTSU Follow Up Module to the Company Secretary Team and this would then be shared with the Board. **Helen Martin and Sarah Locke** The Board NOTED the Freedom to Speak Up Guardian Report and APPROVED the policy.
BoD 127/22	**Register of Compliance with Code of Governance** Paula Shobbrook presented the Register of Compliance with Code of Governance, highlighting the following key points:

	• The Register of Compliance with Code of Governance had been endorsed at the Audit Committee.
	• There were 105 areas that were self-assessed against. For areas that were non-compliant, an explanation was required.
	  ○ On page 139 of the meeting materials, A.5.12. related to the Governors being provided with agenda and the minutes from the Board Part 2 meeting. The agenda was provided to the Governors as part of the Part 1 meeting materials, but the Part 2 minutes were not provided. The Chief Executive and/or Chairman meet with the Governors in a timely manner to talk through the agenda items from the Board Part 2 meetings and the discussions that took place.
	  ○ On page 145 of the meeting materials, B.1.2. stated that half of the Board of Directors should be comprised of Non-Executive Directors. This was currently not compliant due to the numbers of vacancies in the Non-Executives.
	  ○ All other areas were self-assessed as compliant.
	Paula Shobbrook thanked Yasmin Dossabhoy for assistance in completion of the register of compliance.
	The Register of Compliance with Code of Governance was APPROVED by the Board.

BoD 128/22	**Board Assurance Framework (Close/Sign off previous years Framework)** Fiona Hoskins presented the Board Assurance Framework (BAF) for the previous year, highlighting the following key points: • The BAF had been presented at the Quality Committee and at the Audit Committee. • The end of year position was felt to be an accurate reflection of the organisational position. • Risks where the target scores were not or were partially met had been transferred onto the 2022/23 BAF. The Board Assurance Framework (Close/Sign off of previous years Framework) was APPROVED by the Board.
BoD 129/22	**Board Assurance Framework (Annual Framework)** Fiona Hoskins provided an update on the Board Assurance Framework for the coming year, highlighting the following key points: • The new BAF had been developed in partnership with Jo Sims and executive leads. • The current risks against the delivery of the Trust strategic framework which would be presented to the Board at a future meeting. **ACTION**: The Board Assurance Framework for 2022/23 would be presented at a future Board of Directors meeting. **Paula Shobbrook**. The Board Assurance Framework (Annual Framework) was NOTED by the Board.
BoD 130/22	**Quality Impact Assessment Policy** Fiona Hoskins presented the Quality Impact Assessment Policy, highlighting the following key points:

	• The Quality Impact Assessment Policy had been presented at the Quality Committee in April 2022. • The policy was produced following the Kirkup and Francis reviews, both of which had highlighted the importance of a robust Quality Impact Assessment approach to ensure that adequate reviews are carried out and actions taken which may have had an adverse impact on quality. • The policy had been written based on best practice guidance and sets out the expectations at the Quality Impact Review Group. Caroline Tapster and Pete Papworth highlighted that this was very important given the financial position of the Trust. The Quality Impact Assessment Policy was APPROVED by the Board.
BoD 131/22	**Annual SIRO Report** Peter Gill presented the Annual SIRO Report, highlighting the following key points: • The report had been presented at the Audit Committee. • The Data Protection Officer provided an outcome within the report that the Trust would not comply with the data security protection toolkit at the end of June 2022. • There were 90 out of 110 assertions compliant. • Information Asset owner work and Information Governance training are unlikely to be compliant by end of June 2022. • A status of requiring more work to be done would be submitted. • Internal Auditors provided a report at the Audit Committee on the data security detection tool kit which was very positive in terms of the integrity with which the work had been completed. Paula Shobbrook recognised that the Board were disappointed to be declaring non-compliance but after carefully consideration of the risks and the priorities within the organisation it was decided that patient care was a priority and therefore made the decision to declare a non-compliance which had been supported by Executives. The Annual SIRO was NOTED by the Board.
BoD 132/22	**Seal of Documents Register** There were no questions raised about the Seal of Documents Register. The Seal of Documents Register was NOTED by the Board.
BoD 133/22	**Gifts and Hospital Register** Cliff Shearman asked why there were no names of those members of staff that had received Gifts and Hospitality. This was not raised due to concerns for any of the items declared, but instead there could be a link to a conflict of interest. The Chair advised that this had been discussed at the Audit Committee and this would be reviewed for the Gifts and Hospitality Register for 2022/23. Karen Allman asked how the value was decided. Yasmin Dossabhoy advised that there are some process enhancements required and this would be reviewed going forward. Matt Thomas felt that there would be members of staff that were not making declarations but that it was important to identify the name of the individual and the company from which the Gift/Hospitality was made.

	Richard Renaut raised that it had been discussed previously about having a nil return policy to avoid inconsistency and that it would be useful to include examples on the form for declaration. The Gifts and Hospital Register was NOTED by the Board of Directors.
BoD 134/22	**Register of Interests** There were no questions raised about the Register of Interests. The Register of Interest for staff was NOTED by the Board. The Register of Interest for Directors was APPROVED by the Board.
BoD 135/22	**Board Meeting Schedule** Yasmin Dossabhoy informed the Board of Directors that it had been identified that there was a need to review the flow of information presented to the Board of Directors and the timing of the reports to be provided. A draft proposal would be presented at the next Board Part 1 meeting taking into account the Committee papers going forward. **ACTION**: Draft proposal for the Board meeting schedule would be presented at the July 2022 meeting taking into account the Committee reports and presentation at the Board. **Yasmin Dossabhoy** The Board Meeting Schedule update was NOTED by the Board.
BoD 136/22	**Final Annual Operational Plan** Richard Renaut informed the Board that the draft annual operational plan had been presented at the Board last month and all updates to the plan had been set out in the final annual operational plan presented and in the cover sheet. Pete Papworth advised that the regulator had not approved the operational plan, in terms of the financial position and activity recovery. New activity trajectories had been submitted and a resubmission of the operational plan was expected on 20 June 2022. The Final Annual Operational Plan was APPROVED by the Board with delegated authority to the Chief Financial Officer and the Chief Executive to make any non-substantive amendments with advice to the Board accordingly.
BoD 137/22	**Annual Certificates – Availability of Resources and Systems for Finance and Compliance** Pete Papworth presented the Annual Certificates for the Availability of Resources and Systems for Finance and Compliance, highlighting the following key points: • Self-certification for general condition 6 of the provider licence was confirmed and assurance for this was evidenced as part of the final accounts in report year ended 31 March 2022. • Self-certification for general condition 7 of the provider licence was noted that although there was an expectation to have sufficient resources to continue services, a narrative was included to highlight the significant deficit which had been supported by cash reserves. • General condition 7 may need to be reviewed following the final operational plan submission in June 2022. The Annual Certificates – Availability of Resources and Systems for Finance and Compliance was APPROVED by the Board.

BoD 138/22	**Annual Certificates – Annual Certificates for Certification of Governance and AHSCs and Training of Governors** Paula Shobbrook presented the Annual Certificates for Certification of Governance and AHSCs and Training of Governors, highlighting the following key points: • Performance was monitored through the single oversight framework and performance reports. • The data had been reviewed through all of the various Committees. • The compliance with the NHS Foundation Trust code of governance was reviewed annually and a statement was also included in the annual report explaining areas of non-compliance. • In relation to the training of Governors, training had been provided through a number of forums and informal Governor briefings. The Annual Certificates – Annual Certificates for Certification of Governance and AHSCs and Training of Governors was APPROVED by the Board.
BoD 139/22	**Questions from the Council of Governors and Public** The Board received a question from Dave Triplow, Public Governor: • Fiona Hoskins mentioned that soon into the pandemic the counselling support was overwhelmed, and Helen Martin mentioned that staff had reported to feeling 'burnt out'. Was there now sufficient counselling and psychological support for the staff? o Karen Allman answered that there was a regular review of the resources and support that was offered. There had been some additional funding which meant that the Wellbeing and Occupational Health services were being supplemented in order to reduce waiting times which was having an impact. Along with the counselling, there were a variety of different services that were available, and some support was available through the Dorset Hub which was an ICS service but waiting times for that were longer. The services available were increasing and the feedback that had been provided from staff that have used those services was very positive. The Trust continued to look to do more and actively ensure that staff get access to the services as soon as possible. o Fiona Hoskins added that there had been some low-level training. There had been a number of Mental Health first aiders trained in the Trust and 23 nursing staff completing the PNA (Professional Nurse Advocate) training which was about restorative practice and supervision in practice and after most significant events debriefing sessions are held so the staff are referred to the relevant services in a timely way.
BoD 140/22	**Any Other Business** Karen Allman wished good luck for those members of staff that were taking part in the hospital show. The Chair thanked Paula Shobbrook on behalf of the Board for her term as Acting Chief Executive. Paula Shobbrook extended her thanks to Fiona Hoskins for her term as Acting Chief Nursing Officer.
	The date and time of the next Board of Directors Part 1 Meeting was announced as Wednesday 27 July 2022 at 13:15 via Microsoft Teams.

Meeting Date	Minute No.	Matter Arising / Action	Lead	Due Date	Progress	Status
30/03/2022	BoD 073/22	**Annual Board Effectivess Report:** The annual board effectivess report would be scheduled for a future Board meeting following the completion of Board Committee reviews	SL	September 2022	Annual Board Effectiveness Report to be brought back following completion of Board Committee reviews.	In Progress
25/05/2022	BoD 122/22	**Integrated Performance Report:** Matt Thomas to review the proportion of medically ready to leave patients that are planned admission/emergency admission.	MT	July 2022		In Progress
25/05/2022	BoD 126/22	**Freedom To Speak Up:** Helen Martin to forward the FTSU Follow Up Module to the Company Secretary Team and this would then be shared with the Board.	HM/SL	July 2022	Helen Martin has sent the module to Sarah Locke. Sarah to send round to the Board.	In Progress
25/05/2022	BoD 127/22	**Board Assurance Framework (Annual Framework):** The Board Assurance Framework for 2022/23 would be presented at a future Board of Directors meeting	PS	July 2022		In Progress
25/05/2022	BoD 135/22	**Board Meeting Schedule:** Draft proposal for the Board meeting schedule would be presented at the July 2022 meeting taking into account the Committee reports and presentation at the Board.	YD	July 2022		In Progress

Chief Executive Report
July 2022

At the time of writing this report we are just emerging from a heatwave. I would like to thank all our staff for their work over this past month and specifically over the last couple of weeks where the pressures from the heat, the emergency care demand, elective recovery, and Covid still being ever present, mean that our people continue to work under a lot of pressure.

With this being my first Chief Executive Report to the Board meeting in public and my second month as Chief Executive of University Hospitals Dorset NHS Foundation Trust, I want to thank all patients, staff, partners and the wider community for having made me feel so welcome.

I feel privileged to have been appointed as Chief Executive of UHD and have spent a considerable amount of time getting to know and listen to colleagues around the Trust. I have been incredibly encouraged by the strength spirit of the team at UHD and the hard work and perseverance of staff in delivering high quality safe services.

My immediate priorities remain to focus on patient safety and our staff; to reduce the pressure our hospitals continue to face of urgent and emergency care, and rightly reducing waits for people needing elective (planned) care. None of this can be solved by UHD alone and I have spent time with system partners as part of my induction.

1. Strategic Update –National Perspective

1.1 Integrated Care Boards and Integrated Care Systems

From 1 July 2022, Integrated Care Boards (ICBs) were established with a statutory function of arranging health services for their population and have responsibility for performance and oversight of NHS services within their Integrated Care Systems (ICSs). ICSs are partnerships of health and care organisations that together plan and deliver joined up services to improve the health of people in their area.

I was delighted to have been appointed as a board member to the ICB. It is great to be an integral part of the Dorset ICS, building on the partnerships of the past and making Dorset the best we possibly can for the future of health and care. We are committed to being agile, improving care and supporting people in their health and care decisions.

1.2 **Single Oversight Framework Segmentation**

Ahead of the official launch of ICSs, NHS England published its 2022/23 System Oversight Framework on 27 June 2022. This includes an approach to focused assistance provided to providers and systems, with NHS England and NHS Improvement having allocated trusts and ICBs to one of four segments. These range from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). I was pleased that as a trust, we are in segment 2, with the Dorset ICB also being in segment 2.

1.3 **NHS Incident Response Level**

Nationally, we are currently seeing an increase in Covid rates. Having reviewed the current and predicted data around Covid and in response to the increasing numbers of staff and patient illness, on 4 July 2022 we took the difficult decision to revert back to mask wearing in all areas in our hospitals.

Nationally we remain in a level 3 incident.

1.4 **Approach to the second phase of NHS England/Improvement's Elective Recovery Plan.**

As part of the second phase of the elective recovery plan, all providers have been assessed by NHS England/Improvement based on confidence of delivering against the targets of reducing the cancer 62 day backlog back to pre-pandemic levels by March 2023, and reducing the number of patients waiting more than 78 weeks for elective care to zero by April 2023. Those providers at the highest risk have been including in a Tier 1 grouping, which means additional support and oversight. Twenty Tier 1 providers have been identified.

The Tier 2 grouping includes providers who are less challenged but still are at material risk of cancer 62 day backlogs or 78 week elective care waits in April 2023. For this group of providers, the Region will lead and develop delivery plans.

Our clinical and operational teams across the Trust have been working hard to address the current position and plan for the future, with us being one of twenty-four Tier 2 providers. We are doing as much as possible to address the backlog of our waiting lists and help every patient with their care. Our current position is laid out in the Integrated Performance Report. We are planning to achieve the target of treating all patients over 78 weeks by the end of March 2023.

1.5 **Fuller Stocktake Report**

The Fuller Stocktake Report, focusing on the Next Steps for Integrating Primary Care, was published on 26 May 2022. The report was the outcome of a stocktake on integrated primary care including general practice, community pharmacy, dentistry and optometry across systems. The aim is to tackle the operational challenges driving pressure across systems with recommendations for changing care models for two distinct groups of patients:

- Firstly, those patients who require urgent care with the recommendation to introduce a same day care solution including an ambition to improve experiences for those looking for urgent appointments outside of core hours; and
- Secondly, those patients who would most benefit from continuity of care in general practice and a more holistic approach.

ICBs and ICSs are now expected to focus on making improvements for patients in these two groups. The Chief Commissioning Officer will be leading this work for Dorset.

1.6 **National Pay Award**

The national pay award was announced this week.

There is a mixed reaction amongst staff to the award, as colleagues understand how it relates to them individually.

2. System Pressures

On 30 June 2022, the ICS moved into escalation level 4 due to an increasing trend of patients not meeting the clinical criteria to reside in hospitals, leading to impacts on emergency departments, deteriorating waiting times and ambulance handover delays.

On the 5 July 2022 David Sloman wrote to all acute trusts asking them to implement the 100 day discharge improvement challenge, laying out 10 high impact changes. The Integrated Care System is leading the response to this with all partners in Dorset.

On 16 July 2022 all Trusts received a letter from NHSE, asking us to focus on reducing ambulance handover times, especially in the light of the heatwave and to improve patient safety.

Within UHD we are using all the experience and learning from other Trusts and nationally to improve our pathways for patients at this time.

3. Quality and safety operational performance

Operational pressures, driven by high numbers of urgent patients with serious illness requiring admission and a reduced ability to discharge patients ready to leave hospital, continue within UHD. This same picture is being seen across the NHS. We are tremendously grateful to our staff for going the extra mile to support patients and colleagues.

Against the above national and local perspectives and our own position within UHD, we are focusing on three key priorities this year:

- Emergency care and hospital flow;
- Maximising elective care; and
- Investing in our workforce.

with a range of initiatives and activities underway to support these.

Unlocking flow – our ability to progress a patient's care to discharge – and getting emergency care systems right benefits patients and staff across our hospitals is critical to almost everything we do.

We are focusing on four key areas where we know we can make a difference: our emergency departments, same day emergency care, operational flow and discharge. We are working hard both within the Trust and with our partners to implement changes in these four areas.

During June, the Trust continued to have high bed occupancy levels contributing to ambulance handover delays and the amount of time patients were spending in the emergency department. Challenges with patients with "No Reason to Reside" remained leading to bed pressure; with there being an average of 214 of these patients per day.

The number of Covid admissions/contacts increasing across the organisation also contributed to maintaining high bed occupancy. The Trust also experienced increasing numbers of staff isolating.

Both Bournemouth and Poole hospital sites continued to have all escalation & extremis beds open in June. Despite this, occupancy remained high at 93.4%, and in some instances has exceeded 100% on a single site.

The Trust continues to operate elective recovery alongside continued focus on responding to Covid activity, managing an increase in demand and management of workforce capacity shortfalls. The high numbers of No Reason to Reside patients and an increase in trauma demand are also impacting recovery.

4. Financial performance

Our Annual Report and Accounts were submitted in June 2022 and have been published on the Trust's website.

At the end of June 2022, the Trust had a reported deficit of £4.613 million against a planned deficit of £395,000. This adverse variance reflects the current shortfall in the Trust's cost improvement plan. In these first few months we have discussed the importance of using public money wisely and reducing waste and duplication across the organisation. We held a workshop and there were a number of areas where we identified opportunities to improve that would also support our cost improvement plans. The Trust is taking proactive steps to further progress its cost improvement plan in a timely manner.

5. Our Workforce

Our current vacancy rate is 6.2% and turnover 14.6% with sickness absence running at 5.6%. Our hotspots and areas where we are planning to recruit include nurses and health care assistants especially in care of older peoples' services, healthcare scientists, pharmacy and radiographers. We continue to run proactive recruitment campaigns across the Trust.

We have some great recruitment videos attracting people to come and work in Bournemouth, Poole and Christchurch and also working as a Dorset ICS. We also work closely with Bournemouth University and BCP to see and create new opportunities about recruitment and retention, demonstrating the lifestyle benefits of this area of the country are all things that we use to attract people to join UHD.

We have now introduced monthly staff awards across UHD. There have been over 50 nominations in this first month.

There was a first women's network meeting in June. Thank you to Sam Murray who is part of our Pharmacy team for getting this to happen. I have agreed to be the Executive Lead.

Staff briefings are held once a month, with active briefing and feedback from staff. These are a hybrid of 'in person' and 'on Teams'.

6. Transforming our hospitals; Buildings development

The Trust has submitted its outline business case to enable and enhance the reconfiguration of the UHD estate. This is the next phase of developments and will support the service transformation designed to create a major emergency hospital at the Royal Bournemouth Hospital and a major planned hospital at Poole Hospital. This is to be achieved through investment in new, high quality, digitally enabled facilities, to be delivered with modern methods of construction and with a view to the achievement of net zero carbon.

The Trust has also approved the UHD Green Plan which is available on the Trust website. Staff are encouraged to engage in Ecoearn where people can build awareness about how to live in a more healthy and sustainable way.

7. Transforming our hospitals: Antenatal services

From September 2022, all of our antenatal services will be moved to Poole Hospital as part of our plans to develop a combined maternity service. Currently maternity services run across both the Royal Bournemouth and Poole hospital sites, with women travelling across hospitals for different appointments during their pregnancy. In 2024 a combined maternity service will operate on the Royal Bournemouth site in the new BEACH Building (representing Births, Emergency care, and Critical Care and Child Health). Until that time, all antenatal appointments and in-hospital birthing options will be run from Poole hospital.

8. UHD Appointments

Our new Chair, Rob Whiteman CBE, who brings a wealth of experience, joined UHD on 1 July. Rob has been Chief Executive of the Chartered Institute of Public Finance and Accountancy for the last eight years and has held many other executive and non-executive roles. Rob brings significant experience of working with the NHS from his time as Chair of North East London Sustainability and Transformation Programme (STP) and as a non-executive director and Chair of audit at Whittington Health NHS Trust and Barking, Havering, and Redbridge University Hospitals NHS Trust. I am looking forward to working closely with him.

Finally, I would like to thank Paula Shobbrook for her leadership as Acting Chief Executive prior to me joining the Trust, Fiona Hoskins for her role as Acting Chief Nursing Officer and also Philip Green for his support as Acting Chair prior to Rob joining. We appreciate all their contributions.

Siobhan Harrington
Chief Executive

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 6.1

Subject:	University Hospitals Dorset (UHD) NHS Foundation Trust Integrated Performance Report (IPR) June 2022

Prepared by:	Executive Directors, Alex Lister, Sophie Jordan, Judith May, David Mills, Fiona Hoskins, Matthew Hodson, Carla Jones, Irene Mardon, Jo Sims, Andrew Goodwin
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the Board of Directors and Sub Committees members on the performance of the Trust during June 2022 and consider the content of recovery plans
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny.
Areas of Board Focus	High Bed occupancy levels contributing to ambulance handover delays and the amount of time patients are spending in the emergency department. Continuing challenges with 'No Reason to Reside' (NRTR) leading to bed pressure and elective access to theatre capacity. The number of Covid admissions/contacts increasing across the organisation contributing to maintain a high bed occupancy and increase numbers of staff isolating. Impact on reduced hospital flow has the potential to impact on patient safety, experience and increased cancellations. Workforce availability to meet escalating capacity levels, that drives increased agency costs and impact on staff wellbeing. Impact on hospital reputation and increased challenge to elective care recovery as a result of having to allocate more capacity aside for emergency /urgent care response. The impact this may have on the fundamentals of care, in particular, deconditioning of patients.
Urgent & Emergency Care	**Operational Performance: Key Points** Emergency flow remains a key challenge. The IPR provides the detailed performance against the new national Urgent & Emergency Care standards. Headlines include: • Ambulance conveyances were higher in June to both sites • Volumes of ambulance delays remain consistent with May 2022 and remain an area of work that further progress needs to be made. • Daily ED attendances saw daily average increases in the last month. • ED mean time improved at the RBH site, but deteriorated at PH. • There were 105 x 12 hour waits from Decision to Admit (DTA), 17 more than May.

(colours based on change from last month)

		Jun-22		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	317	300	308
Time to Initial Assessment	15 mins	11	24	18
12 Hour ED Waits	0	523	246	769
Internal Care Standards				
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	159	282	166
Mean Clinically Ready To Proceed to Leave Dept	60 mins	296	128	212

Weekly Rapid Decompression flow meetings continued in June, chaired by the COO to target and oversee actions to improve crowding in the Emergency Departments and flow through the sites. This now feed through to the weekly Dorset System Ambulance Recovery cell. Medium term transformation work continues through the Improving Hospital Flow Work programme with support from ECIST. Interprofessional standards to support Urgent and Emergency Care flow have been agreed via TMG and are appended for noting.

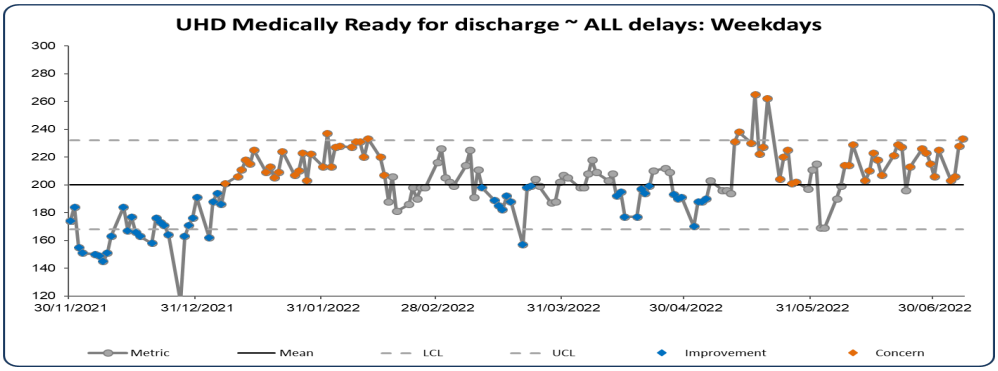
Occupancy, Flow & Discharge

Both sites continued to have all escalation & extremis beds open in June, occupancy remained high at 93.4%, and in some instances has exceeded 100% on a single site. Sites have predominately reported OPEL 4 escalation through the month.

The number of patients ready to leave with No Reason to Reside (NRTR) remained at an average 214 patients per day. Occupied bed days remains high for patients with a longer length of stay (7/14/21+) Challenges across the Dorset System continue to impact on discharging patients MRFD across UHD sites as follows:

- Transition into the new model for complex discharge, managing to maintain rate of discharge.
- Deficit of domiciliary care capacity across Dorset
- Limited flow to spot-purchase care home settings
- Social Worker vacancies impacting on delay in timely complex discharge planning and decision-making at UHD

A workshop took place with BCP & Dorset Health Care to reconnect teams and understand the challenges and opportunities post covid. Future model scoping sessions have commenced w/c on 9/5. 45% of complex discharges should go out on P1 in line with national modelling – weekly redesign sessions now in place from early June. Work stream 4 Transforming Our Discharge task and finish groups delivering in line with decompressing ED and ambition of Transforming Hospital Flow. Care Group engagement to be focused on the 10 high impact interventions to improve discharge over the next 100 days – national directive with clinical oversight at regional meetings moving into August 2022. Pilot UHD / National definition for Estimated Day of Discharge for improving early discharge planning to commence mid-June.



<table>
<tr><td>Surge, Escalation and Ops Planning</td><td>At the time of writing, UHD has 80 confirmed Covid inpatients, the situation was improving but hospitals are experiencing an uptick on patients with covid, which correlates to the national picture and Epicell modelling. Levels remain above the 5% national planning requirements and outbreaks have made placement of patients a clinical challenge. Reduced additional covid inpatient capacity is required resulting in an increase in the availability of ‘green’ (non Covid) elective and non-elective capacity. Covid outbreaks on wards continue to be managed differently after national guidance was circulated, improving access to specialty beds which is vital when occupancy levels are so high due to a challenging MRTL position.

The operational teams continue to work up the winter capacity plan which includes a number of mitigations to reduce the beds required/occupancy levels in Q3 & Q4. The implications of further covid surges will also need to be considered.</td></tr>
<tr><td>Referral to Treatment (RTT)</td><td>The Trust continues to operate elective recovery alongside continued focus on responding to COVID activity, managing an increase in demand, and management of workforce capacity shortfalls in a number of key areas. High numbers of patients with 'no criteria to reside' in hospital and an increase in trauma demand are also impacting on recovery.

• The RTT standard was not met in June 2022, with 58.2% of patients being treated within 18 weeks.
• In June, the number of patients waiting >104 weeks reduced by 39%. 118 patients were waiting v planning trajectory of 120.

<table>
<tr><th></th><th>May 22</th><th colspan="2">June 22</th></tr>
<tr><td>Referral to treatment 18-week performance</td><td>59.2%</td><td>58.2%</td><td>Target 92%</td></tr>
<tr><td>104 weeks</td><td>194</td><td>118</td><td>Trajectory 120 by June 22</td></tr>
<tr><td>Hold or reduce >52+ weeks</td><td>3,325</td><td>4,493</td><td>4,776 by June 22</td></tr>
<tr><td>Stabilise Waiting List size</td><td>72,568</td><td>73,932</td><td>+1,364 v May 2022</td></tr>
</table>

2022/23 Planning Requirements
• Eliminate 78 week waits by March 2023.
• Hold or where possible reduce the number of patients waiting over 52 weeks.
• Stabilise the waiting list.

Note: The Trust is currently working towards delivering a single, unified Patient Administration System (PAS) to better manage patient care across all our hospital sites. The impact of this managed change programme is that duplicate patient pathways will exist within the Patient Treatment List (PTL) for a period until administrative validation is complete, and the duplicate removed. The presence of duplicate pathways is increasing the reported total waiting list position, number of >52week waiters and impacting the reported RTT performance. Validation of waits over 78 weeks has been prioritised.</td></tr>
<tr><td>Cancer Standards</td><td>The total number on the UHD PTL continues to be above 3500 and ranks 19th when compared nationally. The high increases in referral numbers for the above mentioned tumour sites continues to challenge all performance</td></tr>
</table>

	standards. However, of the 30 trusts with the largest PTL's nationally, UHD has the 3rd lowest % of backstop patients and the lowest % of backstops within the Wessex Cancer Alliance at 6.3%. The rate of two week wait referrals in May saw an overall increase of 13% when compared to May 2021.

Measure	Target	Q3 21/22 - FINAL	Q4 21/22 - FINAL	Apr 22 - FINAL	May 22 - FINAL	Jun 22 Predicted	Jul 22 Predicted
Cancer Plan 62 Day Standard (Tumour)	85%	70.9%	69.3%	71.5%	69.6%	71.2%	60.0%
62 Day Screening Standard (Tumour)	90%	87.0%	83.8%	86.7%	73.9%	84.6%	66.7%
31 Day First Treatment (Tumour)	96%	96.8%	97.3%	97.0%	96.6%	98.8%	97.6%
Subsequent Treatment - Surgery	94%	93.9%	89.8%	95.3%	87.7%	89.8%	100.0%
Subsequent Treatment - Radiotherapy	94%	100.0%	99.3%	100.0%	99.3%	96.7%	100.0%
Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%
Faster Diagnosis	75%	66.6%	71.9%	71.9%	71.8%	68.4%	64.9%
Over 104 days (treated in month)	N/A	36	44.5	13	25.5	12.5	2.5

- 28-day FDS performance in May fell short of the 75% threshold reporting 71.8% with five tumour sites achieving the standard.
- 31-day standard
- The 62-day performance in May was below the 85% threshold (69.9%), However, remains above the current national average of 65.5%.

DM01 (Diagnostics report)

The DM01 standard has achieved 80.5% of all patients being seen within 6 weeks of referral, 19.5% of diagnostic patients seen >6weeks.

1% of patients should wait more than 6 weeks for a diagnostic test

May	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	11,963	9,635	2,328	**19.5%**

DM01 performance has deteriorated in June compared to May. Recovery of performance in MRI seen in June and CT expected to recovery in July 2022. Increased demand for diagnostics and workforce gaps is impacting on the Trust's recovery of diagnostics performance in echocardiology and endoscopy.

Elective Recovery Actions

Five Trust-wide improvement programmes are providing a foundation for improvements in elective care recovery:

- ***Theatre improvement programme*** *- to optimise theatre efficiency and utilisation and improve staff and patient experience of theatres*
- ***Outpatient*** *Enabling Excellence and Transformation programmes - including three elements:*
    a. *Enabling Excellence programme - to deliver 'back to basics' improvements focused on achieving immediate and sustainable efficiency improvements in Outpatients*
    b. *Digital Outpatients transformation, and*
    c. *Outpatients Pathway Transformation programme - optimising use of virtual consultations, advice and guidance and patient initiated follow up pathways.*
- ***Diagnostics recovery****: Endoscopy, Echocardiology and imaging*
- ***Cancer recovery and sustainability:*** *Developing a sustainability plan to improve Cancer Waiting Times across 6 priority tumour sites which aligns with the Dorset Cancer Partnership objectives.*
- ***Data and validation optimisation****: Ensuring access to the best quality data for elective care delivery and planning, including clinically led, digital first validation.*

Health Inequalities

The Dorset Intelligence & Insight Service (DiiS) Health Inequalities dashboard enables analysis waiting times disaggregated by ethnicity and deprivation (Dorset Patients only).

Waiting list by Index of Multiple Deprivation (IMD)
Analysis of the waiting list by IMD identifies that 8.4% of the Trust's waiting list are patients living within the bottom 20% by Index of Multiple Deprivation (IMD). An increase of 0.2% in latest month. This increases to 9.3% when analysing patients waiting over 52 weeks.

Waiting list by ethnicity
Where ethnicity is recorded, 10.5% of patients are within community minority ethnic populations. This percentage reduces to 10.3% when analysing patients who have waited greater than 52 weeks (down 1.4% compared to May)

Learning disabilities
Patients recorded as having a learning disability on the waiting list equate to 0.68% of the waiting list. This rises to 0.86% when analysing patients waiting over 52 weeks.

Infection Prevention and Control:

Quality, Safety, & Patient Experience Key Points

- Work has commenced on the follow up of outbreaks and PIR for cases identified in Q3 and Q4 2021 to 2022.It is too early to feedback on any trends and themes, it is however evident that the psychological impact on staff from the outbreaks in 2020 to 2021 remains a factor on teams responding to the pressure of increased cases and staff illness.

Hospital Associated cases trend

	2021/2022												2022/2023		
Organism	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Cdiff	4	8	8	8	5	8	6	6	4	2	8	3	9	10	9
eColi	4	4	9	9	10	7	8	7	9	7	2	4	6	1	7
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	3	2	4	4	5	5	1	4	4	3	7	5	4	4	2

- Community cases of COVID-19 have been steadily increasing and this has had a subsequent impact on admissions and staff illness. The BA4 and BA5 variant is now becoming more dominant which is evidently the reason behind this increase.
- Outbreaks have been reported within Wards on both sites.
- A collaborative project looking at MSSA is underway within Dorset. Themes identified within the PIR for these cases point towards poorly maintained vascular access devices and poor skin integrity being a common factor in bacteraemia, there may be some benefit in looking at skin decolonisation for high risk patients as a future QI project for UHD.
- Cases of Clostridioides Difficile have increased over the past 2 years. The frequency of patients relapsing, and the severity of cases has also increased. This is a common trend across the South West, an ongoing collaborative project across the region is gathering data to help us to understand the reasons behind this increase. However, our rates per 100K admissions is below the England rate (36 vis 45 per 100K). Current themes from Post Infection Review indicate the challenge of ensuring prompt identification, sampling and isolation of patients is a key factor for the Trust to improve upon but these are not contributory factors for patients acquiring infections.

Clinical Practice Team

Moving & Handling

- Our ability to meet the face-to-face level 2 training requirements continues to be a challenge. The risk register entry remains at 10

	(moderate). Please note due to staffing challenges a small number of training sessions have been cancelled in order to prioritise patient care. **Falls prevention & management** • Themes from recent serious incidents have been aggregated and presented at the OPS Directorate Governance meetings, learning shared and actions suggested. • Continue to raise awareness that the falls eLearning module is now available to Poole based staff on their green brains **Tissue Viability** • The number of patients being referred to the service remains high • Poole based staff being encouraged to complete the TV eLearning module as now available on their green brains • Continue to actively participate in the Pan Dorset Joint Wound Formulary Group The Clinical Practice Team have continued to support ward teams when staffing has been challenging across both sites, as well as undertaking DATIX administration and RCA/SI investigation responsibilities for ward areas.
Patient Experience:	**Friends & Family Test** FFT Positive responses have marginally declined in June at 88.3% compared with 89.7% in May. (our lowest positive response this year was recorded in August at 86.36%) **PALS and Complaints** In June there were 576 PALS concerns raised, 44 new formal complaints and 36 Early Resolution complaints (ERC) were processed. The number of formal complaints that were responded to and closed in June was 18. Regular meetings with care group leads continue with a focus on closing of complaints. **Key themes** from PALS and complaints: Communication – Absent or incorrect, Organisation process – Waiting times, accessing care, Clinical – staff competencies **Red Flags** A reduction in reported Red Flags has continued with 45 reported this month, compared to 159 in April and 41 in May. The most commonly reported Red Flags are a lack of enhanced care workers and delays providing fundamental care; a reflection of the level of Health Care Support Worker vacancies on the Poole Hospital site and unfilled shifts requested through temporary staffing. A refresh on the criteria for raising a Red Flag has commenced with nursing staff across the Medical Care Group; noted as the highest reporting areas **Section 42s** The number of 'open' S42 enquiries has increased and was escalated through safeguarding as a concern. There are multiple causes including internal UHD pressures to return Enquiry forms and Social Care pressure to review and 'close' enquiries. GDONs and Safeguarding have agreed an action plan to increase visibility of Enquiries within their areas and overall themes across UHD. This will support learning from events within areas. **Mixed Sex Accommodation Breaches** In June we had 1 episode of Mixed Sex Accommodation, which affected 7 patients. An investigation within the medical care group is ongoing to share learning, and ward education has already taken place.

Workforce Performance:

Workforce Key Points

		Actual this month	Variance on last month
Turnover		14.8%	0.4%
Vacancy		6.3%	-0.5%
Sickness Rate		5.1%	0.3%
Covid-absence non-sickness		0.2%	0.0%
Appraisals	Values based	13.0%	4.9%
	Medical & Dental	59.4%	3.7%
Statutory and Mandatory		84.4%	1.0%

Note: the YTD (12 month rolling data) Indicators to June 2022 can be found on the Workforce Integrated Performance Report page

UHD turnover is tracking at 14.6% 12 months rolling with an actual this month of 14.8%, an increase of 0.4% on May

Vacancy Rate is 6.2% 12 months rolling, actual in month for June is 6.2%, a decrease of 0.5% on previous month.

Overall Sickness absence 12 months rolling is being reported at 5.6%. In June sickness absence increased to 5.1%, an increase of 0.3% compared to May

Statutory and Mandatory training: Overall Compliance remains fairly strong. Poole Hospital has improved to 77.8% and RBCH has improved to 89.5% with overall UHD Trust compliance standing at 83.7%.,

CPO Headlines:

Internationally Educated Nurses Retention
A £75k bid has been made to NHSEI International Recruitment Accelerated Development Transformation Fund. This will support the recruitment, development and retention of internationally educated nurses and midwives.

Covid Pay, Terms and Conditions
The National staff terms and conditions section of the Covid-19 guidance was withdrawn in its entirety on 7th July 2022.

Embedding a Just and Learning Culture (J&LC) across UHD
People Management development will be rolled out from July, to include J&LC principles as a golden thread running through policy and leadership training. A J&LC session will feature in this year's LERN Conference, being held on 3rd November 2022. This will explore the relationship between incidents, speaking up and a safety culture.

Medical Locum Rates
A new Trust-wide suite of medical locum rates was introduced on 1st July 2022. A workshop is taking place on 14th July to discuss the new rates and process of escalation, and to offer additional training on the Locum's nest booking platform.

Occupational Health and Enhanced Wellbeing Service	**Pre-Placement Referrals**: Activity levels remain high. 230 pre-placement appointments were given in June 2022. **Management Referrals**: In June 2022, 146 management referrals were given. Currently there is a 4/5 week wait for an appointment with an OH Nurse Advisor or OH Doctor. The wait for appointments are reducing in line with increased staffing and streamlining of appointments. **Resourcing** June data indicates continuing high levels of general recruitment and an increase in Medical Recruitment activity. Services are reporting significant levels of HCSW and Registered Nurse vacancies, and recruitment activity and events are focused on addressing this, and retention activity. **International Recruitment** – International Qualified Nurse recruitment is on track to meet our 120-nurse target, **Temporary Workforce:** We have seen a marginal increase in registered nursing demand, with a decrease in the overall fill rate to 77.9% in June compared to May. The number of medical bank shifts requested in June remained stable with 942 Shifts filled and a 11% increase fill rate to 72%. Medical & AHP agency bookings indicate a 25% increase in spend from previous month to £298k
Organisational Development	An online Staff Recognition system is planned to replace the heritage thank you processes. Proposal underway to join an NHS specific online staff recognition application being developed by Royal Papworth NHSFT and Amazon Web Services offering a flexible and sustainable offering. The interim measure, “Thank You” postcards have been very popular 9 candidate applications are being processed for the Level 7 Senior Leader Apprenticeship in partnership with Bournemouth University due to commence in September
Trust Finance Position	**Finance** During June, the Dorset Integrated Care System has continued to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who are medically ready for discharge. Within the Trust; both Emergency departments continue to operate under extreme pressure and we continue to care for patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate regularly at Operational Pressures Escalation Level (OPEL) 4. At the end June 2022, the Trust has reported a deficit of £4.613 million against a planned deficit of £359,000 representing an adverse variance of £4.254 million. This adverse variance reflects the current shortfall in the cost improvement plan. Recognising this challenge, on the 30 June the Trust convened a (FRS) Financial Recovery Summit. On the 5 July the outcome of the summit was considered by the Trust Management Group (TMG), where an outline plan has been proposed and agreed. Further detailed plans are due for submission at TMG on the 19 July. It should be noted the in month run rate for June has improved mainly due to additional income in relation to NHSE Drugs income of £374,000 and the

	Injury Cost Recovery scheme of £191,000. There has also been a positive movement in the agency pay cost trend when comparing to previous months and the same period last year. The Trust has set a full year capital budget of £131.9 million, including £103.8 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme enabling works. As at 30 June capital spend is £15.9 million against a plan of £27.3 million, this value includes the adoption of the IFRS 16 standard at £6.9 million. New Hospital Programme spend (NHP) is £2.5 million behind plan and STP Wave 1 funded projects are behind plan by £6.2 million. These programmes are expected to remain consistent with the full year budget albeit with monthly variances throughout the year reflecting the complexities of the project phasing and building works. The Trust ended June with a cash balance of £84.12 million, all of which remains fully committed against the medium-term capital programme. The Trusts payment performance remained strong in June, with 95% of invoices paid within the agreed terms
Options and decisions required:	No decisions required
Recommendation:	**Members are asked to note:** • Note the content of the report • Note the Interprofessional standards to support Urgent and Emergency Care flow • Note and consider the areas of Board focus
Next steps:	Work will continue in addressing the actions raised as part of the escalation reports and through Trust Management Group

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	**To be a great place to work**, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best. **To ensure that all resources are used efficiently to establish financially and environmentally sustainable services** and deliver key operational standards and targets. **To continually improve the quality of care** so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience **To be a well governed and well managed organisation** that works effectively in partnership with others, is strongly connected to the local population and is valued by local people. **To transform and improve our services in line with the Dorset ICS Long Term Plan**, by separating emergency and planned care, and integrating our services with those in the community.
BAF/Corporate Risk Register: (if applicable)	**Risks scoring ≥12:** **UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak – increased score to 16 **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** - Demand for acute inpatient beds will exceed bed capacity (Demand & Capacity)

	UHD 1460 – UEC national metrics **UHD 1429** – Ambulance handovers **UHD 1053 –**Long Length of Stay / Discharge to Assess /NRTR **UHD 1074** - Risks associated with breaches of 18-week Referral to Treatment and 52 week wait standards **UHD 1292** – Outpatient Follow-up appointment backlog. Insufficient capacity to book within due dates **UHD 1386** – Cancer waits increasing due to increased referrals. **UHD 1276** – Delayed patient care due to delays in surgery for #NOF patients **UHD1574 -** Lack of Breast screening staff impacting on waiting times **UHD 1397**- Provision of 24/7 Haematology/ Transfusion Laboratory Service **UHD 1342 -**The inability to provide the appropriate level of services for patients during the COVID-19 pandemic **UHD 1283 -** There is a risk that we cannot adequately staff radiotherapy radiographer roles due to vacancies and maternity leave.
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Board (Full report)	July 2022
Quality Committee (Quality)	July 2022
Finance & Performance Committee (Operational / Finance Performance)	July 2022
Trust Management Group	July 2022

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




June 2022

Created July 2022

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	ytd	ytd var	trend
SAFE																												
Quality	Presure Ulcers (Cat 3 & 4)			12	6	10	8	12	12	13	16	11	15	12	15	8	10	6	7	6	13	14	5	4	5	2	11	-27	
	Inpatient Falls (Moderate +)			5	2	3	5	4	4	5	2	4	6	2	7	1	3	6	1	1	7	8	3	3	5	1	9	-3	
	Medication Incidents (Moderate +)			1	2	5	4	9	2	4	4	1	0	1	1	1	6	2	8	2	3	2	2	3	0	0	3	1	
	Patient Safety Incidents (NRLS only)			1379	1341	1654	1581	1537	1492	1239	1006	1140	1145	1073	1159	1229	1036	1178	1127	967	1106	932	916	936	935	947	2818	-540	
	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
		MSSA		1	2	3	9	8	4	6	4	3	2	4	5	5	5	1	4	4	3	7	5	4	4	2	10	1	
		C Diff		7	6	1	3	1	2	9	3	4	8	8	8	5	8	6	6	4	2	8	3	9	10	9	28	8	
		E. coli		3	12	5	8	2	11	3	3	4	4	9	8	10	7	8	7	9	7	2	4	6	1	7	14	-3	
1																												
Mortality	SMR	Latest Jan 21	(source Dr Foster)	97.92	93.17	105.66	103.50	88.04	125.62	103.90	92.89	83.31	91.41	85.38	103.11	108.12	100.45	96.01	90.35	86.03	100.65	81.36					81.40		
	Patient Deaths		YTD	207	185	265	244	249	469	299	217	165	185	170	232	223	202	222	238	247	270	203	241	227	211	209	647	154	
	Death Reviews		Number	105	85	124	111	127	207	152	103	120	152	133	165	177	156	170	152	172	171	116	124	109	84	103	296		
	Deaths within 36hrs of Admission			30	35	40	36	49	47	39	37	30	29	33	48	38	19	33	44	36	48	34	29	41	31	37	109	13	
	Deaths within readmission spell			15	13	15	22	25	36	18	16	12	14	10	26	22	17	13	12	12	21	15	22	13	18	35	66	5	
CARING																												
	Complaints Received			57	48	51	56	62	53	53	51	60	68	62	52	57	51	39	20	27	48	38	65	55	63	80	198	-1	
	Complaint Response in month			57	48	51	48	49	43	59	59	47	26	64	53	55	28	32	39	58	37	37	51	37	47	47	131	-2	
	Section 42's			0	2	0	0	0	0	1	0	0	0	22	0	0	14	0	0	13	0	0	13	0	0	7	7	-15	
	Friends & Family Test			90%	91%	91%	91%	91%	91%	91%	93%	90%	89%	89%	86%	86%	87%	87%	89%	91%	90%	89%	88%	88%	90%	88%	89%	-1%	
WELL LED																												
Safety	Risks 12 and above on Register			36	38	39	31	32	27	31	34	35	40	43	44	47	44	49	44	44	42	41	39	36	35	35	106	-8	
	Red Flags Raised*			31	47	51	43	73	129	51	28	41	45	56	80	117	105	160	209	161	180	148	130	159	41	45	245	103	
	*different criteria across RBCH & PHT																											
	Overall CHPPD			9.5	8.8	9.0	9.4	9.4	8.3	9.4	9.3	5.7	5.3	5.2	5.0	4.7	4.6	4.7	4.8	3.3	4.7	3.2	4.6	4.5	4.8	4.7	4.7	-0.8	
	Patient Safety Alerts Outstanding			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
People	Turnover			10.40%	10.70%	10.40%	10.20%	10.00%	9.80%	9.40%	9.20%	9.00%	9.20%	11.50%	12.20%	12.40%	12.10%	12.20%	12.60%	12.81%	12.10%	13.50%	14.00%	14.50%	12.80%	13.30%	14.6%	3.3%	
	Vacancy Rate *(only up to Oct 2020)*			1.0%	0.7%	1.3%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6.0%	6.4%	6.3%	6.2%	1.3%	
	Sickness Rate			4.2%	4.2%	4.2%	4.4%	4.5%	7.1%	4.9%	7.1%	4.7%	4.7%	4.8%	4.9%	5.0%	5.1%	5.2%	5.2%	5.3%	5.1%	5.2%	5.4%	5.6%	5.2%	5.3%	5.6%	0.9%	
	Appraisals	Values Based		41.6%	53.5%	57.3%	61.5%	63.9%	63.7%	63.1%	62.9%	4.6%	9.0%	16.7%	25.7%	35.7%	48.7%	54.5%	58.2%	58.4%	55.3%	59.1%	59.1%	5.1%	7.0%	14.9%	7.7%	-2.4%	
		Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	61.6%	62.7%	56.8%	55.4%	52.5%	50.3%	61.0%	62.8%	54.4%	61.1%	63.1%	54.1%	44.1%	38.8%	56.6%	55.5%	54.7%	56.6%	56.9%	4.1%	
	Statutory and Mandatory Training			86.52%	86.96%	88.37%	85.90%	85.80%	87.20%	86.50%	86.40%	87.20%	87.90%	88.20%	88.10%	88.60%	87.70%	86.50%	85.80%	86.18%	85.72%	85.60%	84.79%	84.50%	83.41%	83.70%	84.2%	-3.6%	

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	ytd	ytd var	trend
RESPONSIVE																												
Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	25	17	29	36	10	17	12	11	7	12	13	19	22	22	18	24	12	4	3	2		5	-18	
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	187	75	70	67	72	98	122	65	51	82	45	53	57	64	77	56	60		116	-23	
	ENA Risk Assessment	Falls		62%	61%	61%	61%	58%	51%	59%	59%	65%	62%	62%	57%	55%	56%	55%	53%	53%	51%	58%	56%	55%			55%	-8.5%	
	**infection eNA assessment*	Infection*		74%	73%	70%	64%	73%	54%	62%	64%	70%	66%	66%	61%	58%	59%	58%	56%	58%	54%	61%	60%	58%			58%	-10.3%	
	went live at RBCH	MUST		64%	64%	63%	65%	61%	57%	63%	63%	69%	66%	65%	61%	59%	60%	59%	57%	58%	55%	62%	60%	58%			58%	-9.6%	
	during April 20	Waterlow		61%	61%	61%	61%	60%	52%	59%	60%	65%	62%	62%	57%	55%	56%	55%	53%	53%	51%	58%	57%	56%			56%	-7.9%	
RTT	18 week performance %		92%	49.0%	56.2%	60.4%	63.4%	64.8%	63.0%	59.3%	58.2%	59.6%	63.2%	65.7%	65.2%	65.4%	64.1%	64.0%	64.0%	61.6%	60.9%	60.4%	61.0%	56.1%	59.2%	58.2%			
	Waiting list size		44,508	41,172	43,123	44,320	44,349	44,117	44,615	45,524	47,133	47,984	48,773	49,099	48,687	49,906	51,491	52,787	52,383	52,972	53,168	54,602	56,038	61,278	72,568	73,932			
	Waiting List size variance compared to Sep 2021 (cf Mar 19 up to Mar 21, cf Jan 20 up to oct 21)		0%	-3%	1.3%	4.1%	4.1%	3.6%	4.8%	6.9%	10.7%	7.8%	9.6%	10.3%	9.4%	12.1%	15.7%	18.6%	1.7%	2.9%	3.3%	6.0%	8.8%	19.0%	40.9%	43.6%			
	No. patients waiting 26+ weeks			16,950	17,001	14,220	12,131	10,738	10,904	11,672	12,408	12,692	12,682	11,972	11,085	10,929	11,508	11,600	11,746	12,904	13,561	13,829	13,765	17,433	19,913	20,428			
	No. patients waiting 40+ weeks			6,395	6,921	7,197	7,799	8,031	7,258	7,006	6,727	6,474	6,151	5,962	5,872	5,971	5,922	5,559	5,413	5,374	5,391	5,764	5,650	7,370	8,521	9,395			
	No. patients waiting 52+ weeks		0	2,050	2,636	2,998	3,242	3,439	4,273	5,325	5,595	4,816	4,156	3,737	3,402	3,408	3,480	3,442	3,322	2,968	2,777	2,680	2,655	2,798	3,325	4,493			
	No. patients waiting 78+ weeks			0	70	92	149	291	542	726	979	1,176	1,268	1,180	1,318	1,635	1,740	1,416	1,329	952	870	864	758	759	550	520			
	No. patients waiting 104+ weeks			0	0	0	0	0	0	0	0	9	24	66	101	133	178	247	248	273	295	408	280	238	194	118			
	Average Wait weeks		8.5	20.8	20.6	19.5	18.3	18.6	18.3	18.3	20.1	19.5	19.5	20.1	20.1	20.1	20.1	17.8	17.8	19.5	18.5	20.1	19.5	19.5	19.5	19.5			
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%	69%	67%	73%	73%	74%	75%	72%	73%	74%	75%	72%	70%	71%	75%	71%	71%	76%	78%			
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%	60%	62%	67%	59%	60%	61%	60%	64%	58%	65%	63%	61%	62%	64%	63%	62%	69%	73%			
	NOFs (Within 36hrs of admission - NHFD)		85%	40%	10%	26%	29%	25%	42%	67%	63%	20%	29%	23%	30%	30%	39%	20%	42%	4%	9%	32%	24%	24%	3%	2%			
Outpatients	**Referral Rates**																												
	GP Referral Rate year on year +/-	*(prev yr baseline)*	-0.5%										200.1%	127.3%	86.0%	66.7%	50.5%	42.0%	38.3%	34.3%	33.5%	32.4%	29.3%	-19.7%	0.4%	-0.6%			
		(19/20 baseline)	-0.5%	-45.8%	-37.8%	-34.4%	-32.0%	-28.2%	-29.5%	-29.0%	-22.4%	-12.6%	-10.2%	-8.6%	-10.8%	-10.8%	-10.9%	-11.3%	-10.7%	-10.2%	-10.8%	-10.7%	-7.0%						
	Total Referrals Rate year on year +/-	*(prev yr baseline)*	-0.5%										169.1%	120.5%	87.2%	70.3%	53.5%	42.6%	37.1%	31.2%	27.1%	26.4%	24.0%	-24.3%	-0.6%	-3.4%			
		(19/20 baseline)	-0.5%	-45.3%	-37.1%	-32.2%	-28.7%	-24.5%	-22.8%	-22.2%	-17.2%	-8.9%	-8.0%	-3.9%	-6.2%	-6.0%	-5.6%	-5.8%	-5.0%	-4.6%	-5.0%	-4.8%	-1.4%						
	Outpatient metrics																												
	Overdue Follow up Appts			13,652	13,941	13,722	13,099	13,941	14,883	15,775	15,669	15,404	15,266	15,330	15,389	16,272	16,487	16,174	15,846	16,393	16,523	16,649	16,503	46,566	36,798	25,671			
	Follow-Up Ratio		1.91	1.46	1.44	1.44	1.48	1.44	1.63	1.54	1.44	1.40	1.36	1.37	1.40	1.47	1.48	1.43	1.44	1.49	1.53	1.45	1.47	1.49	0.94	0.74			
	% DNA Rate		5%	5.7%	6.6%	7.0%	6.6%	6.0%	5.5%	5.0%	5.0%	5.7%	5.8%	6.3%	6.6%	6.7%	6.9%	6.9%	6.8%	7.1%	7.1%	6.7%	6.4%	6.7%	6.9%	8.3%			
	Patient cancellation rate			9.2%	9.9%	10.3%	9.5%	10.4%	12.1%	8.8%	5.4%	8.3%	9.1%	10.5%	12.2%	11.7%	13.0%	12.4%	11.8%	14.0%	12.9%	12.9%	13.2%	12.7%	10.5%	10.7%			
	30% reduction in face to face attendances																												
	% telemedicine attendances		25%	52.9%	44.5%	42.0%	43.1%	39.4%	52.1%	52.8%	42.5%	37.3%	34.1%	31.3%	28.7%	28.5%	26.1%	26.6%	26.7%	27.8%	26.5%	25.7%	25.8%	24.0%	22.6%	22.9%			
DM 01	**Diagnostic Performance (DM01)**																												
	% of <6 week performance		1%	19.5%	16.9%	9.8%	1.4%	2.7%	6.4%	5.9%	2.9%	3.7%	2.6%	1.8%	3.3%	6.1%	5.5%	5.5%	7.8%	14.3%	18.3%	13.1%	15.9%	19.9%	18.6%	19.5%			
Cancer	2 week wait (RBH not being monitored)			99.3%	95.4%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
	62 day standard		85%	76.6%	76.1%	77.9%	80.3%	77.5%	78.5%	71.6%	83.2%	76.1%	76.9%	79.8%	78.8%	77.3%	74.6%	71.3%	71.4%	70.0%	71.6%	65.5%	71.3%	71.5%	69.6%	71.2%	*(June provisional)*		
	28 day faster diagnosis standard		75%	80.3%	72.9%	76.6%	86.7%	78.6%	72.5%	80.2%	83.6%	75.9%	77.6%	75.3%	78.2%	75.2%	72.8%	68.0%	66.4%	65.4%	60.4%	72.3%	73.3%	71.9%	71.8%	68.4%	*(June provisional)*		
Emergency Dept	Arrival time to initial assessment		15	5.7	5.7	5.1	5.0	6.0	6.0	5.0	6.0	9.0	9.0	13.0	14.0	10.0	7.0	5.0	4.0	4.0	4.0	6.0	7.0	7.0	9.0	18.0			
	Clinician seen <60 mins %			31.0%	36.2%	39.9%	43.7%	41.8%	50.5%	52.9%	45.2%	30.6%	27.0%	18.3%	16.1%	17.1%	19.8%	21.4%	24.5%	30.6%	31.6%	23.7%	21.6%	26.9%	24.4%	20.0%			
	PHT Mean time in ED		200	227	206	210	230	235	266	235	205	217	229	239	250	274	266	280	277	298	297	285	300	307	296	317			
	RBCH Mean Time in ED		200	211	217	226	219	259	258	222	206	223	228	250	280	297	278	294	297	304	294	321	374	314	302	300			
	Patients >12hrs from DTA to admission		0	0	0	0	7	8	3	1	0	0	0	0	0	0	5	16	21	34	73	60	89	188	88	105			
	Patients >6hrs in dept			1833	1454	1540	1488	2126	2052	698	1072	1674	2110	2735	3656	4349	3679	4258	3980	4071	3763	4089	4923	4204	4367	4723			
	ED attendance Growth (YTD)	*vs prev yr*										94.3%	17.0%	56.1%	45.8%	37.4%	33.2%	31.5%	31.5%	31.5%	30.2%	31.2%	30.5%	64.3%	29.4%	37.2%			
		vs 19/20		-26.0%	-23.2%	-15.7%	-21.2%	-21.8%	-22.6%	-31.4%	-21.1%	-3.0%	-15.0%	9.0%	0.9%	1.7%	2.3%	2.8%	2.5%	2.8%	0.7%	0.5%	2.9%	-3.0%	-0.3%	-0.2%			
SWAST SCAST	Ambulance handover growth (YTD)	*vs prev yr*										43.0%	35.7%	22.9%	14.6%	9.8%	6.1%	2.7%	1.0%	2.7%	-1.3%	-2.0%	-3.3%	43.0%	29.4%	-16.4%			
		vs 19/20				-6.7%	-7.5%	-7.0%	-4.7%	-11.9%	-4.4%	7.8%	8.8%	8.9%	7.3%	1.7%	2.4%	-0.4%	-2.6%	-0.4%	-5.9%	-7.2%	-7.6%	7.8%	9.9%	-13.6%			
	Ambulance handover 30-60mins breaches			313	228	249	213	261	296	126	190	227	264	341	411	330	290	213	262	281	362	349	280	315	469	462			
	Ambulance handover >60mins breaches			56	52	48	57	103	203	12	20	42	67	117	168	238	203	127	175	164	510	655	727	557	606	629			
Patient Flow	Emergency admissions growth (YTD)	*vs prev yr*										33.2%	17.0%	2.2%	26.7%	21.1%	17.0%	14.4%	13.1%	14.4%	11.5%	10.9%	9.5%	66.1%	30.2%	3.6%			
		vs 19/20		-11.9%	-10.5%	-12.1%	-15.4%	-16.4%	-13.1%	-19.3%	-13.4%	-16.2%	-15.0%	-15.1%	-1.4%	-2.2%	-2.9%	-4.1%	-5.5%	-4.1%	-8.0%	-8.6%	-7.2%	0.0%	-1.7%	-9.7%			
	Bed Occupancy		85%		85.9%	86.0%	85.4%	85.2%	87.4%	84.6%	82.3%	85.1%	90.5%	90.3%	89.7%	92.5%	90.3%	92.4%	92.4%	91.3%	94.9%	94.4%	93.7%	94.7%	94.3%	93.4%			
	Stranded patients:																												
	Length of stay 7 days				380	394	385	311	443	311	347	338	374	390	407	483	467	475	514	500	553	544	530	549	539	539			
	Length of stay 14 days				197	214	219	155	242	155	184	178	195	216	233	296	294	295	328	318	360	359	339	361	355	360			
	Length of stay 21 days		108		108	126	132	86	144	86	105	103	115	132	148	198	198	202	224	224	260	253	238	247	254	256			
	Non-elective admissions				6089	6279	5673	6034	5231	6034	6130	6355	6463	6366	6486	6119	5972	6291	5852	5621	5823	5301	5899	5485	6401	5802			
	> 1 day non-elective admissions				3796	3932	3554	3686	3521	3686	3737	3873	4025	3885	4108	3950	3756	4009	3727	3575	3817	3339	3747	3488	4081	3633			
	Same Day Emergency Care (SDEC)				2291	2346	2118	2344	1710	2344	2387	2481	2437	2478	2374	2166	2211	2275	2123	2044	2004	1961	2149	1994	2317	2168			
	Conversion rate (admitted from ED)		30%		34.40%	36.10%	38.30%	36.90%	42.30%	36.90%	37.00%	33.90%	32.50%	30.40%	29.90%	29.00%	28.30%	30.10%	29.90%	32.70%	31.40%	28.20%	28.70%	29.20%	28.40%	26.90%			

Quality - SAFE

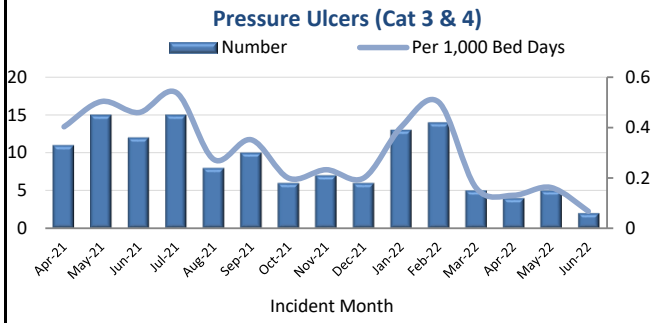
Commentary on high level board position

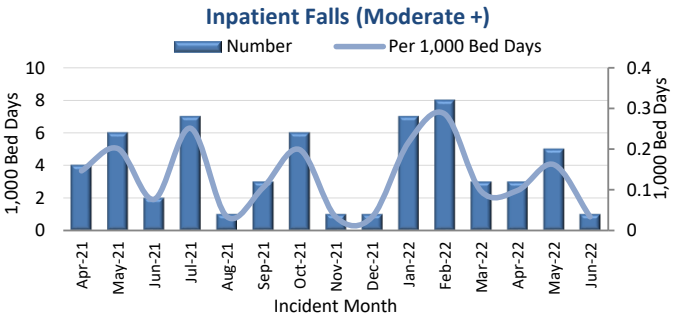
- One category 3 reported due to a combination of pressure and moisture. A category 4 pressure ulcer reported, currently undergoing investigation
- One severe falls incident reported this month resulting in a #nof.
- One (1) new Serious Incident reported in month (June 22). Full report on learning from completed scoping meeting and investigations included in CMO report to Quality Committee and Board.

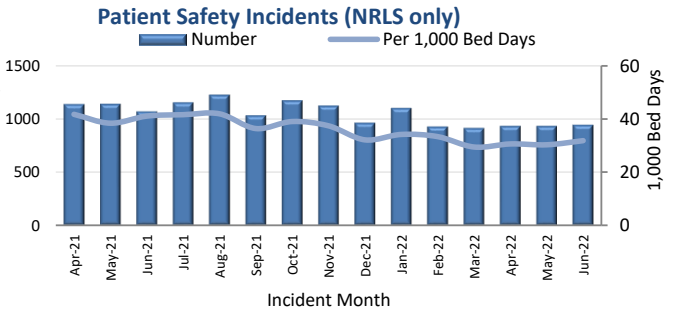
High level Board Performance Indicators

		22/23 YTD	21/22 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	11	38	-27
	Per 1,000 Bed Days	0.12	0.46	-0.34
Inpatient Falls (Moderate +)	Number	9	12	-3
	Per 1,000 Bed Days	0.10	0.14	-0.05
Medication Incidents (Moderate +)	Number	3	2	1
	Per 1,000 Bed Days	0.03	0.02	0.01
Patient Safety Incidents (NRLS only)	Number	2,818	3,358	-540
	Per 1,000 Bed Days	30.92	40.36	-9.44
Hospital Associated Infections	MRSA	0	0	0
	MSSA	10	9	1
	C Diff	28	20	8
	E. coli	14	17	-3

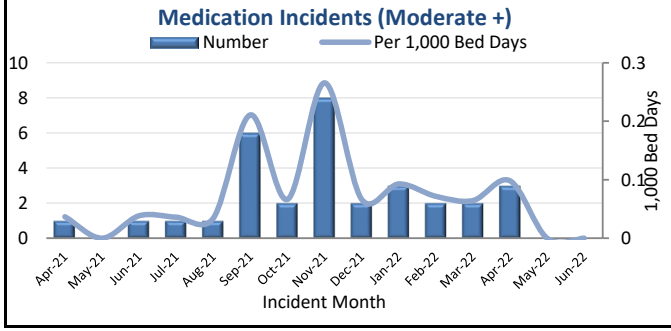
High Level Trust Performance

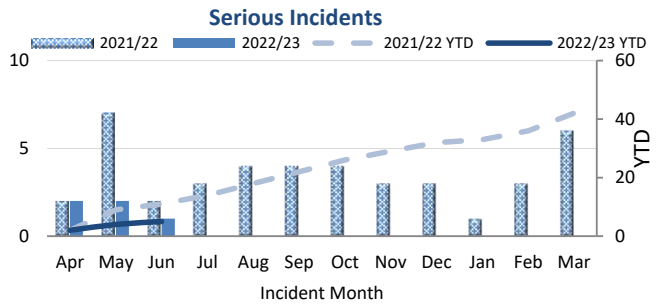


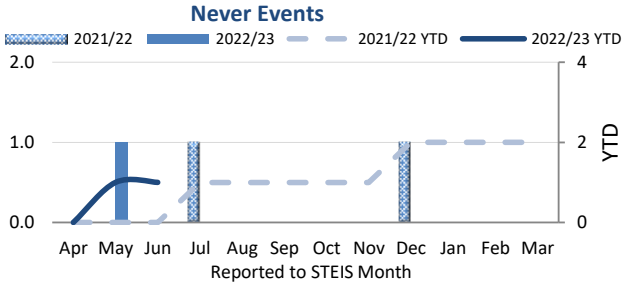




4 (May)	HAI: MSSA	2 (Jun)	0 (May)	HAI: MRSA	0 (Jun)	1 (May)	HAI: E. coli	7 (Jun)	10 (May)	HAI: C Diff (HOHA & COHA)	9 (Jun)







Quality - RESPONSIVE

Commentary on high level board position

- The eNA compliance data is not available. The eNA compliance logic remains different between sites, the merger of Single PAS system has meant that the compliance logic needs to be standardised before the data can be jointly represented. Discussed at next SNMPG and meeting requested for agreement.

High level Board Performance Indicators

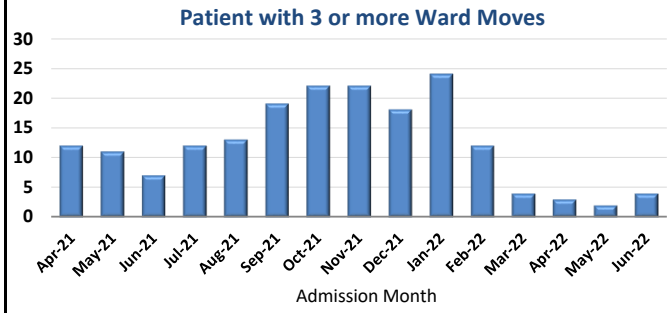
	22/23 YTD	21/22 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)	9	30	-21
Patient Moves Out of Hours (Non-Clinically Justified Only)	163	237	-74
Mixed Sex Acc. Breaches Suspended Apr20 - Sep21	55	0	55

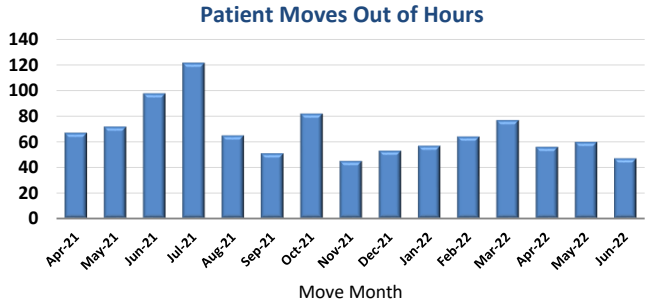
ENA Risk Assessment

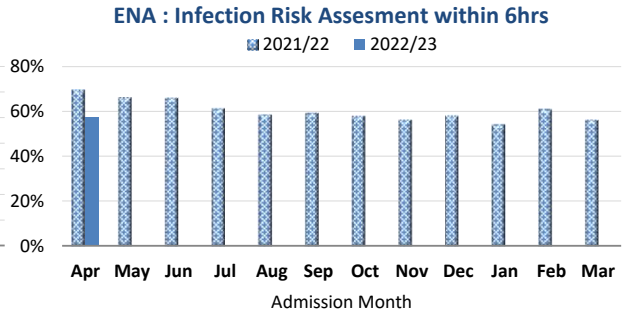
Up to Apr 2022 only

Falls	54.7%	62.7%	-8.0%
Infection	57.5%	67.2%	-9.7%
MUST	58.0%	66.8%	-8.9%
Waterlow	55.6%	62.9%	-7.3%

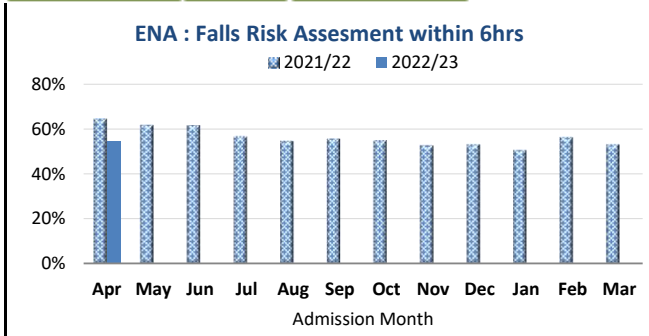
High Level Trust Performance

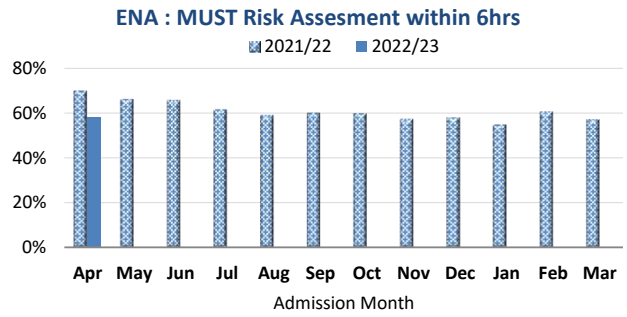


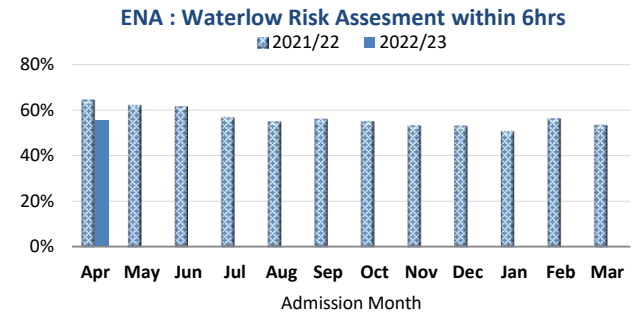




54.7% (Apr)	Falls	N/A	57.5% (Apr)	Infection	N/A	58.0% (Apr)	MUST	N/A	55.6% (Apr)	Waterlow	N/A







Quality - EFFECTIVE AND MORTALITY

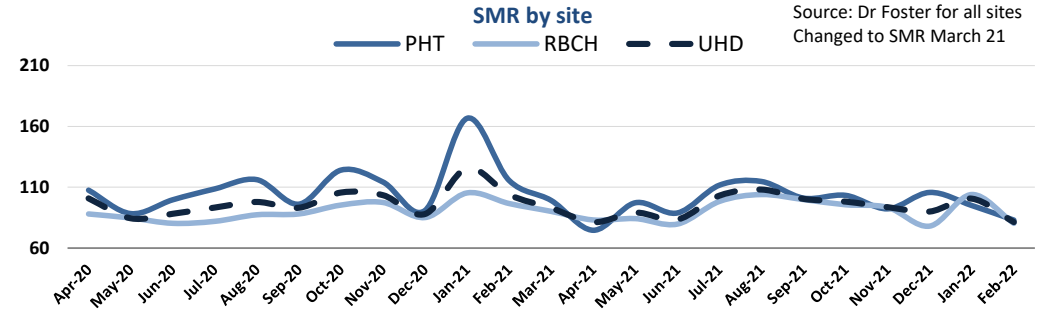
Commentary on high level board position

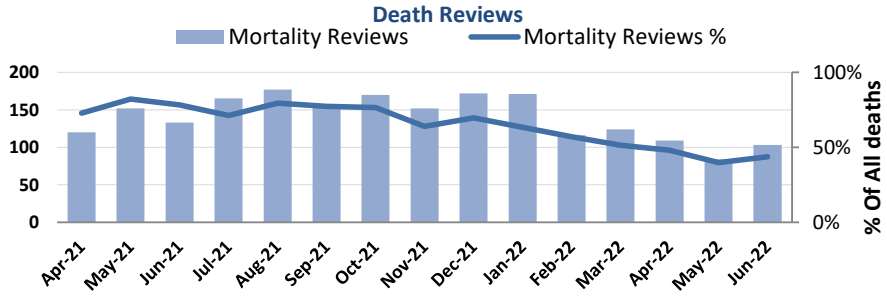
- The Mortality Surveillance Group meets monthly (next meeting 14/7/22) and reviews mortality reports from speciality M&M meetings.
- The UHD Learning from Deaths Policy and the UHD Mortality Policy are under review and will be presented for approval at the August MSG.
- Work progresses on the eLearning from Deaths project. Currently in the IT design phase with pilot testing due to commence across all sites in October 2022.

High level Board Performance Indicators

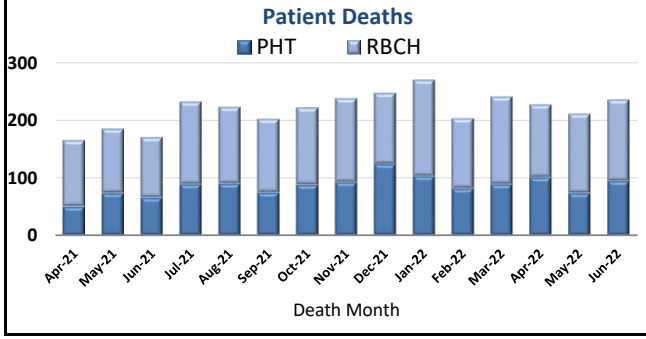
		22/23 YTD	21/22 YTD	Variance
SMR (Source: Dr Foster for all sites)	Latest (Feb-22 - UHD)	81.4	103.9	
Patient Deaths	YTD	674	520	**154**
Death Reviews Note: 3 month review turnaround target	Number	296	405	**N/A**
	Percentage	44%	78%	
Deaths within 36hrs of Admission		109	92	**17**
Deaths within readmission spell Patient readmitted within 5 days		66	36	**30**

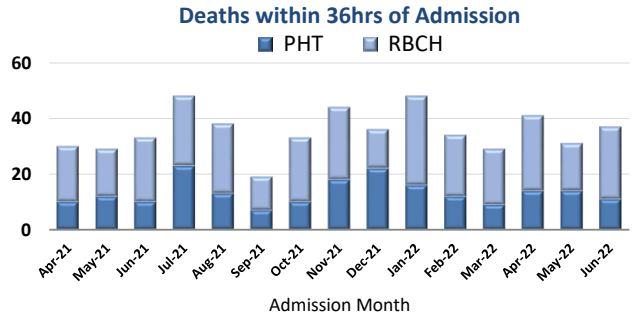
High Level Trust Performance

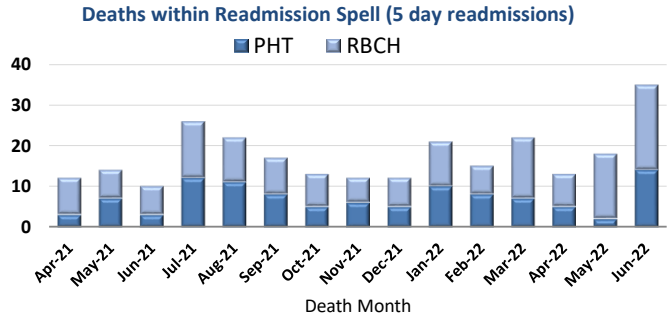




100.6 (Jan)	SMR	81.4 (Feb)	211 (May)	Patient Deaths	236 (Jun)	57.1% (Feb)	Deaths Reviewed	51.5% (Mar)







Quality - CARING

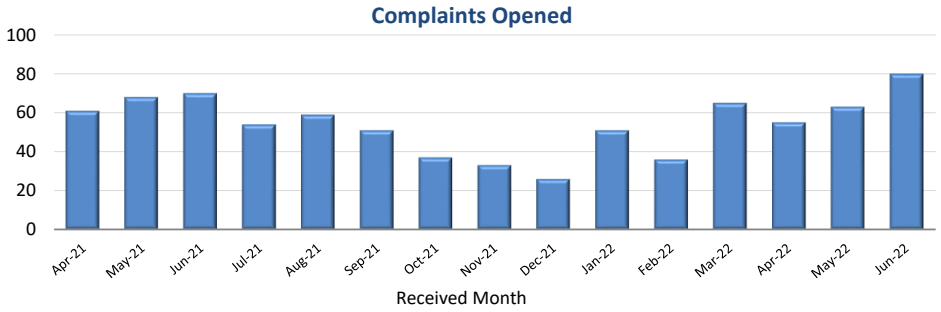
Commentary on high level board position

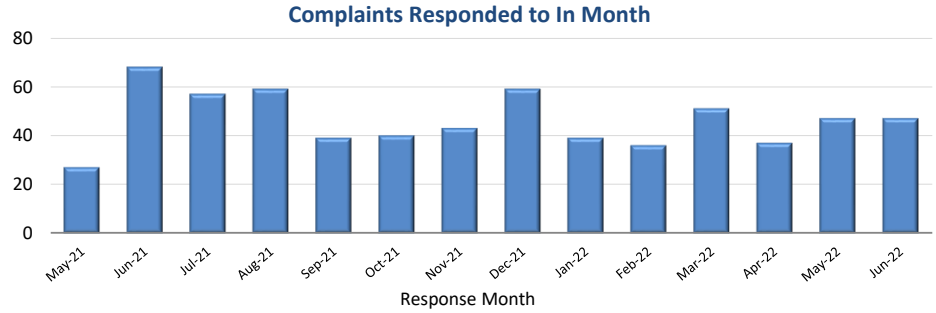
- FFT Positive responses have marginally declined in June at 88.3% compared with 89.7% in May. (our lowest positive response this year was recorded in August at 86.36%)
- In June there were 576 PALS concerns raised, 44 new formal complaints and 36 Early Resolution complaints (ERC) were processed.
- The number of formal complaints that were responded to and closed in June was 18.
- Regular meetings with care group leads continue with a focus on closing of complaints.
- In June there were 162 outstanding open complaints, 54 of which have been open longer than the extended target of 55 working days. Additional support has been funded by the medical care group in atttempt to reduce the number of open complaints they hold. The delay is due to operational pressures delaying complete investigations and a delay in writing letters to complainants.
- Key themes from PALS and complaints:
  - Communication – Absent or incorrect
  - Organisation process – Waiting times, accessing care
  - Clinical – staff competencies
- The number of 'open' S42 enquiries has increased and was escalated through safeguarding as a concern. There are multiple causes including internal UHD pressures to return Enquiry forms and Social Care pressure to review and 'close' enquiries.

High level Board Performance Indicators

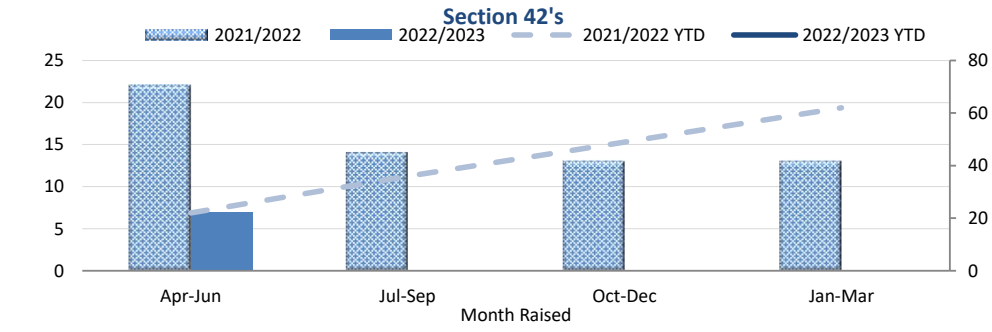
	22/23 YTD	21/22 YTD	Variance
Complaints Opened	198	199	-1
Complaint Response Compliance	TBC		
Complaint Response in month	131	133	-2
Section 42's	7	22	-15
Reported quarterly			
Friends & Family Test	89%	89%	-1%
New guidelines from June 2020			

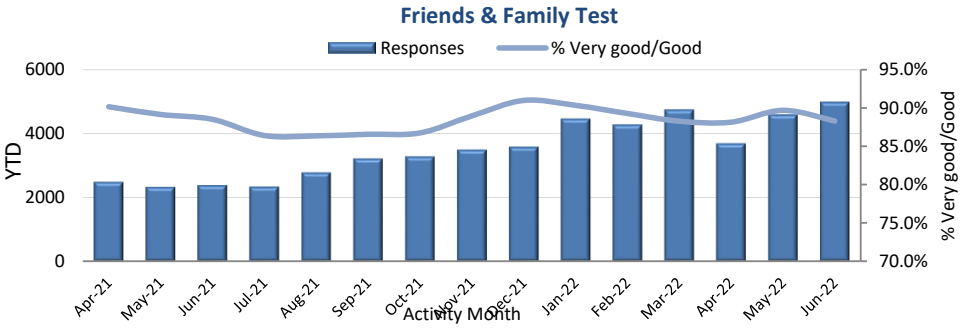
High Level Trust Performance





47 (May)	Complaint Responses	47 (Jun)	63 (May)	Complaints Opened	80 (Jun)	89.7% (May)	FFT % V.Good/Good	88.3% (Jun)





Quality - WELL LED

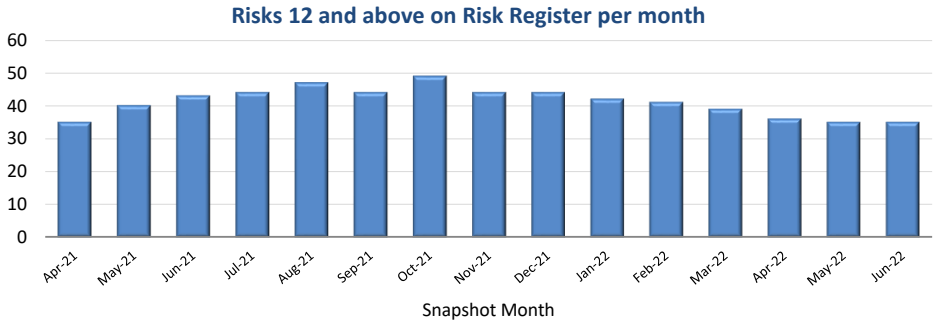
Commentary on high level board position

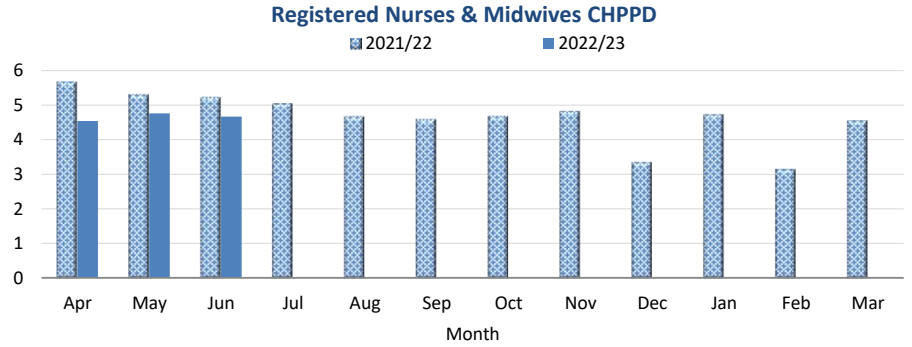
- Risk register update (as at 10/7/2022) provided in Quality Committee, TMB, and Board report
- Heat map risk reports provided to Finance and Performance Committee, Workforce Committee and Operations and Performance Group .
- Board Assurance Framework (BAF) 22/23 Q1 presented to Quality Committee 25/7/2022
- No outstanding Patient Safety Alerts

High level Board Performance Indicators

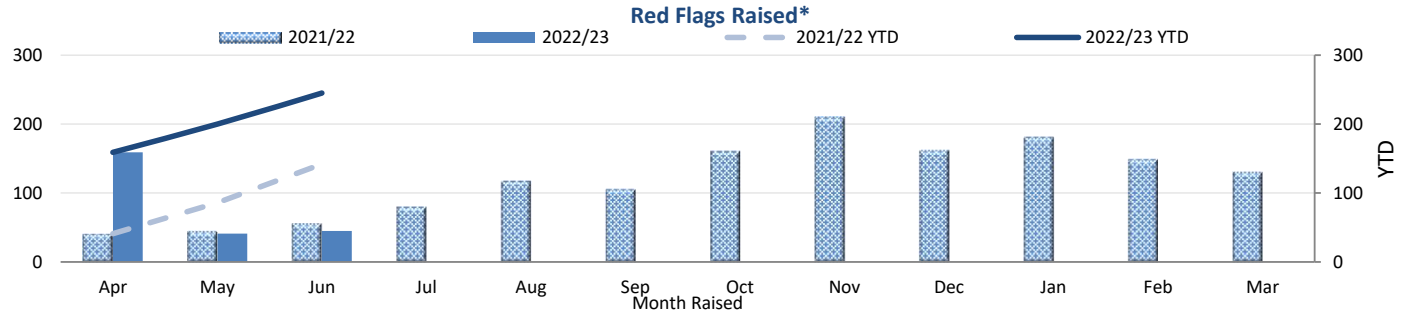
	22/23 YTD	21/22 YTD	Variance
Risks 12 and above on Register	35	43	-8
Red Flags Raised*	245	142	103
*Source: SafeCare from Dec21. Criteria aligned.			
Registered Nurses & Midwives CHPPD	4.7	5.4	-0.7
Patient Safety Alerts Outstanding	0	0	0

High Level Trust Performance





35 (May)	Risks 12+	35 (Jun)	4.8 (May)	RN & RM CHPPD	4.7 (Jun)	41 (May)	Red Flags Raised	45 (Jun)



Workforce

Commentary on high level board position

UHD turnover is tracking at 14.6% 12 months rolling with an actual this month of 14.8%, an increase of 0.4% on May

Vacancy Rate is 6.2% 12 months rolling, actual in month for June is 6.3%, a decrease of 0.5% on previous month.

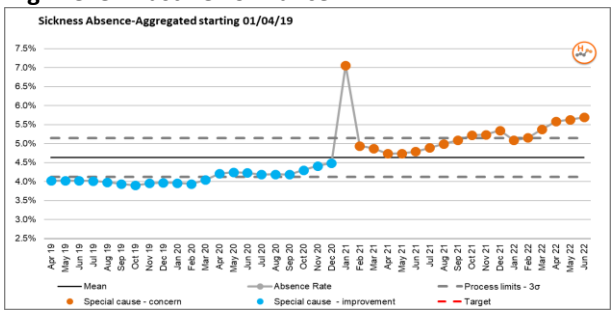
Overall Sickness absence 12 months rolling is being reported at 5.6%. In June sickness absence increased to 5.1%, an increase of 0.3% compared to May

Statutory and Mandatory training: Overall Compliance remains fairly strong. Poole Hospital has improved to 77.8% and RBCH has improved to 89.5% with overall UHD Trust compliance standing at 83.7%.,

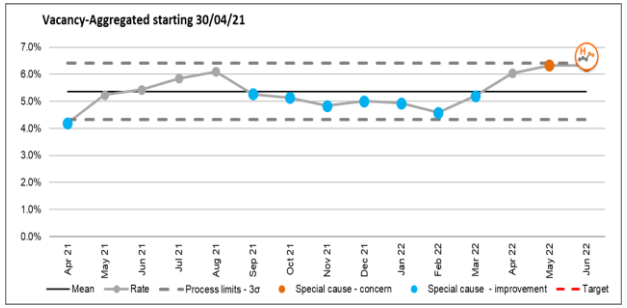
High level Board Performance Indicators

		22/23 YTD	21/22 YTD	Variance
Turnover (12 month rolling)		14.6%	11.3%	3.3%
Vacancy		6.2%	5.0%	1.3%
Sickness Rate (12 month rolling)		5.6%	4.8%	0.9%
Appraisals	Values Based	7.7%	10.1%	-2.4%
	Medical & Dental	56.9%	52.7%	4.1%
Statutory and Mandatory Training		84.2%	87.8%	-3.6%

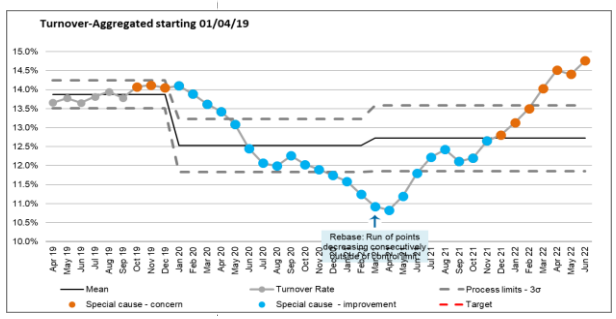
High Level Trust Performance



54.7% (May) | Appraisals (Medical) | 56.6% (Jun)

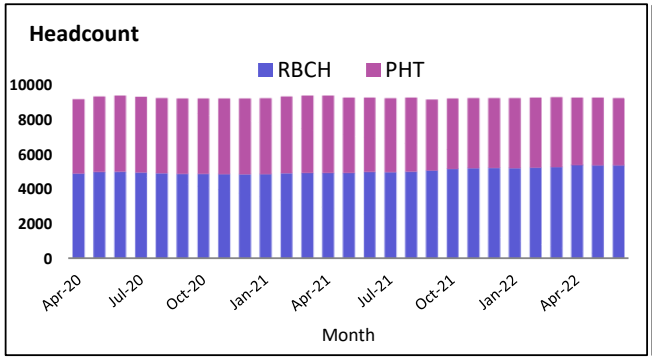


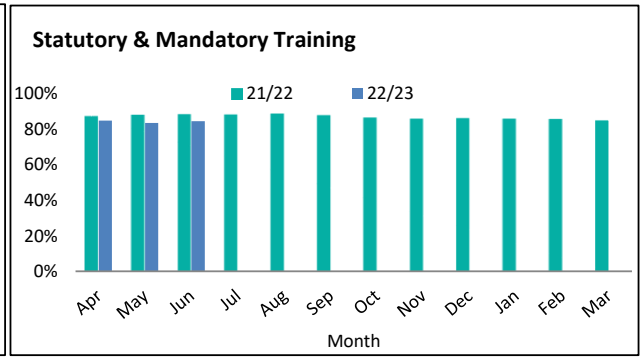
7.0% (May) | Appraisals (Values) | 14.9% (Jun)

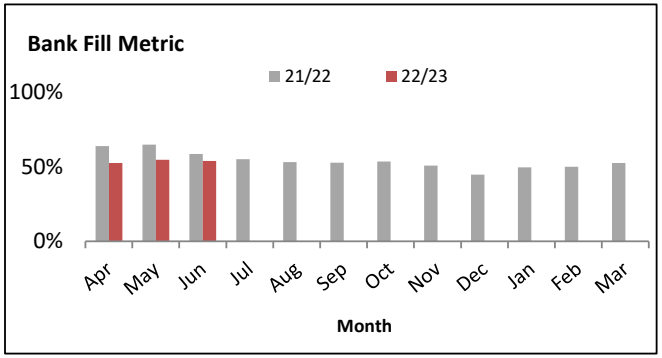


12.8% (May) | Turnover | 13.3% (Jun)

5.2% (May) | Sickness Absence | 5.3% (Jun)







Emergency

Commentary on high level board position

Urgent and Emergency Care remains a significant challenge for UHD and Nationally.

Attendances in June increased to almost 14,500 representing an additional 27 patients per day compared to May, an increase of almost 50 per day in 2 months. The overall meantime has deteriorated by 9 minutes, driven primarily by an increase at the Poole Department. There was a small decrease at RBH.

There were increases in the number of patients waiting more than 12 hours in the department, and those waiting for more than 12 hours from referral. This was driven by crowding particularly at Poole, where 523 patients spent more than 12 hours in the department. The mean wait from decision to admit to transfer to a bed at Poole was just under 5 hours.

Ambulance handovers deteriorated in June, with 629 waiting more than an hour to hand-over. Again predominantly driven by pressures at the Poole with RBH showing a marginal improvement in month, the split of breaches being 50/50. Dorset has not achieved the submitted improvement trajectory (along with most other SW regions) and will continue to be under Regional NHSE scrutiny. The CCG are leading a weekly Ambulance handover recovery meeting and UHD is aligning the rapid decompression work stream to this forum.

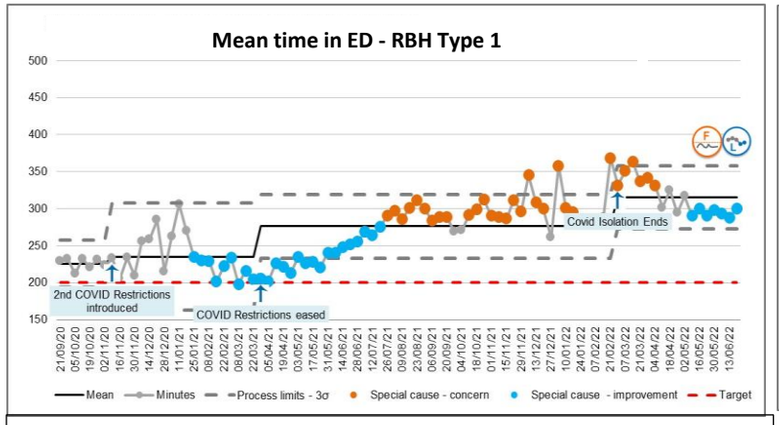
High level Board Performance Indicators

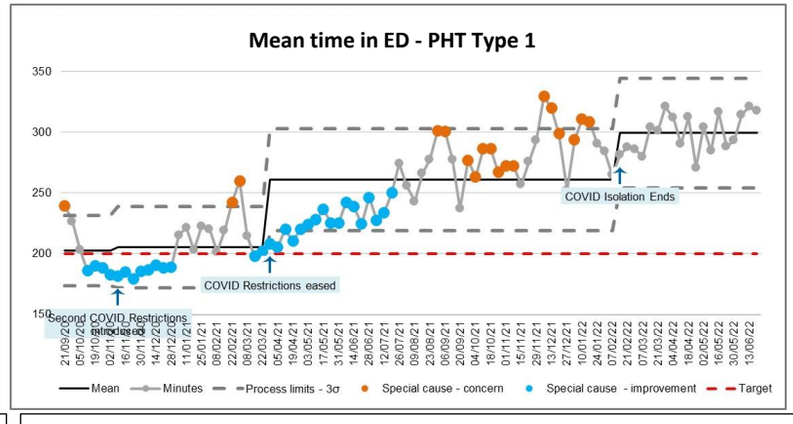
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	**18**
Clinician seen <60 mins		**20.0%**
PHT Mean time in ED	200	**317**
RBCH Mean Time in ED	200	**300**
Patients >12hrs from DTA to admission	0	**105**
Patients > 12hrs in dept		769
YTD ED attendance Growth vs 22/23 (vs 21/22)		-0.2% (37.2%)
Ambulance Handover		
YTD Ambulance handover Growth vs 22/23 (vs 21/22)		-16.4% (-13.6%)
Ambulance handover 30-60mins breaches		462
Ambulance handover >60mins breaches		629
Emergency Admissions		
YTD Emergency admissions growth vs 22/23 (vs 21/22)		-9.7% (3.6%)

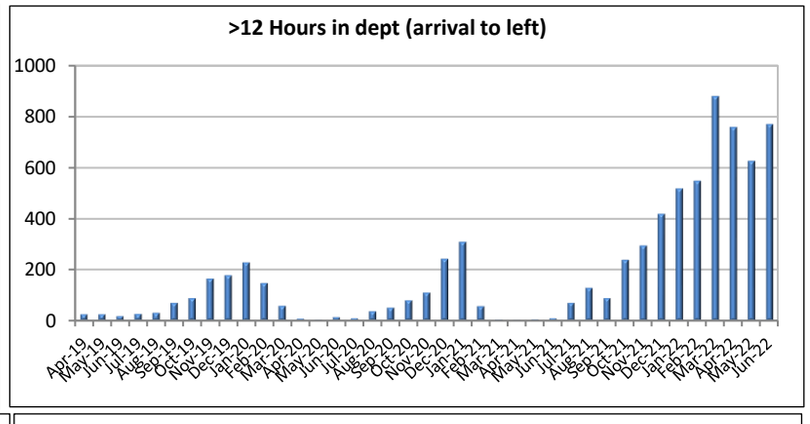
9 mins May-22 → Mean time to initial assessment → 18 mins Jun-22

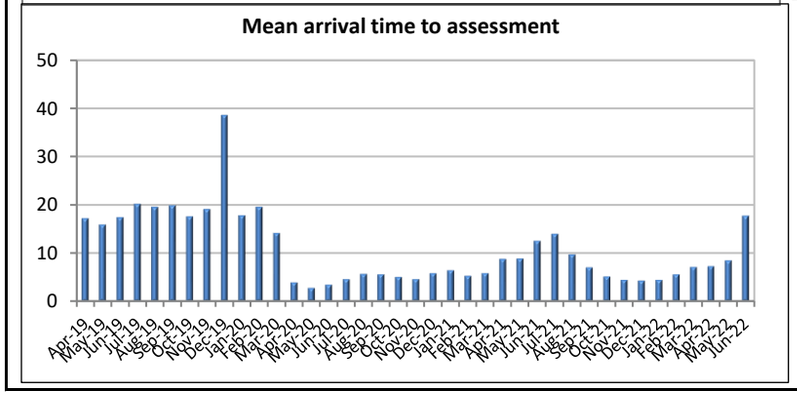
299 mins May-22 → Mean time in Dept. RBH & PHT → 308 mins Jun-22

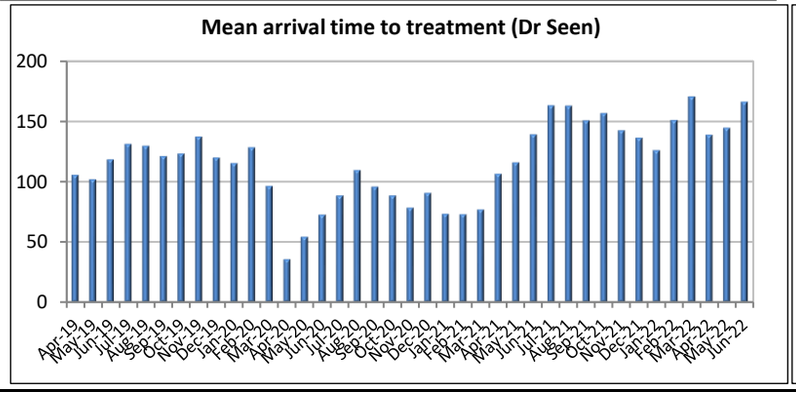
High Level Trust Performance

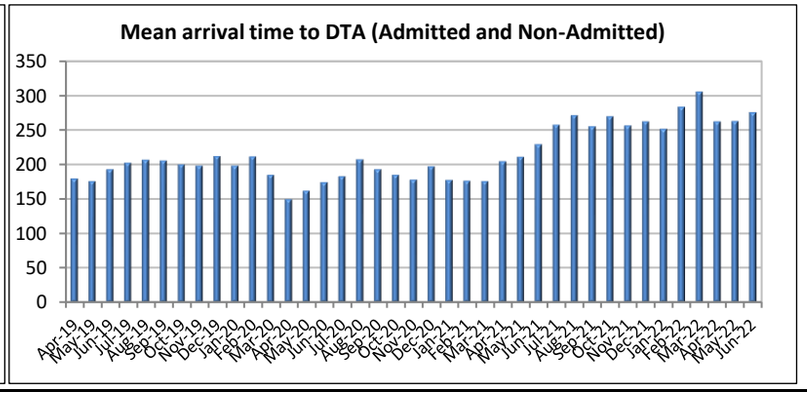












Patient Flow

Commentary on high level board position

Patient Flow

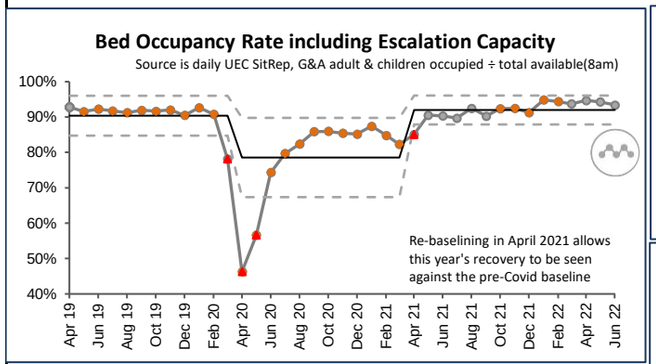
Bed occupancy has decreased fractionally in June to 93.4% (-0.9%) compared to the previous month. The high occupancy rate which is above the 85% national standard is attributed to the significant number of MRFD patients residing in acute beds. This has had a negative impact on the number of outliers across specialties. The figure also includes escalation/extremis beds which have been opened to support the pressures of covid occupancy, maintaining elective activity and emergency care demand.

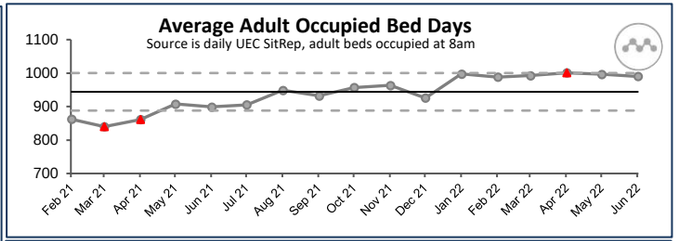
The ED conversion rate has decreased to 26.9% (-1.5%) and this is below the national standard. Monthly occupied beds day charts are averaged to express the occupancy in terms of beds (also correcting for each month having a different number of days). The adult volume is slightly lower than previous months but still above the 17-month average. More patients were discharged than admitted in the month, resulting in a net discharge of 14 patients. The mean bed wait for patients is 240 mins, i.e. 4 hours, which is higher than the previous month. The chart at bottom-right shows how the mean wait time has risen overall during the last year, impacting on flow out of the Emergency Department and ambulance

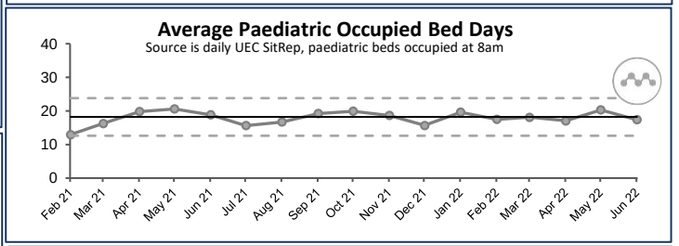
High level Board Performance Indicators & Benchmarking

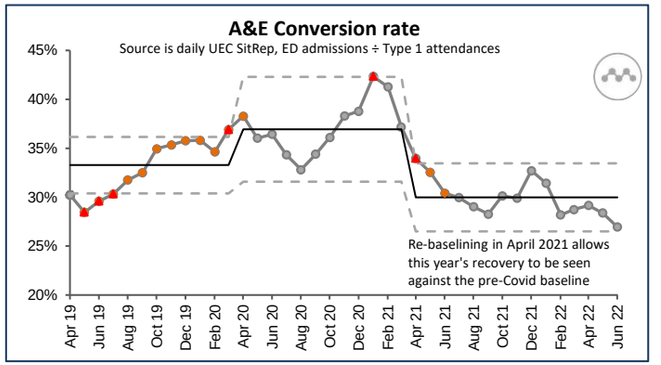
June 2022	Standard	Merged Trust
Patient Flow		
Bed Occupancy		
(incl. escalation in capacity)	85%	93.4%
(excl. escalation in capacity)		96.2%
Occupied Bed Days		30,225
Daily average Occupied Bed Days		*1007.5*
Admissions v Discharges		7,158 v 7,172
Net admissions	<= 0	-14
Non-elective admissions		5,802
> 1 day non-elective admissions		3,633
Same Day Emergency Care (SDEC)		2,168
Conversion rate (admitted from ED)	30%	26.9%
Mean bed wait: minutes *w/c 27 June*		240.17

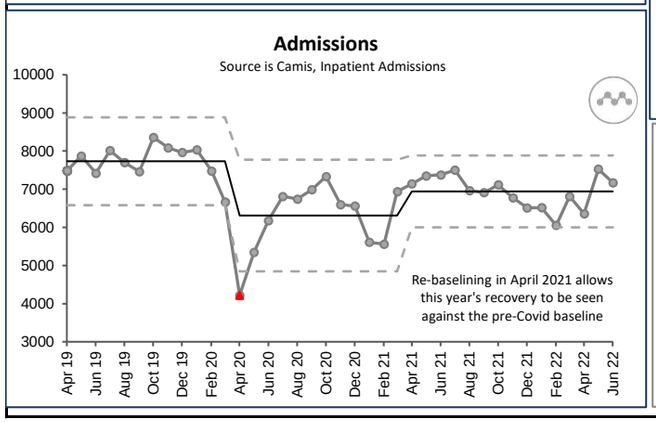
High Level Trust Performance

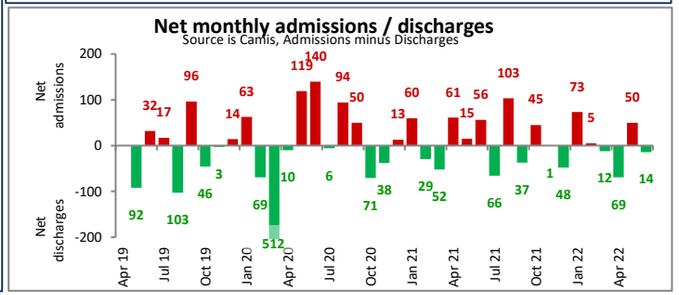


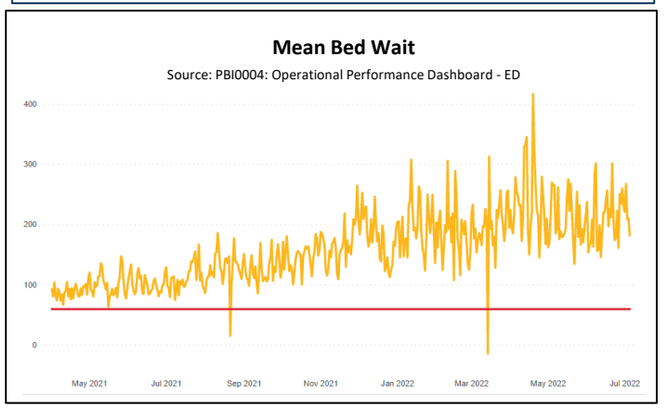












Length of Stay and Discharges

Commentary on high level board position

Patient Flow

The average number of beds per day occupied by patients with a length of stay>7 days has remained steady (the OBD chart below left shows a slight decrease but this due to June having fewer days than May). The number of patients with a length of stay over 21 days has increased fractionally to 256 (+2 patients). This is not a significant change in performance, continuing the generally high numbers so far in 2022, and remains above pre pandemic levels. The increased stay for stranded patients continues to have a detrimental impact on the national UEC metrics, particularly 12 hr DTA and ambulance handovers.The average number of patients who are ready to leave/have no reason to reside (MRTL/NRTL) remains at 214 patients this month. The overall delayed discharge position continues to challenge hospital flow. The overall proportion of NRTR patients has decreased to 27%, a 1% reduction in month. Internal processes accounted for 17% of patients no longer meeting Criteria to Reside (C2R).

Challenges across the Dorset System continue to impact on discharging patients MRFD across UHD sites as follows: 1. Transition into the new model for complex discharge, managing to maintain rate of discharge. Ambition that this will improve now that we are back to responsible commissioner.

2. Deficit of domiciliary care capacity across Dorset.3. Limited flow to spot-purchase care home settings

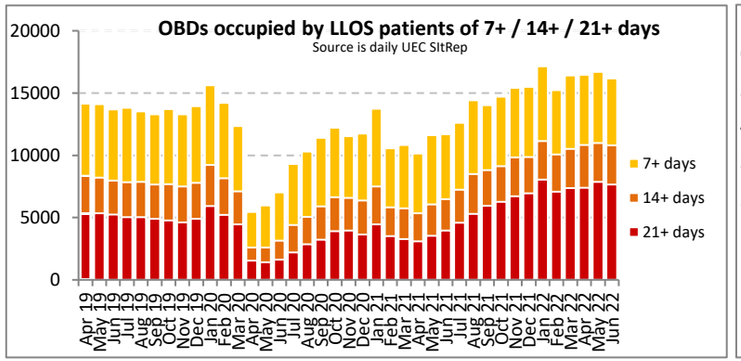
4. Social Worker vacancies impacting on delay in timely complex discharge planning and decision-

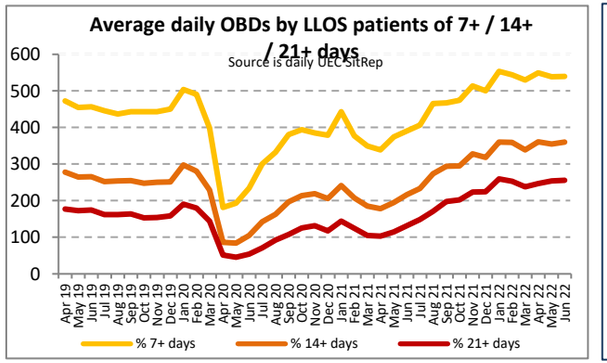
High level Board Performance Indicators & Benchmarking

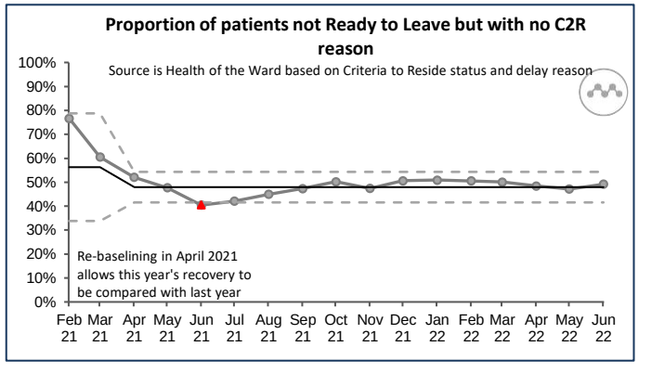
June 2022	Standard		Merged Trust	
Length of Stay and Discharges				
Stranded patients:				
Length of stay 7 days		*42%*	539	*53.5%*
Length of stay 14 days		*21%*	360	*35.7%*
Length of stay 21 days	108	*12%*	256	*25.4%*

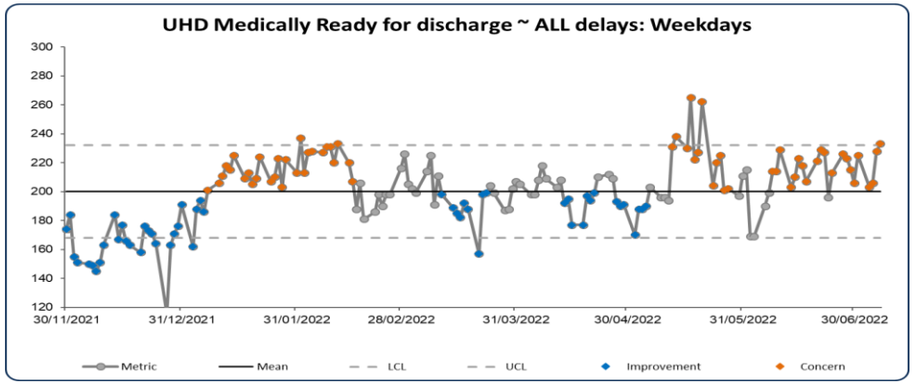
Criteria to Reside (excludes Ready to Leave)	Physiology	4%
	Function	12%
	Treatment	25%
	Recovery	9%
	Not Recorded	**49%**
Proportion of patients who are Ready to Leave		26%

High Level Trust Performance









Escalation Report

Jun-22

Trauma Orthopaedics : 13% compliance achieved against fractured neck of femur target of 95% of clinically appropriate patients to surgery within 36hrs.

Activity	Response

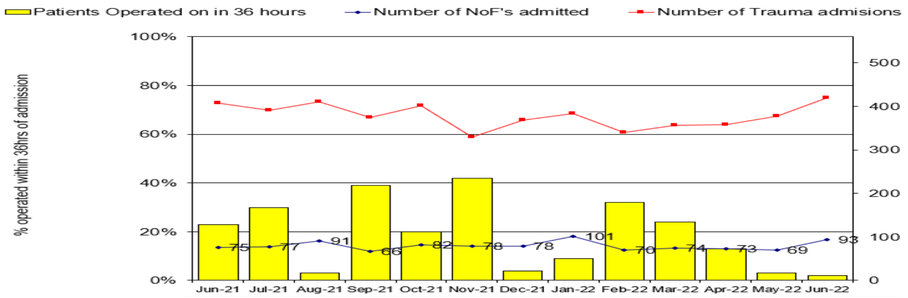
Definition of Trauma Quality Targets & Compliance Achieved

NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission.
June 2022 Compliance: 2%
CCG 2018-19 Quality Target: 95% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission or of being clinically appropriate for surgery, increasing to 95% by March 2019 (internal target remains at 95% on a monthly basis).
June 2022 Compliance: 13%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
June 2022 Compliance: 89%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	3
Patients on anti coagulants	3
Other NoF/trauma patients prioritised	53
Loss of weekend capacity due to theatre staffi	0
Awaiting x-ray/scan availability	0
Required medical review pre-op	5
awaiting transfer from RBH	1
Awaiting specialist surgeon	15
Total breached NoFs	80

Demand on Trauma Directorate during June 2022



	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Patients Operated on in 36 hours	23%	30%	3%	39%	20%	42%	4%	9%	32%	24%	13%	3%	2%
Number of NoF's admitted	75	77	91	66	82	78	78	101	70	74	73	69	93
Number of Trauma admisions	407	391	411	374	401	330	368	384	340	357	358	377	420

Escalation Activity in June 2022

June remained a very busy month with 420 trauma admissions including 93 patients a fractured neck of femur (# NoF). 18 patients were admitted with a femoral shaft fracture of which 15 were operated on. Attainment of NHFD standards were severely affected by a poor start to the month with 55 patients outstanding for theatre including 13 with a fractured NoF. Patients with a fractured NoF admitted on the 1st of the month did not get to theatre until the 3rd of the month.
Significant variation in demand, 11 days in June we had 4 or more admitted, between the 14th and 17th June we had 20 NoF's admitted. All patients are clinically are prioritised and patients referred from clinic for surgery with 10-13 day old fractures take clinical priority. 8 patients required a THR for their # NoF.
The service continued under sustained and significant pressure, the whole month in level 3 escalation, peaking at 69 patients outstanding with the minimum for the month being 42 patients waiting both as inpatients and at home.
Approximately 23 theatre sessions below pre Covid template in June.
Theatre staffing and radiographer availability continue to affect the availability and utilisation of our trauma lists.

Mitigations and Reset

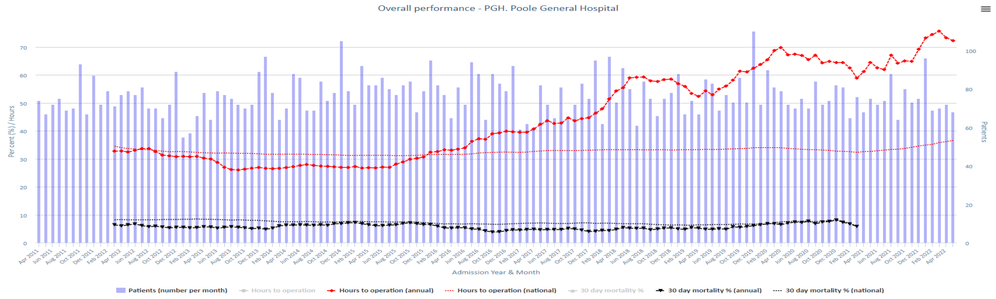
.
Bi weekly Trauma Improvement group in place to review opportunity and blocks to safety, productivity and efficiency. Remedial action plan created and action log in place. Trauma summit completed and action plan in place. Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate.
Virtual fracture clinic capacity increased to provide same day access.
Bed base, reduction in core capacity (108 to 89) to support Covid capcity and Critical Care capacity.
No overall change in average daily NOF admissions leading to backlog of patients awaiting surgery remains 3.25 per day.
Daily trauma escalation operational huddle in place.
Short term theatre capacity increase to support escalation response, elective programe reduced to support.
Trauma Ambulatory Care Unit (TOACU) opened at the end of July 21 80% admission avoidance rate improving to 90%. Service impacted at times of capacity issues as used for inpatient capacity. Service now had consistent ringfencing resulting in up to 40 pts/wk with admissions avoidance >80%.
High level of MRFD patients accross trauma (35%), liason and linking with Trust operational flow project ongoing.

Complexity of Case Load

Soft Tissue	No. of pts
Patients requiring returns to theatre	15
Additional theatre slots required	20
Complex Surgery	**No. of pts**
Total Hip Replacements for NoFs	8
Revisions carried out	2

Of the 18 patients with a fractured shaft of femur 15 required surgery which is surgeon specific and time consuming in theatre.
15 patients required 2 or more surgical interventions resulting in an additional 20 theatre visits several of who required complex second procedures requiring whole theatre sessions.
14 patients required 2 or more surgical interventions resulting in an additional 16 theatre visits 7 for soft tissue equating to 3 soft tissue lists, 4 patients who had an MUA of their ankle and then required definitive fixation (2 lists) and 3 patients with dislocated joints who required replacement joints (3 lists).

Neck of Femur QSPC Focus



Name	Code	Number of cases submitted	Case ascertainment: total cases compared to last year (%)*	Acute length of stay (days)	Overall hospital length of stay (days)	Documented final discharge destination	Discharge to original residence within 120 days	Hip fractures which were sustained as an inpatient*	Documented not to have developed a pressure ulcer	Documented not to have had a reoperation within 120 days*	120 day follow up
Poole General Hospital	PGH	891	96.7	15.9	16.1	100.0	69.8	2.4	90.8	70.4	82.2
Norfolk and Norwich Hospital	NOR	849	100.8	15.0	14.9	99.9	59.2	2.9	89.9	2.8	0.0
Leicester Royal Infirmary	LER	827	100.7	14.3	21.9	100.0	83.6	3.7	99.9	0.0	0.0
Queen Elizabeth Hospital, Edgbaston	QEB	803	91.8	13.5	15.7	97.5	56.2	2.6	99.9	0.0	0.0
University Hospital Aintree	FAZ	788	109.1	17.6	22.4	100.0	59.5	3.9	98.1	87.8	8.2

June Update on virtual fracture clinic

2019/20				2020/21				2020/21			
Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355	Jan-20	860	40.2	314	Jan-21	598	52.5	383
Apr-19	953	40.6	387	Feb-20	889	39	365	Feb-21	852	50	400
May-19	972	43.7	425	Mar-20	716	50.4%	361	Mar-21	1117	52.1	438
Jun-19	1012	44.6	451	Apr-20	494	63.6%	308	Apr-21	1039	50.6	452
Jul-19	1064	44.6	467	May-20	716	55.9%	400	May-21	972	43.7	425
Aug-19	926	38.9	352	Jun-20	861	50.8%	438	Jun-21	1012	44.6	451
Sep-19	986	41.1	375	Jul-20	1040	51.1%	473	Jul-21	986	41	375
Oct-19	839	39.4	365	Aug-20	1038	47.8%	448	Aug-21	1117	52.1	438
Nov-19	924	38.4	355	Sep-20	1100	49.3%	452	Sep-21	1040	51.1	473
Dec-19	832	40.2	332	Oct-20	934	50.3%	467	Oct-21	1038	47.8	448
				Nov-20	743	53.2%	478	Nov-21	928	56.8	425
				Dec-20	563	55.6%	403	Dec-21	839	40.2	345
								Jan-22	788	52.3	478
								Feb-22	860	40.2	314
								Mar-22	889	39	365
								Apr-22	716	50.4	361

In comparison to 2019 activity there has been an increase in patients managed virtually, with up to 64% of all referrals managed as such. Over the comparable months there has been an over all increase to 55% versus 40% in 2019. This has undoubtably helped to mitigate demands on face to face fracture clinics and remains a huge success.

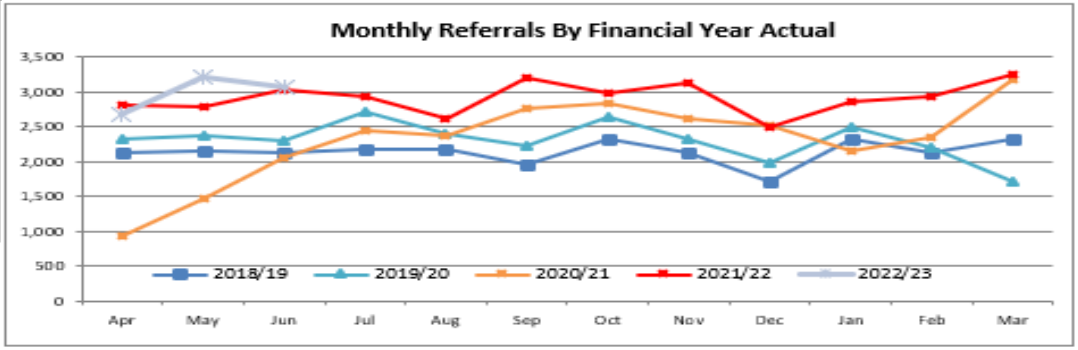
Cancer - Actual May 2022 and Forecast June 2022

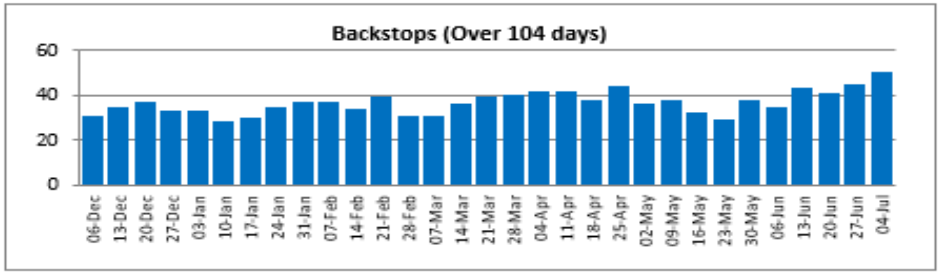
Commentary on high level board position

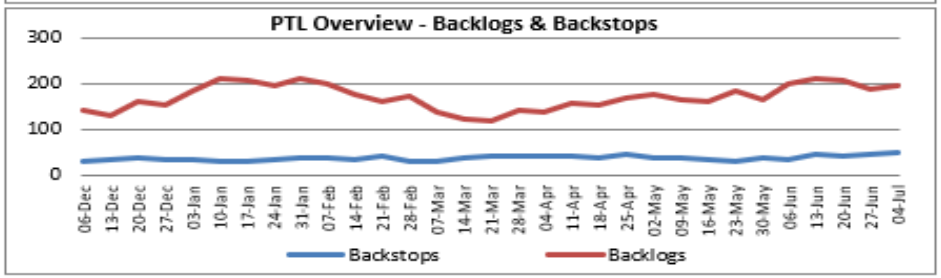
The rate of two week wait referrals in May saw an overall increase of 13% when compared to May 2021. The sites seeing the biggest increases were colorectal (+28%), lung (+26%), upper GI (+25%) and skin (+21%). June referrals were at similar levels seen the previous year, however the sites seeing increases in referrals in month were colorectal (+12%), gynae (+10%) and urology (+9%) The total number on the UHD PTL continues to be above 3500 and ranks 19th when compared nationally. The high increases in referral numbers for the above mentioned tumour sites continues to challenge all performance standards. However, of the 30 trusts with the largest PTL's nationally, UHD has the 3rd lowest % of backstop patients and the lowest % of backstops within the Wessex Cancer Alliance. 28-day FDS performance in May fell short of the 75% threshold reporting 71.8% with 7 tumour sites achieving the standard. The provisional performance for June is showing a slight decrease in performance which is currently at 68.4%. Data completeness in May against this standard was above the target of 95% achieving 97.6%. The Trust has consistently achieved the 31-day standard and is expected to be achieved in June. Two out of three subsequent treatment KPI's were achieved in May, with the exception of surgery mainly due to theatre capacity in urology. The 62-day performance in May was below the 85% threshold (69.9%), however remains above the current national average of 65.5%.

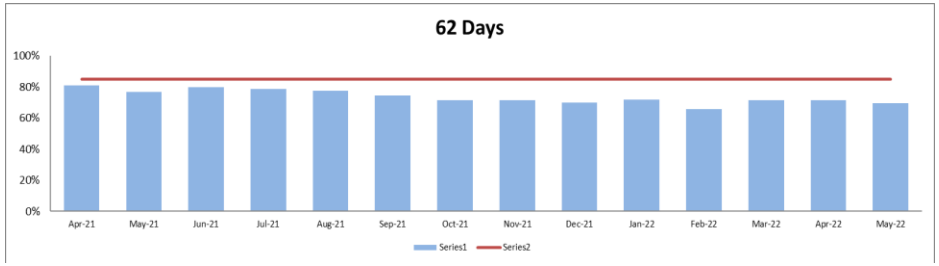
High level Board Performance Indicators & Benchmarking

Cancer Standards	Standard	UHD May-22	Predicted Jun-22
31 day standard	96%	96.6%	98.8%
62 day standard	85%	69.6%	71.2%
28 day faster diagnosis standard	75%	71.8%	68.4%

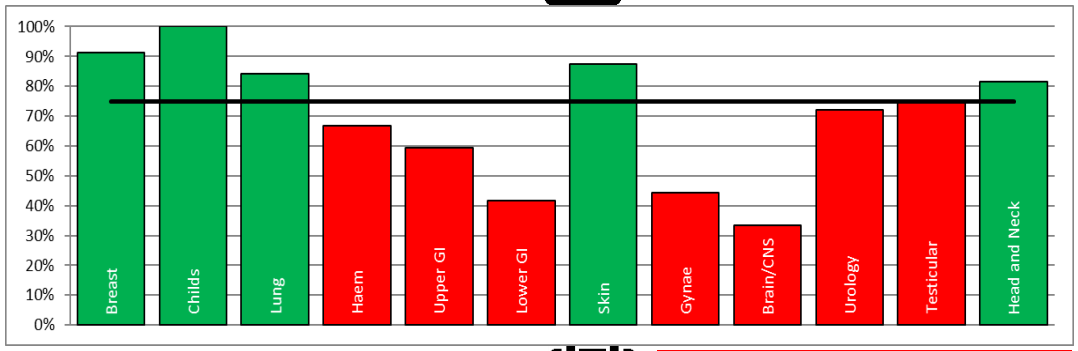




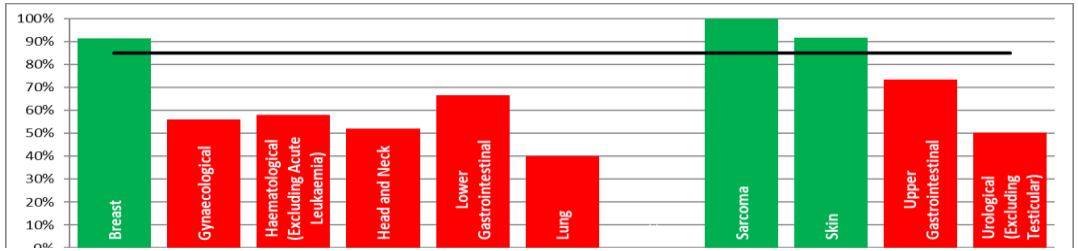




Target 75% | **28** | **UHD: May 2022: 71.8%**



Target 85% | **62** | **UHD: May 2022: 69.6%**



Elective & Theatres

Commentary on high level Board position

18 Weeks Referral to Treatment
At the end of June 2022, the Trust's 18 week RTT performance is **58.2%** (92% standard).

- 4,493 patients were waiting over 52 weeks for treatment, an increase of 1,168 compared to May. The percentage of the waiting list over 52 weeks is currently **6.1%** .
- 520 patients are waiting over 78 weeks, a decrease of 30 since May, and 194 patients are waiting over 104 weeks. The 104 week wait position has reduced by 76 in June 2022.
- The overall **waiting list size** has grown in 21/22. Some of the recent growth is due to duplicate pathways existing in the reported PTL whilst the Trust transitions from two PAS systems to a single Patient Administration System. A programme of validation is now underway to remove these duplicate entries.
- Reduced capacity for elective care due an increase in Covid positive patients, high bed occupancy and workforce gaps have also contributed to this waiting list position.
- **99.58%** of patient referrals have been allocated a clinical prioritisation code (P code) .

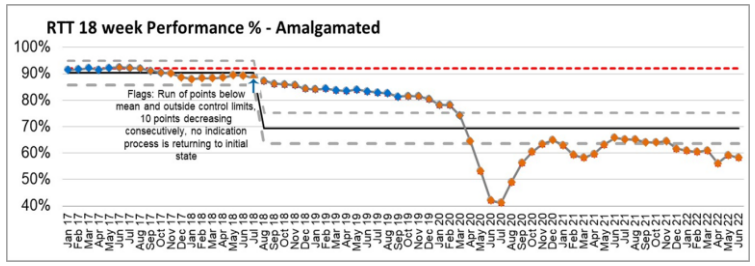
Theatre utilisation
The current staffed theatre (main) utilisation rate has **increased to 78%**. Day case utilisation has also improved, increasing by 4% since last month to 73%.

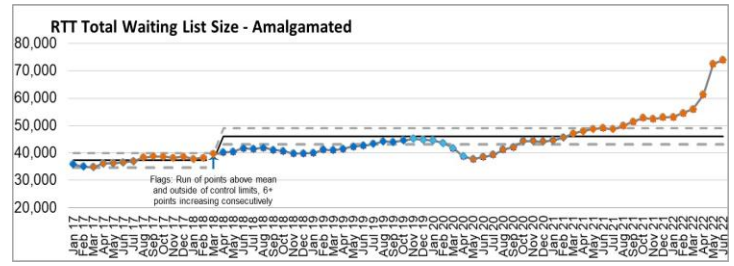
Trauma
The percentage of patients with a fractured neck of femur treated within 36 hours of admission has deteriorated, reducing to 2%.

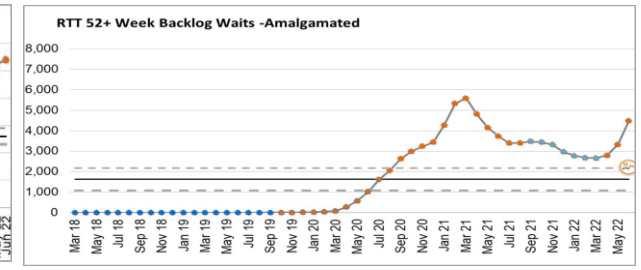
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	58.2%	
Waiting list size	51,491	73,932	17%
Waiting List size variance compared to Sep 2021 %	0%	43.6%	
No. patients waiting 26+ weeks		20,428	23%
No. patients waiting 40+ weeks		9,395	26%
No. patients waiting 52+ weeks (and % of waiting list)	6.1%	4,493	31%
No. patients waiting 78+ weeks		520	69%
No. patients waiting 104+ weeks		118	41%
Average Wait weeks	8.5	19.5	
% of Admitted pathways with a P code		99.58%	
Theatre metrics			
Theatre utilisation - main	80%	78%	
Theatre utilisation - DC	85%	73%	
NOFs (Within 36hrs of admission - NHFD)	85%	2%	

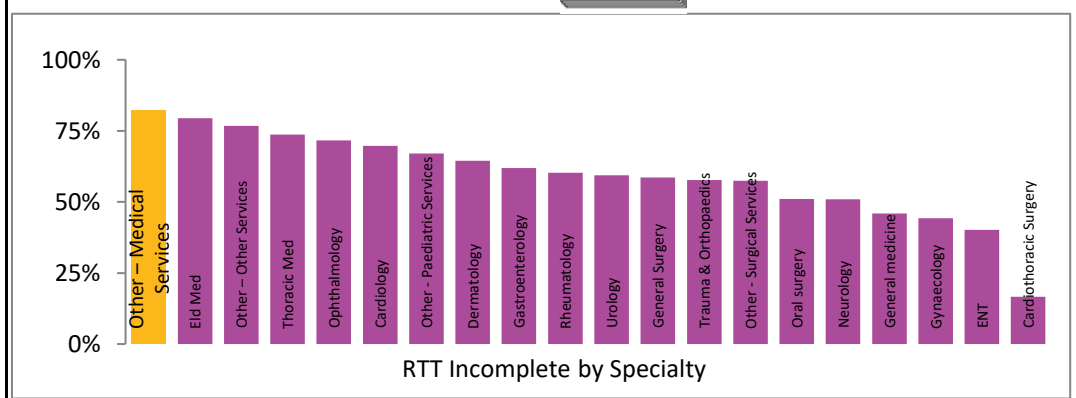
High Level Trust Performance



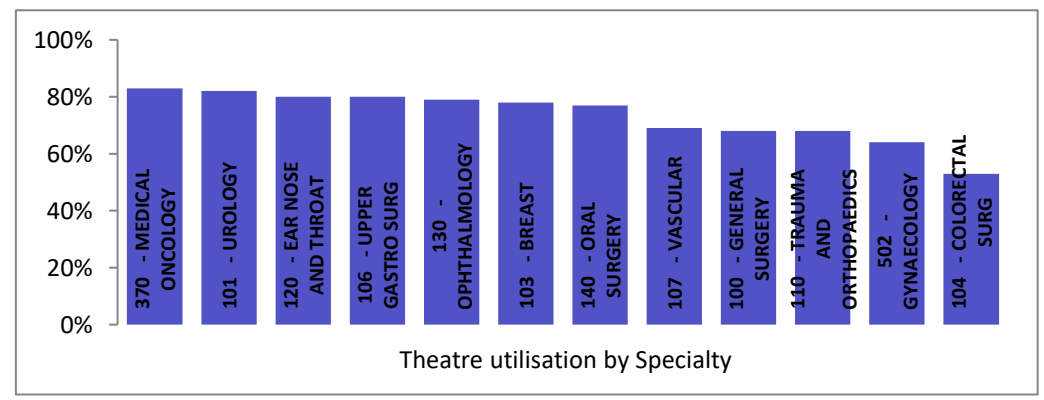




RTT Incomplete 58.2% <18weeks 18 WEEKS (Last month 59.2%) Target 92%



Theatre Utilisation 73.3% (Last month 73.5%)



Referral to Treatment (RTT)

What is driving under performance?	What actions have been taken to improve performance ?

92% of all patient should be seen and treated within 18 weeks of referral.
In June 2022, **58.2%** of all patients were seen and treated within 18 weeks at UHD.
The overall waiting list (denominator) was **73,932** which is higher than previous months and 43.6% above the September 2021 waiting list of 51,491.

4,493 RTT waits exceeded 52 weeks, which is an increased position however below the Trust's operational plan trajectory for June 2022 (4,776).

June 2022 (compared with previous month)
43,039 increase < 18 weeks
20,428 increase > 26 weeks
9,395 increase > 40 weeks
4,493 increase > 52weeks
520 decrease > 78 weeks
118 decrease > 104 weeks

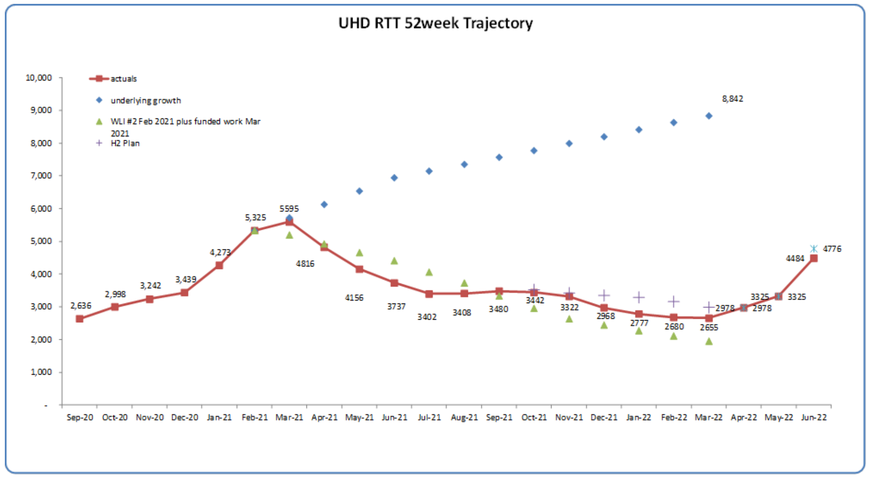
During June 2002 some improvements in recovery of elective care have been delivered however the Trust continues to operate elective recovery alongside continued focus on responding to COVID activity, managing an increase in demand, and management of workforce capacity shortfalls in a number of key areas. High numbers of patients with 'no criteria to reside' in hospital and an increase in trauma demand are also impacting on recovery. This has led to an overall reduction in routine elective activity including outpatient appointments and surgical procedures compared to 2019/20.

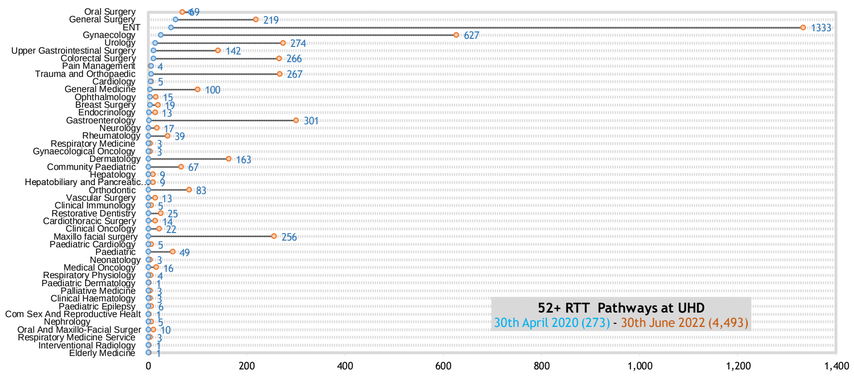
The Trust is currently working towards delivering a single, unified Patient Administration System (PAS) to better manage patient care across all our hospital sites. The impact of this managed change programme is that duplicate patient pathways will exist within the Patient Treatment List (PTL) for a period of time until administrative validation is complete and the duplicate removed. The presence of duplicate pathways is increasing the reported total waiting list position, RTT performance and number of >52 week waiters.

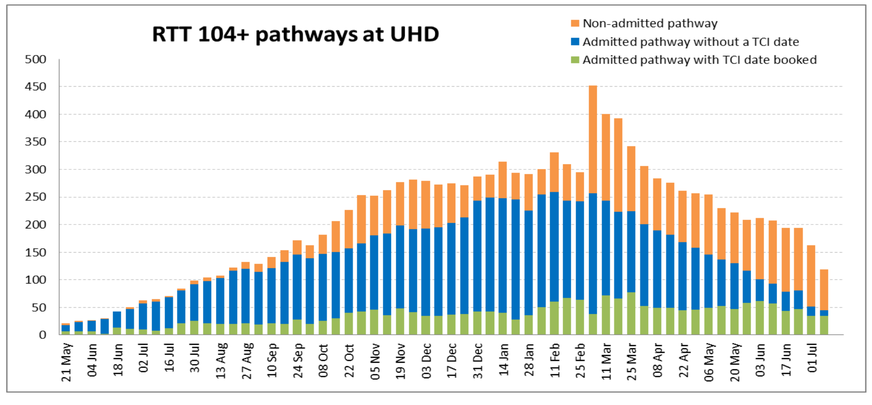
104 week-waiters improvement plan

To support ongoing reduction of people waiting over 104 weeks for treatment, local recovery plans are in place and additional monitoring and tracking of improvement has been established.

An Elective programme is in place to oversee improvements in performance, activity and reducing the number of patients waiting a long time for treatment. The programme accounts to the Chief Operating Officer through the Trust Operational and Performance Group.







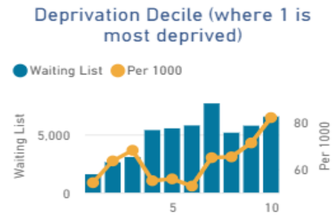
Five Trust-wide improvement programmes are providing a foundation for improvements in elective care recovery:

- A **Theatre improvement programme** - to optimise theatre efficiency and utilisation and improve staff and patient experience of theatres
- **Outpatient Enabling Excellence and Transformation programmes - including three elements:**
  - Enabling Excellence programme - to deliver 'back to basics' improvements focused on achieving immediate and sustainable efficiency improvements in Outpatients
  - Digital Outpatients transformation, and
  - Outpatients Pathway Transformation programme - optimising use of virtual consultations, advice and guidance and patient initiated follow up pathways.
- **Diagnostics recovery**: Endoscopy, Echocardiology and imaging
- **Cancer recovery and sustainability:** Developing a sustainability plan to improve Cancer Waiting Times across 6 priority tumour sites which aligns with the Dorset Cancer Partnership objectives.
- **Data and validation optimisation:** Ensuring access to the best quality data for elective care delivery and planning.

Health Inequalities
The Dorset Intelligence & Insight Service (DiiS) Health Inequalities dashboard enables analysis waiting times disaggregated by ethnicity and deprivation (Dorset Patients only).

Waiting list by Index of Multiple Deprivation (IMD)

Analysis of the waiting list by IMD identifies that 8.4% of the Trust's waiting list are patients living within the bottom 20% by Index of Multiple Deprivation (IMD). An increased of 0.2% in latest month. This increases to 9.3% when analysing patients waiting over 52 weeks.
Total waiting list by IMD (Dorset only patients)



Waiting list by ethnicity
Where ethnicity is recorded, 10.5% of patients are within community minority ethnic populations. This percentage reduces to 10.3% when analysing patients who have waited greater than 52 weeks (down 1.4% compared to May)

Learning disabilities
Patients recorded as having a learning disability on the waiting list equate to 0.68% of the waiting list. This rises to 0.86% when analysing patients waiting over 52 weeks.

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- On-going focus on PA consulting work which include PIFU, Advice and guidance, Virtual consultation and Capacity & Demand specialty reviews to support identifying optimisation of clinic templates etc.
- Single PAS project has impacted on workforce capacity to ensure fully optimised clinic utilisation
- High levels of very short notice additional clinics/cancellation
- Suspension of text reminder service impacting on DNA rates
- Digital projects to support process efficiencies not realised i.e. eRS-EPR referral triage process, RPA to support single PAS project

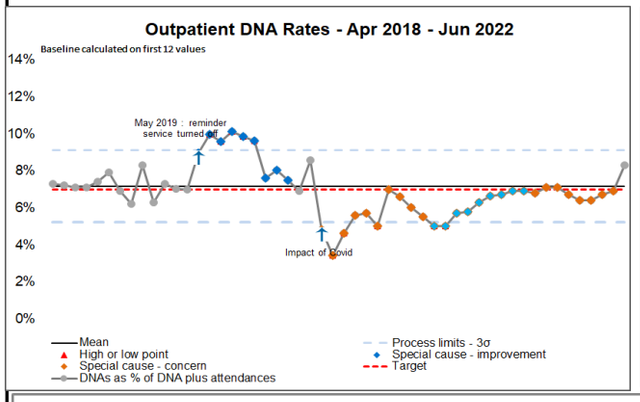
Diagnostics

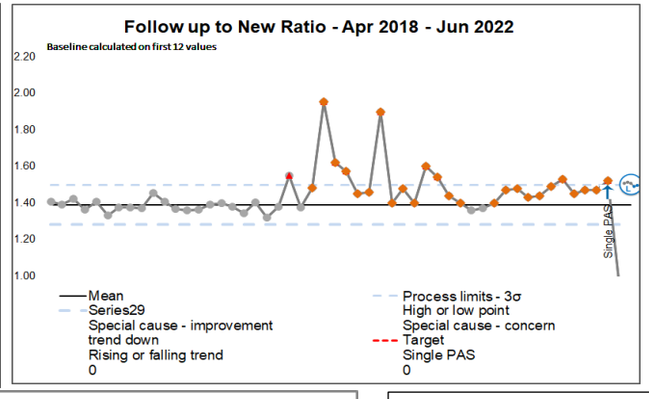
- Decrease against May position from 81.4% to 80.5% of all patients being seen within 6 weeks of referral.
- Endoscopy position has increased from 48.0% in May to 57.5% in June
- Echocardiography has decreased from 52.0% in May to 45.9 % in June
- Neurophysiology has decreased from 99.2% in May to 97.6% in June
- Radiology has increased from 93.1% in May to 96.0% in June (planned recovery of US in August, cardiac CT is the predominant challenge)

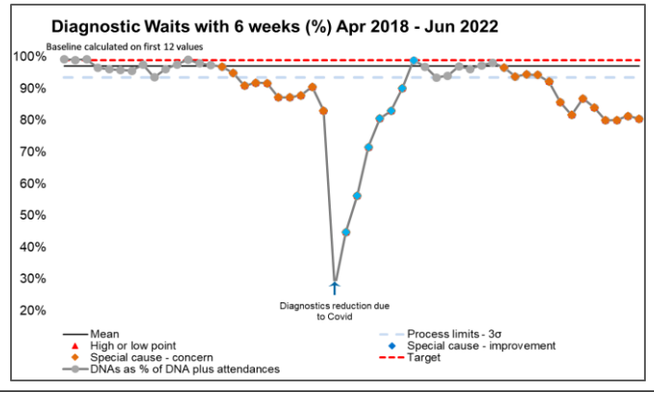
High level Board Performance Indicators & Benchmarking

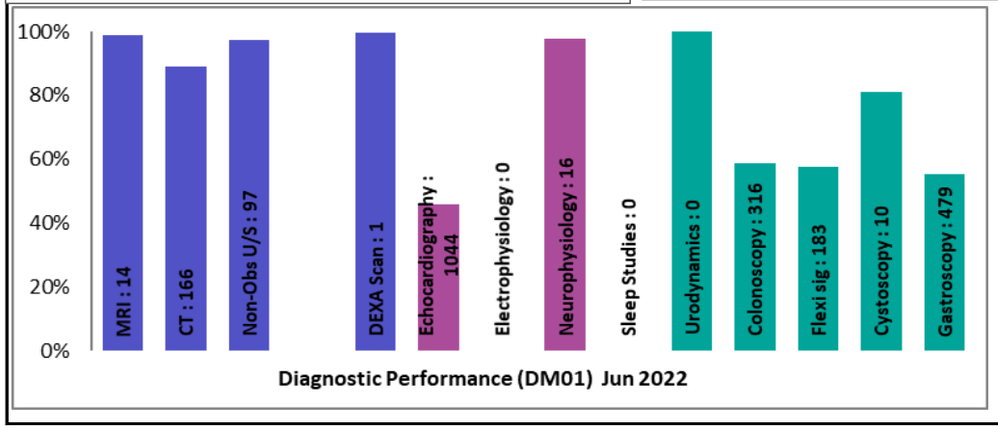
Referral Rates		Standard	Last Year	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	30580	30389	**-0.6%**
Total Referrals Rate year on year		-0.5%	46364	44766	**-3.4%**
Outpatient metrics					
Overdue Follow Up Appointments					**25671**
Follow-Up Ratio		1.91			**0.74**
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%		3266 / 35892	**8.3%**
Hospital cancellation rate	*(Hospital Canx / Total Booked Appts)*			7796 / 52556	**14.8%**
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*			5602 / 52556	**10.7%**
Reduction in face to face attendances					
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%		8224 / 35892	**22.9%**
Diagnostic Performance (DM01)					
% of >6 week performance	*(6+ Weeks / Total)*	1%		2328/11963	**19.5%**

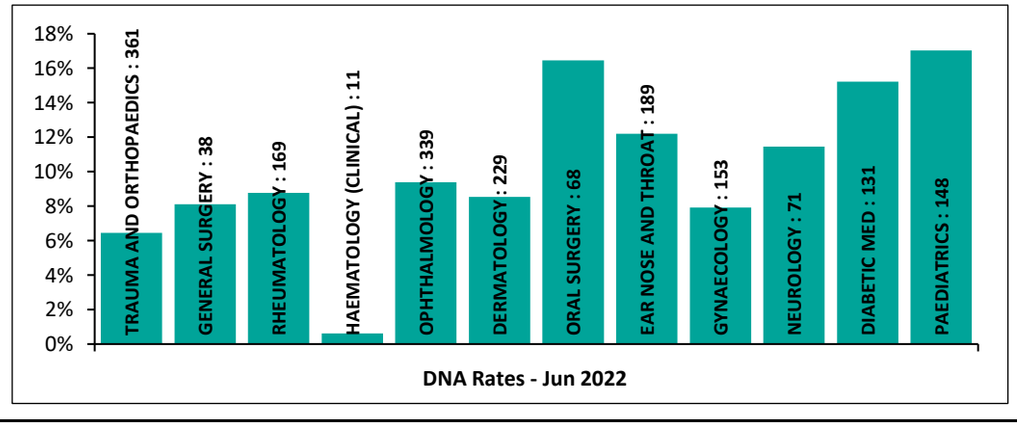
High Level Trust Performance











SCREENING PROGRAMMES

Commentary on high level board position

Breast Screening

A much more consistent level of screening has taken place through the month of June which is demonstrated in the restoration figures. Tier 5 women (overdue their invitation) has reduced to 276 this month.

This is as a result of decommissioning Iris van which has enabled staff to be utilised more effectively across the remaining 3 mobile units and two static sites we have.

The Poole area within the round has now recovered and there is now a plan to explore moving back to pre-covid invitations of timed appointments in this area which will help reduce the heavy admin workload.

The June KPI targets have been exceeded which demonstrates the excellent achievements this month and the round length has increased to 51%.

High level Board Performance Indicators & Benchmarking

Breast Screening	Standard	Merged Trust
Screening to Normal Results within 14 days	95.00%	99.00%
assessment appointment within 3 weeks	95.00%	100.00%
Round Length within 36 months	90.00%	51.00%
Longest Wait time (Months)	36	40

SCREENING PROGRAMMES

Commentary on High Level Board Position

Bowel Cancer Screening

Age Extension

Age extension for the Dorset Programme was launched in May 2021 with invitations to 56 year olds and the bowel scope cohort.

The programme is ready to invite 58 year olds in 2022/23. However, the Regional Commissioning team have confirmed that the planned 'Go Live' date of 4th April has been delayed. The date currently remains unconfirmed due to ongoing contract negotiations over FIT kits.

This may become a risk to programme performance later in the year if the expectation is that the cohort of 58 year olds due an invitation in Q1/2 need to be invited in the remaining months of this financial year. The programme will not have the colonoscopy capacity to manage that level of unplanned increased demand.

The team are currently working with the Southern Hub to review invitation rates based on this situation.

Key Performance Standards

*** Uptake Standard** (*Number of subjects aged 60 to 74 who adequately participated in screening within 6 months of the invitation)*:
The average uptake rate was 74% through 2021 (acceptable performance = >52%; achievable performance = >60%). To date for 2022, uptake is averaging 72%.

*** SSP Clinic Wait Standard** (*Proportion of patients with an abnormal FIT result offered an appointment with a Specialist Screening Practitioner (SSP) within 14 days):*
The clinic wait standard has been maintained at 100% via virtual clinics (acceptable performance = 95%; achievable performance = 98%).

*** Diagnostic Wait Standard** *(Proportion of patients with an abnormal FIT result whose first offered diagnostic test date falls within 14 days of their SSP appointment)*:
Following a drop in performance in February 2022, during the ventilation work at the RBH site, the diagnostic wait standard has been recovered and achieved at 96-100% March to June.

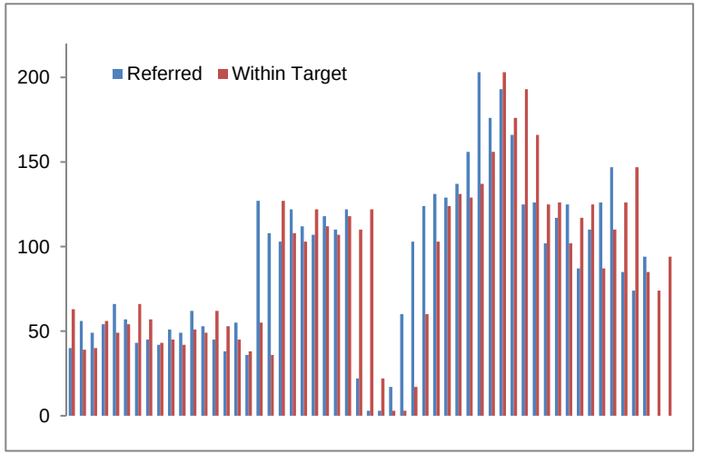
There is lower than anticipated screener availability on the RBH and PGH sites in July and August due to annual leave and ward commitments. However, the programme invitation rate has been reduced due to the delay in age extension to 58 year olds. Therefore the loss in activity will be mitigated with additional WLI lists if required.

The team are reviewing the potential need for insourcing lists later in the year.

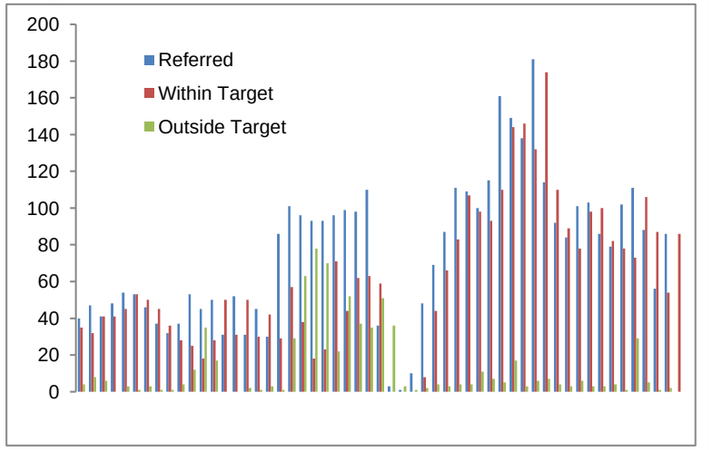
High Level Board Performance Indicators

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

Clinic Wait Standard



Diagnostic Wait Standard



Maternity

Commentary

Homebirth service has resumed this month with a more robust process in placed to determine if the service can be open or closed.

Haven birth centre has been closed due to staffing levels resulting in the lowest number of births occurring there in 4 years.

National funding available for recruitment of international educated midwives, submission due 19th August 2022.

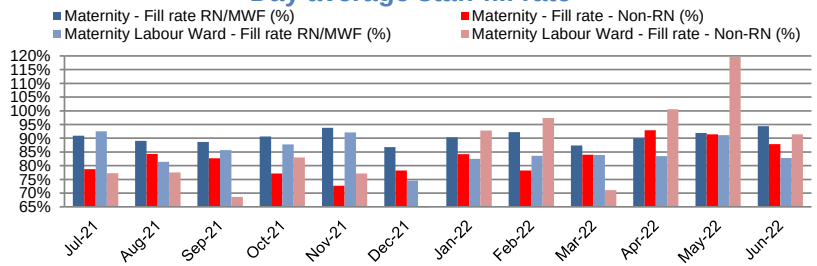
10 Italian Midwives are visiting the Trust on 28th July 2022.

Labour ward Matron interview 20th July 2022

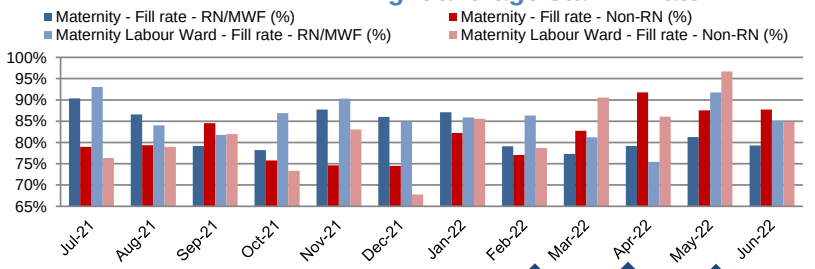
CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Outstanding	Good	Outstanding

Screening incidences		1	
Serious Incidents Reported		0	
HSIB Cases Reported		0	
HSIB / NHSR /CQC Concerns		0	
Coroner Reg 28		0	
Maternity Safety Support Programme		0	
FFT Maternity User Response	Good / Very Good	315	88.7%
	Poor / Very Poor	12	3.4%
	Neither	10	2.8%
	Don't Know	18	5.1%

Day average staff fill rate



Night average staff fill rate



Training Compliance PROMPT June 2022

	Number Compliant 07/21 06/22	Number of headcount Staff @ June 2022	Percentage Compliant
Midwives Band 5	10	8	80%
Midwives Band 6	160	113	70.6%
Midwives Band 7	30	18	60.0%
Midwiifery Managers,	8	6	75%
Consultant Obstetricians	6	17	11%
Obstetric Trainees (Doctors)	2	18	33.33%
Obstetric Anaesthetics	12	15	40%
HCAs/MCAs/MSWs	47	47	56.63%
ODP	11	11	24.44%

Maternity

HSIB Referal case (0)

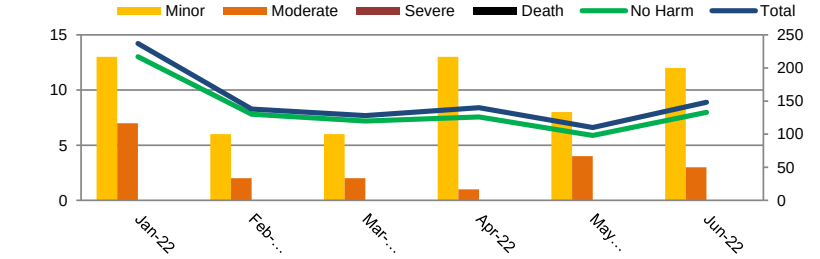
Screening Incidents (1)

Severe Incidents (0)

Perinatal Mortuary Review Panel

UHD no new PMRT cases in June.

Datix Incidents



No Harm	217	130	120	126	98	133
Minor	13	6	6	13	8	12
Moderate	7	2	2	1	4	3
Severe	0	0	0	0	0	0
Death	0	0	0	0	0	0
Total	237	138	128	140	110	148

Learning from incidents (Recent HSIB Report)

There were no HSIB Reportable cases for June 2022

FINANCE

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(359)	(4,613)	(4,254)
Capital Programme	27,331	15,947	11,384
Closing Cash Balance	73,236	85,122	11,886
Public Sector Payment Policy	95.0%	95.0%	(0)%

Commentary

During June, the Dorset Integrated Care System has continued to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who are medically ready for discharge. Within the Trust; both Emergency departments continue to operate under extreme pressure and we continue to care for patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate regulaly at Operational Pressures Escalation Level (OPEL) 4.

At the end June 2022, the Trust has reported a deficit of £4.613 million against a planned deficit of £359,000 representing an adverse variance of £4.254 million. This adverse variance reflects the current shortfall in the cost improvement plan. Recognising this challenge, on the 30 June the Trust convened a (FRS) Financial Recovery Summit. On the 5 July the outcome of the summit was considered by the Trust Management Group (TMG), where an outline plan has been proposed and agreed. Further detailed plans are due for submission at TMG on the 19 July.

It should be noted the in month run rate for June has improved mainly due to additional income in relation to NHSE Drugs income of £374,000 and the Injury Cost Recovery scheme of £191,000. There has also been a positive movement in the agency pay cost trend when comparing to previous months and the same period last year.

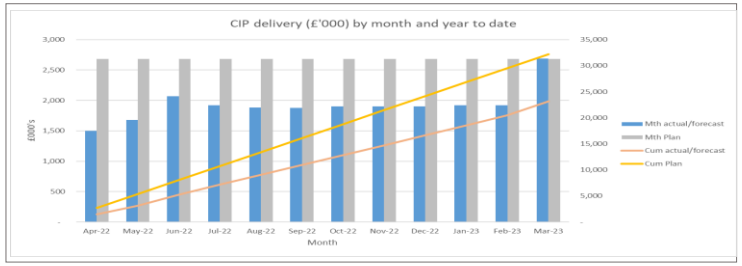
The Trust has set a full year capital budget of £131.9 million, including £103.8 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme enabling works. As at 30 June capital spend is £15.9 million against a plan of £27.3 million, this value includes the adoption of the IFRS 16 standard at £6.9 million. New Hospital Programme spend (NHP) is £2.5 million behind plan and STP Wave 1 funded projects are behind plan by £6.2 million. These programmes are expected to remain consistent with the full year budget albeit with monthly variances throughout the year reflecting the complexities of the project phasing and building works.

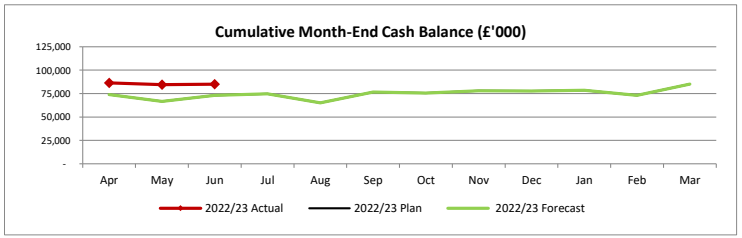
The Trust ended June with a cash balance of £84.12 million, all of which remains fully committed against the medium-term capital programme.

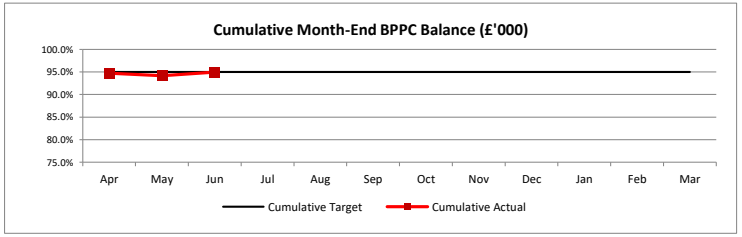
The Trusts payment performance remained strong in June, with 95% of invoices paid within the agreed terms.

REVENUE	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Surgical	(34,599)	(35,340)	(741)
Medical	(43,417)	(44,627)	(1,210)
Specialties	(44,869)	(45,562)	(692)
Operations	(5,712)	(5,881)	(169)
Corporate	(18,683)	(18,772)	(89)
Trust-wide	146,739	145,563	(1,176)
Surplus/ (Deficit)	**(541)**	**(4,618)**	**(4,077)**
Consolidated Entities	0	72	72
Surplus/ (Deficit) after consolidation	**(541)**	**(4,546)**	**(4,005)**
Other Adjustments	181	(67)	(248)
Control Total Surplus/ (Deficit)	**(359)**	**(4,613)**	**(4,254)**

CAPITAL	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Estates	2,940	1,802	1,137
IT	1,839	485	1,353
Medical Equipment	436	99	338
Donated Assets	316	469	(153)
Strategic Capital	21,800	13,091	8,710
Total	**27,331**	**15,947**	**11,384**





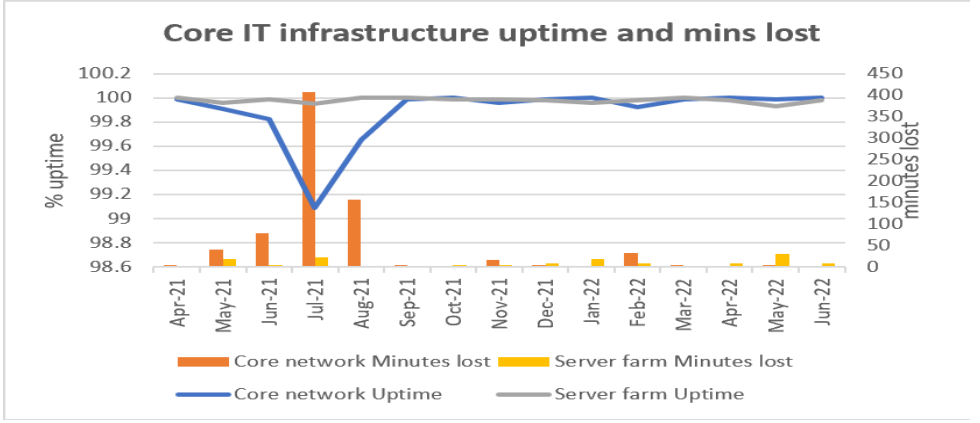


Informatics - July 2022

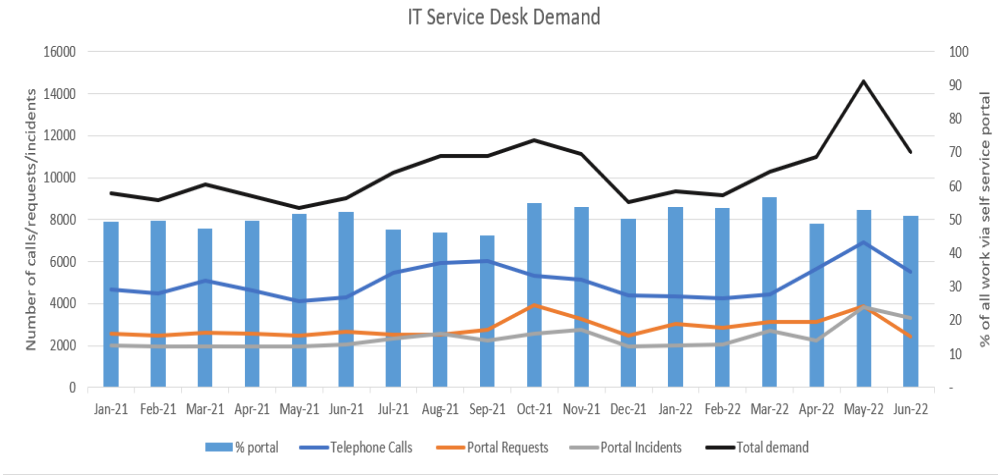
Overall Commentary: A key focus for Informatics over the last month was the migration from Internet Explorer v11. This entailed the testing of over 450 applications and the rewriting of many Single Sign ON (SSO) profiles to ensure they would work in Microsoft Edge. This work, led by Project Manager Matt Curley and supported by Senior Infrastructure Engineer Mark Syder was fully succesful and enabled the trust to turn off IE11 on time on 27 June 2022 and hence avoid any security issues. The deployment of the Single Sign-On application is nearing completion at the user level – more than 8000 users have now been enrolled, 85 applications have been profiled and the application "agent" has been deployed on more than 5300 devices. Consequently we are getting to the point where Single Sign-On is well saturated around the trust bringing significant user benefits as well as tighter security with features like "fade to lock", authentication using two factors (ID card and PIN), and a continuous audit trail of application login behaviour which can be scrutinised if necessary.

Business As Usual/Service Management

Graph 1: core Infrastructure availability



Graph 2: Service Desk demand



Projects/Developments/Security/IG

Table 3: flow of Informatics projects since Nov 2018. c 150 closed projects per year.

Informatics Projects since November 2018						
Project Type	**Pending Approval**	**Not Started**	**Deferred**	**In Progress**	**Completed**	**Total**
eForm/Automation Project	0	13	6	37	213	269
Infrastructure Mandatory	0	1	1	6	27	35
Projects	0	59	9	83	324	475
Service Improvement Projects	0	0	0	0	3	3
Grand Totals	**0**	**73**	**16**	**126**	**567**	**782**

Table 4: Project Totals and Escalation

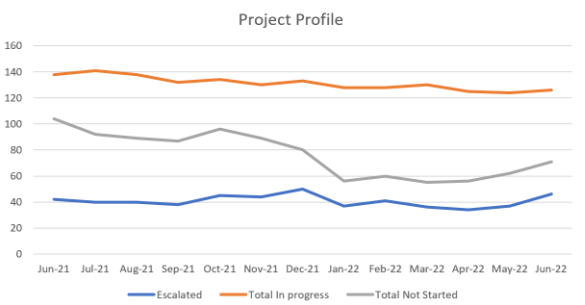


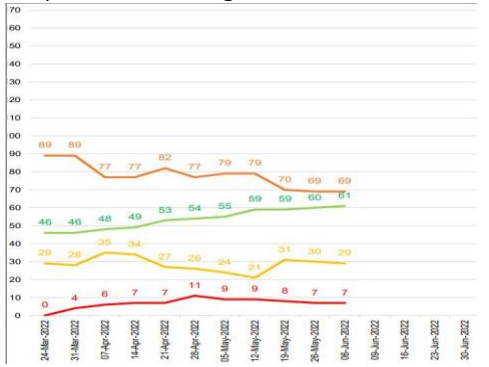
Table 5: Cyber Security - Obsolete systems

	Supported	Obsolete	Mitigated	Unsupported
Windows Desktops	43.2%	56.8%	0.0%	56.8%
Windows Servers	81.1%	18.9%	18.6%	0.4%

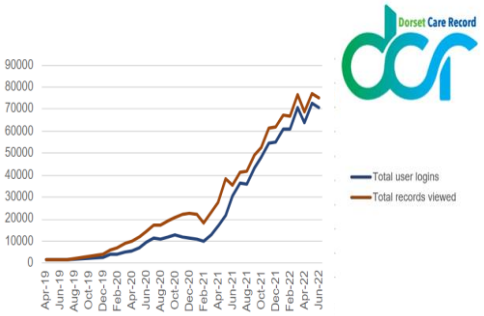
Table 7: FOI compliance

	Total rec'd	Compliance
January '22	55	91%
February '22	57	77%
March '22	63	78%
April '22	48	77%
May '22	49	84%

Graph 6: Well managed Information Assets



Graph 8: DCR growth



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.1

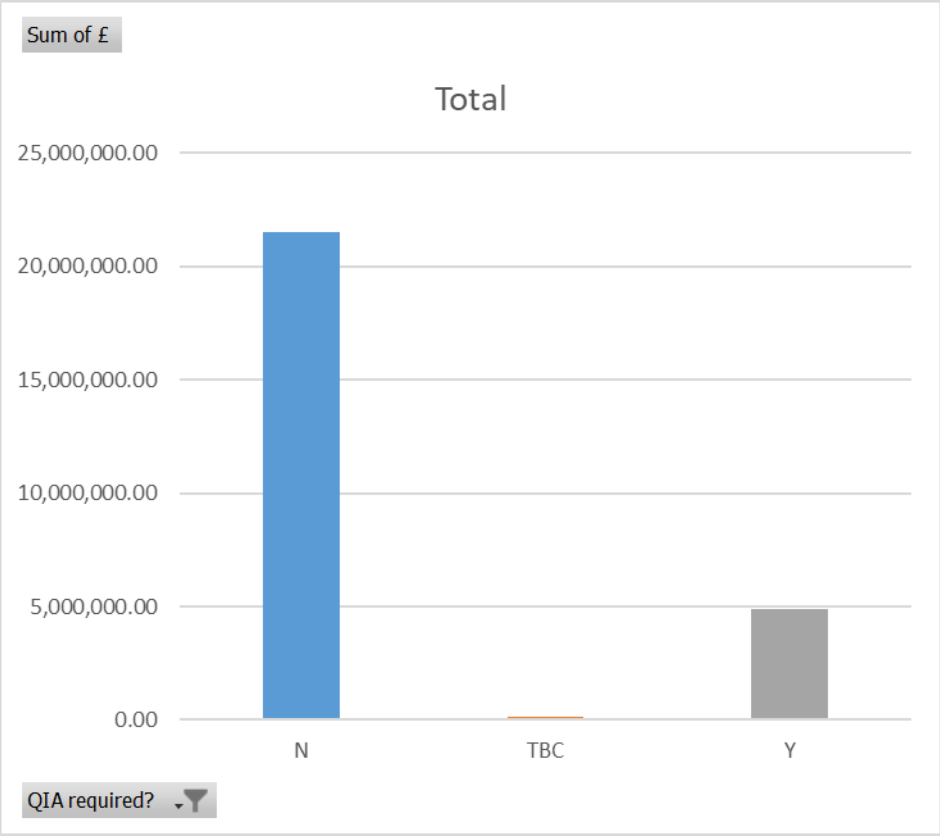
Subject:	QIA Overview

Prepared by:	Helen Rushforth, Head of Productivity and Efficiency
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	For noting
Background:	Following the Francis report into Mid-Staffordshire hospitals and the subsequent Kirkup review of Liverpool Community Trust it is considered critical that all Trusts have a robust Quality Impact Assessment approach to mitigate against the risks of decisions made on a financial basis having an adverse effect on quality. The update report summarises the current position of the QIA process on the Cost Improvement Programme for 2022/23, in line with our policy.
Key points for Board members:	The QIA process is a fundamental part of the Trust's approach to decision making. The QIA Review Group (Chief Medical Officer, Chief Nursing Officer and Associate Director of Risk and Quality Governance) should sign off all schemes and if necessary can stop a scheme continuing. There are no items for escalation.
Options and decisions required:	The Board is asked to note the current status of the QIA programme
Recommendations:	N/A
Next steps:	N/A

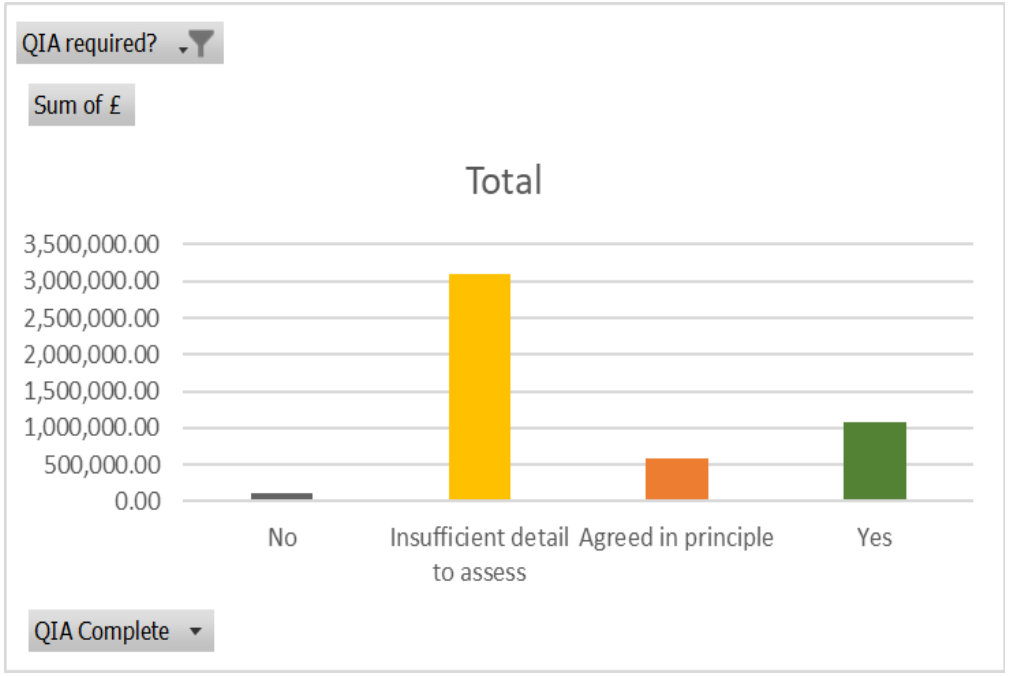
Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	1. Continually improve quality of patient care 3. Use our resources well
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	All CQC domains.

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



Of the £26.515m Productivity and Efficiency programme identified to date c. £4.865m requires a QIA
(NB. CIP includes cash releasing, cost avoidance and productivity)
The majority of CIP not requiring QIA relates to underspend against budgeted COVID schemes.

Of the schemes requiring QIA £1.085m has been agreed with a further £583k agreed in principle. C £3.088m is insufficiently detailed to allow review with c. £107k not yet complete



Row Labels	Bank - rate review	Skill mix reviews	Pay: Corporate services	Pay Other (bal)	Procurement (excl drugs) - Clinical	Procurement (excl drugs) - non-clinical	Medicines optimisation	Pathology & imaging networks	Non-Pay: Corporate services	Digital transformation	Non-pay Other (bal)	Income Private Patient	Income Non-Patient Care	Income Other (bal)	Grand Total
Surgical Care Group	25,000	221,000		331,370	72,058	46,128	1,848		22,004		97,808	334		50,000	867,550
Medical Care Group		79,434		120,000	100,736	102,586	61,156			77,000	55,819				596,731
Specialties Care Group		395,591			7,125	87,413	30,000	303,001	288,087		69,102		100,000		1,280,319
Operations		297,851	12,592						226,851		4,408				541,702
Corporate		824,937	32,342						7,014	311,878	618,930				1,795,101
Non Directorate	583,333	1,504,721		1,000,000	486,861									5,569,000	9,143,915
Grand Total	**608,333**	**3,323,534**	**44,934**	**1,451,370**	**666,780**	**236,127**	**93,004**	**303,001**	**543,956**	**388,878**	**846,067**	**334**	**100,000**	**5,619,000**	**14,225,318**

The above analysis shows the cumulative impact of savings of different types across the organisation. It should be noted that COVID savings appear in both pay and non-pay categories. Vacancy factor appears within the skill mix reviews category.

Significant work is on-going to increase the value of the cost improvement programme following a Financial Recovery summit, as soon as the plans have sufficient detail they will be considered by the QIA panel. Throughout the process of planning for the recovery we have emphasised the need to fully consider the risks to quality throughout our decision making process and the requirement to ensure the QIA has been completed has been regularly noted.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.2

Subject:	Guardian of Safe Working Hours Report January - March 2022 for Poole and RBH.

Prepared by:	Dr. Jayaprakash
Presented by:	Ruth Williamson

Purpose of paper:	For scrutiny. To summarise the number of exception reports for period 1st January – 31st March 2022
Background:	The Guardian post was created as part of the 2016 Junior Doctor contract, to ensure hours worked, and levels of supports, are safe for doctors and patients, based on exception reports.
Key points for Board members:	The number of exception reports raised has decreased from the previous quarter. The majority of the exception reports were generated from gastroenterology, cardiology, and oncology rotas. There was a junior doctor forum meeting during this period details of discussions are within this report. These are now held face to face and also available via Teams. Exception reporting is actively encouraged by the Trust. Dr Ram Jayaprakash is demiting the role of guardian of safe working. We would like to thank him for all of his work supporting our doctors in training.
Options and decisions required:	To consider funding for further medical and non-medical staff to support junior doctors (such as appointing graduated and preceptor physician associates for ready for March 2023, advanced nurse practitioners and prescribing pharmacists).
Recommendations:	Continue to promote exception reporting to allow early recognition of problems Ongoing support of the executive team at the junior doctors forum.
Next steps:	Awareness of the role of Guardian of Safe Working and ongoing commitment to the process of exception reporting and addressing concerns raised.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register		
Strategic Objective:		
BAF/Corporate Risk Register: (if applicable)		
CQC Reference:		
Committees/Meetings at which the paper has been submitted:		**Date**

Guardian Report March 2022, for the period 1st January – 31st March 2022

University Hospitals Dorset: The Royal Bournemouth and Christchurch Hospitals

High level data

Number of doctors / dentists in training (total): 226

Number of doctors / dentists in training on 2016 TCS (total): 226

Amount of time available in job plan for guardian to do the role: 1.5 PAs/6hrs per week

Admin support provided to the guardian (if any): 0.13 WTE

Exception reports

Speciality	Exceptions raised 1st Jan – 31st Mar 2022	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
General Surgery	30	4	0	30	0
General Medicine	36	0	0	36	0
Geriatric Medicine	28	0	0	26	2
Cardiology	8	4	0	8	0
Vascular Surgery	5	3	0	5	0
Acute	2	0	0	2	0
Ophthalmology	4	0	0	4	0
Gastroenterology	22	10	0	22	0
Respiratory	3	0	0	3	0
Total	138	21	0	136	2

(Source: Allocate)

Brief Overview of Exception Reports Raised

There were a total of 138 exception reports for this period, this is a large increase from the previous period in which 91 exception reports were submitted. Large increases in reporting are evidenced in General Surgery (6 previously), Vascular Surgery 5 (0 previously), Gastro 22 (4 previously).

Of the 138 exceptions there were 2 patient safety concerns during this period which were raised from Geriatric Medicine and General Surgery.

Patient Safety Concerns – General Surgery and Geriatrics:

Grade of Doctor	Specialty	Details
ST1	Geriatric Medicine	Covering all the OPM outliers with one SHO. I have let the seniors and rota coordinators know that I am the only SHO but did not get extra SHO on that day.
FY1	General Surgery	As documented in the report the reasons why but essentially on the Saturday, given weekends are so poorly staffed, she felt like she wouldn't be able to leave without causing a safety incident and therefore suffered through the day. No-one touched hanbleep until past 3pm both days (whilst Dr 1 and Dr 2 were on ward round) meaning neither of them could go for a break until the more urgent tasks had been completed.

Number of Exceptions Reported as per Specialty:

Specialty	Exceptions Reported quarter 1st July – 30th September	⇧ ⇩	Exceptions Reported quarter 1st Oct – 31st December
Cardiology	4	⇧	8
Acute	1	=	1
Gastroenterology	4	⇧	22
General Surgery	6	⇧	30
General Medicine	43	⇩	36
Geriatric Medicine	29	⇩	28
Ophthalmology	2	⇧	4
Respiratory	1	⇧	3
Vascular Surgery	0	⇧	5
Haematology	1	⇩	0

(Source: Allocate)

Reasons for Exceptions Raised

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
88	19	3	11	17

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	IMT1/ST1	IMT2/ST2	IMT3/ST3	ST4	ST5	ST6
78	6	20	8	10	0	0	1

(Source: Allocate)

Outcomes for this Period

Overtime payment	Time off in lieu	No further action	Cancelled	Created in error	Request for more info	Compensation and Work Schedule Review	Initial Decision Upheld
108	0	25	0	0	0	2	3

(Source: Allocate)

Locum Bookings

Locum bookings (Bank) by department					
Specialty	**Number of shifts requested**	**Number of shifts worked**		**Number of hours requested**	**Number of hours worked**
Emergency Medicine	601	445		5,572	4,132
Anaesthetics	0	0		0	0
Cancer Care	0	0		0	0
Oncology	0	0		0	0
O&G	39	30		324	308
General Surgery	9	3		100	129
General Medicine	1,187	302		12,289	2,775
Haematology	0	0		0	0
Orthopaedic Surgery	1,823	770		18,148	7,165
Ophthalmic	26	20		188	130
TOTAL	**3,691**	**1,570**		**36,621**	**14,639**

(Source: UHD Bank Staff Office)

Locum bookings (Bank) by Grade					
Grade	**Number of shifts requested**	**Number of shifts worked**		**Number of hours requested**	**Number of hours worked**
Foundation Year 1	56	22		483	250
Foundation Year 2	6	6		40	86
ST1-2/Core Trainee	967	603		7,349	6,311
Specialty Registrar (SP3+)	1,044	282		10,725	2,575
TOTAL	**2,073**	**913**		**18,596**	**9,221**

(Source: UHD Bank Staff Office)

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts Worked**	**Number of hours Requested**	**Number of hours Worked**
Acuity	32	32	273	273
Annual Leave	29	27	225	205
Coronavirus	56	46	395	313
Maternity/Paternity Leave	5	2	56	22
Service Demand (e.g winter pressures)	897	233	9,115	1,850
Sickness	210	54	1,908	475
Study Leave	5	2	49	20
Trust vacancy	714	504	6,845	4,771
TOTAL	**1,948**	**900**	**18,865**	**7,928**

(Source: UHD Bank Staff Office)

Locum Bookings via Agency

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	0	0
Foundation Year 2	33	29
ST1/2 - CT1/2	0	0
Specialty Registrar	32	0
TOTALS	**65**	**29**

(Source: UHD Bank Staff Office)

Fines

There were no fines this quarter.

Junior Doctors Forum Meetings

There was 1 Junior Doctor Forum scheduled for this quarter on 2nd November 2021 and was a joint forum. Items discussed were:

1. F&F update –
    - Junior Doctors contract rest spaces for doctors too tired to trave home following a shift is a requirement.
    - During weekdays/in hours this is arranged via the rota co-ordinators to get a room in accommodation, either prior shifts or at time of shift.
    - Out of hours there is no clear pathway in RBCH and a work group has been formed to formulate a pathway.
    - According to our contract this should be provided and therefore if it cannot be and we are forced to pay for accommodation, this should be reimbursed.
2. Well-being funding
    - Well-being fund is £40,000 across both sites and many ideas were shared- it was agreed to make a poll on each site to collate ideas and votes. We will collate these and feedback to Dr Poynter and Dr Al Sharma on each site.

3. Exception reporting
    - Recent review of current exception reporting by Dr Vassallo. Encouraged people to continue to exception report, even if not for time back/payment but if staffing or safety concerns as well.
    - General encouragement to make exception reporting part of every day.
    - Some juniors still not sure how to complete exception reports, agreed to re-sent out how to guide to juniors.
4. Rota concerns
    - Ongoing concerns re rota gaps and not being paid for locum shifts in timely fashion. Idea of possible junior to liaise with rota team regularly re concerns and queries from juniors as a good idea to trial.
5. FY1 shadowing pay
    - Asked to get clarity on what rate of pay for this in the future for the next F1s starting at the trust.
6. Conclusions and thank everyone for coming.

Developments

Prof. Mike Vassallo

Guardian of Safe Working, Royal Bournemouth and Christchurch Ho

Guardian Report April 2022, for the period 1st January – 31st March 2022

University Hospitals Dorset: Poole Hospital

High level data

Number of doctors / dentists in training (total): 208

Number of doctors / dentists in training on 2016 TCS (total): 208

Amount of time available in job plan for guardian to do the role: 1 PAs/4hrs per week

Admin support provided to the guardian (if any): 0.13 WTE

Exception reports

Speciality	Exceptions raised 1st Jan – 31st Mar 2022	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
General Surgery	10	0	7	3	0
General Medicine	4	0	3	1	0
Haem/Onc	10	0	5	5	0
Gastro	20	0	1	18	0
Elderly Care	11	0	10	1	0
Cardiology	21	0	0	21	0
Respiratory	1	0	0	1	0
Dermatology	1	1	1	0	0
Total	78	1	27	51	0

(Source: Allocate)

Brief Overview of Exception Reports Raised

There were a total of 78 exception reports for the quarter 1st January to 31st March 2022, a decrease of 19 from the previous quarter (October-December). This is mostly due to the reduction in reporting from Elderly Care where the reports stood at 21 plus small reductions in other specialties.

Exception reports were generated from various departments: General Medicine, Oncology, Gastroenterology, Elderly Care, Cardiology, Respiratory, General Surgery, General Medicine and Dermatology.

Of the 78 exceptions raised there was 1 patient safety concern from a foundation doctor working in Haematology. The rota coordinator is working on getting extra SHO support.

Specialty	Date Raised	Grade	Detail
Haematology	17th February	F2	I have been advised by the foundation school to exception report this issue. There is very little support for the SHOs working on the haematology ward and this has led to an increased workload / pressure on the SHOs. There have been times where I have had to manage the ward on my own without the support of another SHO or registrar. I am having to review all of the patients on the ward and subsequently address clinical issues / ward jobs. I have raised this issue with the rota coordinator and have also mentioned it to my ES/CS during my placement meetings.

(Source: Allocate)

After each immediate safety concern exception report- the Guardian meets up with the junior doctor concerned and explore ways to prevent future incidents.

Exception Reports – Increase/Decrease from previous quarter

Specialty	Exceptions Reported 1st Oct to 31st December	⇧ ⇩	Exceptions Reported 1st Jan to 31st March
Gastroenterology	21	⇩	20
Geriatric Medicine	21	⇩	11
General Medicine	7	⇩	4
Cardiology	18	⇧	21
Oncology/Haem	14	⇩	10
General Surgery	14	⇩	10
Anaesthetics	1	⇧	0
Respiratory	1	⇦	1
Dermatology	0	⇧	1

(Source: Allocate)

Reasons for Exceptions Raised

One foundation doctor has reported that they were unable to access their educational timed sessions. 5 doctors have reported unable to access natural breaks (registrar and foundation)

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
70	1	1	1	5

(Source: Allocate)

Reporting Grades for this Period -

FY1	FY2	GPST1	ST/CT1-2	IMT1	IMT2	IMT3/ST3	ST4
62	10	0	0	0	0	3	3

(Source: Allocate)

Outcomes agreed

Overtime payment	Time off in lieu	No further action	Unresolved although Agreement made TOIL/Payment	Created in error	Request for more info	Compensation and Work Schedule Review
27	23	1	27	0	0	0

(Source: Allocate)

Locum Bookings via Bank

Locum bookings (Bank) by department					
Specialty	Number of shifts requested	Number of shifts worked		Number of hours requested	Number of hours worked
Emergency	606	295		5,945	2,952
ENT	44	37		489	435
General Surgery	62	36		565	412
General Medicine	1070	548		10,318	5,047
O&G	39	30		324	308
Oncology	100	84		839	732
Trauma & Orthopaedics	561	527		5,075	4,692
Paediatrics	100	72		963	667
TOTAL	**1,592**	**1,094**		**14,985**	**9,856**

(Source: UHD Bank Staff Office)

Locum bookings (Bank) by Grade via Locums Nest					
Grade	**Number of shifts requested**	**Number of shifts worked**		**Number of hours requested**	**Number of hours worked**
F1	14	14		119	367
F2	105	37		1,072	592
ST/CT1/2	1,432	1,048		13,162	11,500
ST3+	1,031	530		10,165	2,787
TOTAL	**2,582**	**1,629**		**24,518**	**15,245**

(Source: UHD Bank Staff Office)

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts Worked**	**Number of hours Requested**	**Number of hours Worked**
Acuity	153	153	1,387	1,387
Urgent Clinical Need	73	56	595	518
Annual Leave	107	58	949	496
Coronavirus	878	392	8,562	3,664
Deanery Vacancy	111	85	1,094	837
Escalations	2	2	19	20
LTFT Cover	12	8	104	87
Maternity/Paternity Leave	15	12	141	124
Service Demand (e.g winter pressures)	169	121	1,531	1,115
Sickness	194	77	1,866	767
Study Leave	31	22	286	214
Trust vacancy	822	634	7,867	5,944
7-day Pilot	15	9	116	73
TOTAL	**2,582**	**1,629**	**24,518**	**15,245**

(Source: UHD Bank Staff Office)

Locum Bookings via Agency

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	11	0
Foundation Year 2	103	2
ST1/2 - CT1/2	1	0
Specialty Registrar	409	70
TOTALS	**524**	**72**

(Source: Source: UHD Bank Staff Office)

Fines

There were no fines this quarter.

Junior Doctors Forum Meetings

There was 1 Junior Doctor Forum scheduled for this quarter on 9th February 2022 and was a joint forum. Items discussed were:

1. F&F update –
    - Junior Doctors contract rest spaces for doctors too tired to travel home following a shift is a requirement.
    - During weekdays/in hours this is arranged via the rota co-ordinators to get a room in accommodation, either prior shifts or at time of shift.
    - Out of hours there is no clear pathway in RBCH and a work group has been formed to formulate a pathway.
    - According to our contract this should be provided and therefore if it cannot be and we are forced to pay for accommodation, this should be reimbursed.
2. Well-being funding
    - Well-being fund is £40,000 across both sites and many ideas were shared- it was agreed to make a poll on each site to collate ideas and votes. We will collate these and feedback to Dr Poynter and Dr Al Sharma on each site.
3. Exception reporting
    - Recent review of current exception reporting by Dr Vassallo. Encouraged people to continue to exception report, even if not for time back/payment but if staffing or safety concerns as well.
    - General encouragement to make exception reporting part of every day.
    - Some juniors still not sure how to complete exception reports, agreed to re-send out how to guide to juniors.
4. Rota concerns
    - Ongoing concerns re rota gaps and not being paid for locum shifts in timely fashion. Idea of possible junior to liaise with rota team regularly re concerns and queries from juniors as a good idea to trial.
5. FY1 shadowing pay
    - Asked to get clarity on what rate of pay for this in the future for the next F1s starting at the trust.

Developments

As the Guardian of Safe Working I have attended a number of meeting surrounding Safe Medical Staffing- and exception reporting along with other indicators such as clinical incidents, job satisfaction, locum spend play an important role in highlighting areas of clinical concern.

Once again a large proportion of the exception reports come from junior doctors on A5 and there was a “Deep Dive” carried out by the chief registrar looking into the reasons for this. This has been highlighted to the Clinical Director and the concerns are currently being addressed

After 3 ½ year in post, I am stepping down from my position as the Guardian of Safe Working. The process has ensured that clinical concerns having been highlighted and addressed promptly so that we can deliver the best quality care to our patients. I would like to commend the junior doctors who have shown such resilience working through such a busy and anxiety provoking time of Covid.

Exception reporting has always been supported at Poole and continues to do so under the umbrella of University Hospitals Dorset

Dr Ram Jayaprakash

Guardian of Safe Working, University Hospitals

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.3

Subject:	Quality Assurance for Responsible Officers and Revalidation plus Annual Organisational Audit Report

Prepared by:	Revalidation Team
Presented by:	Ruth Williamson

Purpose of paper:	To provide assurance around medical appraisal and revalidation
Background:	The AOA was stood down at the end of April 2021 with assurance provided with annual board reports and statements of compliance.
Key points for Board members:	The GMC extended the appraisal window and deferred revalidation for doctors during the pandemic but have now indicated a return to business as usual with annual appraisals expected. A recovery plan is in place with appraisal anniversaries being reset to ensure that revalidation can be completed. Appraisals delayed beyond 15 months are now escalated with a total of 21 GMC first stage referrals for non-engagement submitted. In the last period 184 revalidation recommendations were made with 49 deferrals for a range of issues. The number of appraisers has reduced slightly whilst the number of appraisees has increased.
Options and decisions required:	To receive the report and to continue to support the appraisal and revalidation process and team
Recommendations:	Early support to identify barriers to appraisal to continue the trajectory of restoring annual appraisals.
Next steps:	Maintain appraisal and revalidation for our medical workforce

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

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

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team –of University Hospitals Dorset NHS Trust (UHD) can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: To continue to be an active member of the network meetings and update with any training required. Comments: Professor Alyson O'Donnell has been Responsible officer of UHD since October 2020 when the Trust was formed. Professor O'Donnell was previously Responsible Officer for the Royal Bournemouth Hospital prior to the merger with Poole. She is fully trained in her duties as Responsible Officer and contributes regularly to regional Responsible Officer network meetings and feeds back to the Revalidation Team here. Action for next year: To remain an active member of the network meetings and updates.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: To review the capacity and needs of the merged Trust to ensure that we are meeting the requirements. Comments: Allocation of funds for the basics required for carrying out the responsibility's is there; we have a software system that both sites have been using for over 8 years that is fit for purpose but could be improved upon. Our 360 supplier has been working with the trust for several years and in May 2021 we went through a cost and tender process for both of these products and the annual cost of these are budgeted for. We currently have two administrators who support the Revalidation process for FTE 1.6. The number of medical staff we are employing is increasing annually, and in particular the number of 12 month fixed term positions, some of which are locally sourced or International Medical Graduates which often require additional support to engage in the process, this being their first UK / NHS role.

We have a group of established appraisers within the Trust currently we have 111 covering around 800 doctors these cover between 2 and 25 appraisals each. We aim for appraisers to do 5/6 per year receiving 0.25PA in the SPA allocation of their job plan. There have been several appraisers retire or leave the role in the past 18 months and this has put some pressure on the rest. We have trained 4 new appraisers since the last board report, we are still able to recruit a small number of appraisers although it is getting more difficult each year.

Action for next year: To increase the number of appraisers, to enable an average of 5/6 appraisals per year.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: The Premier IT (PreP) system which is used to monitor appraisals has a GMC connection tool built in. We need to understand the workings of this further as this may be additional or more effective way to check prescribed connections.

Comments: Understanding the workings of the Premier IT GMC Connection tool has not been established. We have got as far as understanding that there is an issue with their system that we have raised with them. We continue to keep GMC Connect updated on an as and when basis when we become aware of leavers and starters.

Action for next year: To cross check GMC connect with the leavers report, which we receive from the Business Intelligence team bi – monthly.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: To work in line with the policy, a review of the policy will take place in March 2023.

Comments: The UHD Policy which was implemented in March 2021 is still current, over the past 12 months we have worked within this policy. We have increased the deadlines within the policy over the past 18 months whilst we continue to work through the repercussion of the Covid year. We are now taking steps to be working within the timescales of our policy before the end of the year.

Action for next year: All doctors to be back to annual appraisals 12 months apart with little slippage.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: To understand when a review is likely to take place for UHD.

Comments: We have had no further update as to when a Peer review is expected for UHD. These have taken place previously in 2015 at Poole and at the RBCH site had their last review in May 2019 (HLROQR)

Action for next year: Continue to keep standards high in preparation for a review.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To continue supporting short term, and locum doctors as we currently do and review policy as and when required.

Comments: All non-training doctors directly employed by UHD on a fixed term contract of at least 4 months will be given access to Premier IT and allocated with an appraiser employed by the Trust if required. All will be invited to an Appraisal Training Session (ATS) where they can meet with the revalidation team. We will look at those with short term contracts individually to determine their individual requirements from the Trust.

Those employed for a shorter term than 4 months or via the bank will be contacted and again we will look at their circumstances and determine what they will require.

We do in most cases offer appraisals to those who request it, where they are connected to us rightfully. Anyone working with us via a locum agency will not be offered an appraisal by the trust. We will of course ensure that we advise, support and enable them to have access to the supporting information they will need to fulfil their revalidation requirements.

For doctors working in the Trust but connected elsewhere we ask that they share with us a copy of their appraisal output, or a letter from their designated body confirming any concerns and that their appraisal covered work carried out in their position at UHD.

Action for next year: Ensure this procedure remains in place for all short-term doctors and we continue to treat each doctor individually.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Our aim, by October 2021 is that all appraisals will have been completed no more than 18 months apart, and by March 2022 we will be expecting all to have annual appraisals once again.

Comments: During the period we have expected all doctors to have an appraisal, being mindful that this may not have been within 12 months of their last appraisal as a considerable number of appraisals were missed during 20/21 due to Covid pressures.

By October 2021 most doctors had an appraisal which was within 12 months. All of those who were not were issued with a Rev 6, notification of non-engagement to the GMC. In total 21 Rev 6's were issued to the GMC in the period.

By March 2022, we were monitoring much smaller numbers of overdue appraisals and working to a 15-month escalation, focussing on support from Care Group Directors as well as the Revalidation Team.

We have continued to use the Appraisal 2020 model through to 2022.

Action for next year: To engage with Clinical Directors to encourage the support and engagement with appraisal before it reaches escalation to the senior team and the GMC.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: To review the information found on our intranet and ensure that it is easily accessible and relevant for all our doctors.

To understand how we can further support and inform our doctors from overseas and our junior doctors with appraisal and revalidation. It is this group of doctors that we have to often give additional support to.

Comments: The intranet is now a merged UHD site, with limited information available regarding Revalidation for Doctors. This is something we would like to improve but capacity of the team means this is not currently a priority.

Those who we are a concern as non-engaging are supported by the revalidation team with additional training and advice given. Where a doctor requires a postponement all circumstances for this are considered and a plan to complete the appraisal with all that is required included. This is carried out with the Responsible Officer and Deputy Medical Officer's support and guidance to re-engage in the process. Welcome sessions are run twice a month and we invite all new doctors to attend, we inform doctors from overseas about the GMC 'New to UK working' Course and a high number do attend this.

Action for next year: We would like to trial an appraisal and revalidation section within the medical induction, this would ensure that we meet with a vast number of new doctors to the trust and we hope this would help with the engagement, especially for our locally sourced and IMG doctors.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: A review of the Policy will be due in 2023 unless any significant changes need to be included there will not be a 2022 review of the policy.

Comments: Our current policy which was agreed by the UHD Joint Local Negotiating Committee in March 2021 follows guidance from NHS England and the GMC. No significant changes need to be made to the policy currently.

However, over the past 24 months we have adjusted the way we respond to those who have a delay in completing their appraisal to give much more support from a team of people before referring to the GMC. This is working for us as a team, and our doctors it may be that during the review in 2023 we include some of this practice as policy. This will be difficult to review until we have all doctors back on an annual 12 monthly appraisal cycle.

Action for next year: Continue to work within policy and begin preparations for the 2023 review.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Look within each specialty and care group to ensure that there is a proportionate number of appraisers to doctors and work with the care group leaders to increase these where required. Comments: Last year at this point we reported 780 connections with 113 appraisers, 12 months later we have 798 connections with 111 appraisers. As noted earlier in the report we have trained 4 appraisers in the 12 months but have lost more than we have recruited. The appraisal administration team have planned to hold regular meetings with Clinical Directors to cover a range of issues and one of these is ensuring each department has a reasonable number of appraisers and understanding the barriers to this. We have had discussions as a wider revalidation team about making the 0.25 SPA allocation for appraising work better for each department and this is something we hope to explore further with the Clinical Directors. Action for next year: Work with Clinical Directors to ensure that adequate SPA is allocated for appraisals.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Continue to hold Appraisers Workshops, which include a variety of relevant information to improve and engage our appraisers year after year. To consider the opportunity of appraisers attending appraiser network events in the year. Comments: We held appraiser's workshops in May 2021 and a second in January 2022 both were held on Teams. Which works exceptionally well for this type of forum. Both dates covered a different topic, and, on both occasions, multiple sessions were held and were recorded so more people could access it. They followed a programme that includes guest speakers, GMC advisors, a key message from the Responsible officer, an open forum, and a presentation from one of our established appraisers. These were received

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

well and are a great opportunity for new information and best practice to be shared.

Action for next year: Appraisers workshops are planned for October 2022 and May 2023

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The Terms of Reference of the Revalidation Governance Committee chaired by the Appraisal Lead and held at RBH site only is being re-mapped and updated for the new organisation. Additionally, the Appraisers Network Forum that has not been held during Covid will be re-inaugurated for UHD and will bring appraisers together on Teams to discuss any current issues.

Comments: The Terms of Reference have been provisionally approved although the first meeting has not yet taken place. The Appraiser network forum has also not been reinstated this is still under discussion as to its overall benefits at a time where peoples capacity for additional responsibilities is considerably stretched. As pressures ease this will be reviewed further.

The Revalidation team along with senior leadership and HR meet monthly to review overdue appraisals and agree actions required.

Action for next year: First Revalidation Governance Committee meeting to be planned as UHD. Further discussions for an appraiser network forum to be held.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: University Hospitals Dorset	
Total number of doctors with a prescribed connection as at 31 March 2022	773 (779)
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	611 (480)
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	162 (299)
Total number of agreed exceptions	129

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To increase the number of recommendations first time by ensuring 360 reports are completed in years 3 and 4. The administration team should continue to set up 360's in good time and ensure that these are regularly monitored. Comments: During the reporting period 1st April 2021 – 31st March 2022 184 recommendations were made to the GMC relating to 156 doctors. The number of recommendations to revalidate first time was 109. 49 recommendations to defer were made, in the main due to minor delays in appraisal meetings or lack of 360. Of these, 3 doctors were deferred twice and have been revalidated in the next period. 1 non-engagement recommendation was made and although this has not yet at the stage where we can follow with a recommendation, progress is being made with engagement by the doctor. We have found that over this period doctors have been finding both patient and colleague feedback much harder to collate. We have been setting up 360 feedback in year three of the cycle to alleviate this issue. Action for next year: Increase the number of doctors who we recommend Revalidation first time for which or this period is 70%. This will come from recognising earlier on when support is needed.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To move towards revalidation recommendation to be made at least two months prior to submission date. Comments: We are now in the main making recommendations to the GMC two months prior to the submission date, and in some cases three months. In the second and third quarter of this period we had many recommendations to make, this was partly due to the end of the extension period that was given in 2020 by the GMC.

When any recommendation is due to be made, where the recommendation is for a deferral or non-engagement the doctor will be fully aware. The team ensure that we support the doctor to achieve a positive recommendation on time. Where this is not, they will be part of the discussions and fully understand the reason for deferral and know what is required and by when for a positive recommendation.

Where a positive recommendation is made, we confirm this within 24 hours to the doctor, as do the GMC within a few days.

Action for next year: To sustain the recommendations at 2-3 months prior to the submission date.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To continue to provide an environment that supports and delivers opportunities for our doctors.

Comments: Doctors are expected to participate in clinical governance half day meetings which are held monthly. They should maintain their own skills and competencies through CPD, participate in clinical audit and research and development as appropriate for their grade and department.

Action for next year: Continue with current practice and review as necessary.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Review the ways of working with both PALS and Risk to understand if there is a more effective way of collating this information rather than a request from each doctor.

Ensure a smooth transition to the main 360 provider, so that the service continues as expected.

Comments: With the appraisal and revalidation function now fully embedded in the Medical Staffing team across both sites we can share

relevant information quickly and understand where there may be underlying issues.

The doctors are still expected to request information regarding any complaints and SUI's from the Patient Advice and Liaison Service (PALS) and risk teams on their sites. These departments provide doctors with a record where they have been named or they are the named consultant which they can then reflect upon and include within their appraisal. We have sought information from these teams to find a simpler solution for gathering this information. Our software provider is looking into a way for us to upload this from our systems to theirs.

360 is now being completed by just one source and we have so far had no issues with the transfer of both sites across to the one source. All doctors are expected to have at least one 360 in the five-year revalidation cycle covering both colleague and patient feedback.

Action for next year: Continue exploring ways to make gathering information for appraisal simpler for all involved.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To have a joint Maintaining High Professional Standards Policy in place across both sites

Comments: A new UHD policy and procedure for Maintaining High Professional Standards is in place which includes the arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns. Regular meetings are held between the RO and GMC Employer Liaison Advisor to discuss any fitness to practise concerns

Action for next year: Review as necessary

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action from last year: Continue with current practice and review as necessary

Comments: The Strategic Workforce Committee receives a report from the Chief Medical Officer on the number and nature of any concerns raised about a doctor that are being investigated under the trust's Maintaining High Professional Standards procedure. This includes the principal place for work for the doctor together with the outcome.

Action for next year: This information should include consideration of any protected characteristics and a timeframe for conclusion of investigations.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: To have a central record of all UHD doctors working within the Trust and their connections with other organisations declared.

Comments: Records are held on the Electronic staff record and the appraisal database for doctors for whom we are the connection. Declarations of interest are submitted to the company secretary office.

We continue to use the Medical Practice Information Transfer Forms (MPIT) to transfer information between Responsible Officers. This form enables us to request information of note from previous employers and share information with new or other employers.

For doctors who work within our organisation but are connected elsewhere we request that they ensure that they declare their full scope of work in their appraisal and are up to date with their annual appraisal. Once complete we ask, they share a copy of their output form or sign off from their appraisal with us to keep within their file.

Action for next year: To continue with the current established processes.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue to monitor outcome of concerns raised about doctors. Comments: A UHD policy and procedure for Maintaining High Professional Standards is in place which includes the arrangement's for investigation and intervention for capability, conduct, health and fitness to practice concerns. The trust has a Raising Concerns policy and a Freedom to Speak up Guardian and Freedom to Speak Up Ambassadors. Action for next year: Continue and review where required.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: To continue to adhere to NHS Employers guidance Comments: The Medical Resourcing Team adheres to the guidance set by NHS Employers for recruitment of doctors. This process includes checking that they are active on the GMC register, and any undertakings that they may have. References are taken for all staff employed directly by the Trust. Action for next year: Continue adhering to NHS Employers guidance and review our practices where required.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

- Following on from the mapping out of both sites processes in 2021, we have now fully embedded these across both sites and have clear procedures in place. We have a single appraisal e-portfolio and 360 feedback providers which has been achieved in the last 12 months and has reduced costs.
- After the 2020/ 2021 year of appraisals being relaxed the 2021/2022 year has been a year of refocusing our doctors on annual appraisals which has required a large amount of additional support from the whole team to achieve this.
- In April 2022 87% of doctors were up to date with annual appraisals compared to 61% in April 2021.
- The new procedure introduced in October 2021 to reduce the number of rejected outputs together with the checklist of requirements is starting to show an improvement.

Actions still outstanding:

- The report from the RBCH Audit in 2019 is outstanding, and therefore we are unable to follow up any actions from this.
- Resolving the GMC Connect issue with Premier IT.

Current Issues:

- The number of appraisers we have in the trust is not enough to cover the growing number of doctors including those we have for one year on a fixed term. We are expecting several our appraisers to retire or reduce their hours in the next 12 months which will have further impact.
- Working on getting all doctors back into the annual appraisal cycle, whilst in the main this is going well, we need to continue with the support for at least the next 6 months.

New Actions:

- Working with Clinical Directors to establish barriers to appraisal in departments early on to offer support where required to increase the number of annual appraisals completed on time.
- An Appraisal and Revalidation segment to be included in Medical Induction so that we can introduce ourselves at the very start of a doctor's time here and outline the requirements at the Trust.

Overall conclusion:

We have had a positive year and as shown in the report made progress in the appraisal numbers as well as embedded new processes and procedures across both sites.

We have lots we would like to achieve over the coming year and hope to increase the appraisal rate further.

Section 7 – Statement of Compliance:

The Board / executive management team – of Official name of designated body: University Hospitals Dorset NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: University Hospitals Dorset NHS Foundation Trust

Name: Siobhan Harrington Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: Chief Executive Officer

Date: _ _ _ _ _ _ _ _ _ _

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.4

Subject:	UHD FT Board Assurance Framework (BAF)

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer

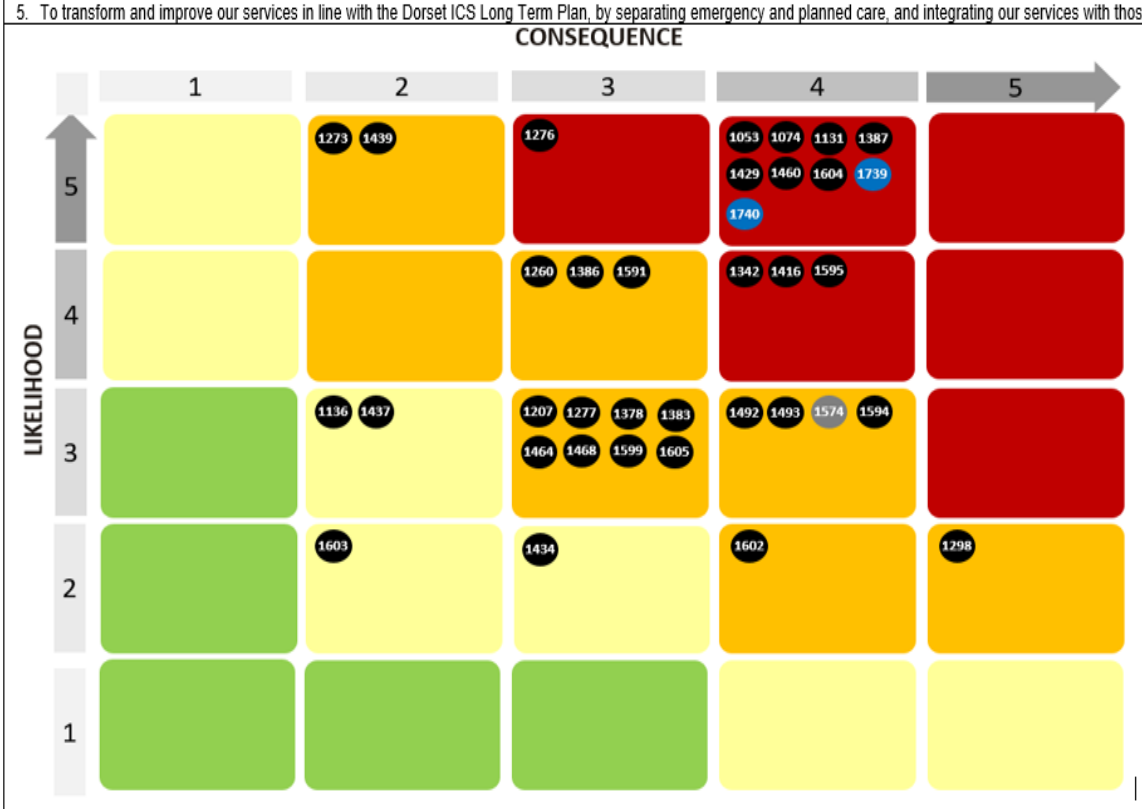
Purpose of paper:	Approval of the Board Assurance Framework 22/23.
Background:	The Board Assurance Framework is a systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.
Key points for members:	The 2022/23 BAF for UHD is linked to the Board Objectives agreed at the Board of Directors meeting in May 2022. In accordance with the UHD FT Risk Management Strategy the Board Assurance Framework for UHD FT will be reviewed quarterly at the Audit Committee and 6-monthly by Quality Committee and the Board of Directors The Q1 report (1 April 22 – 30 June 2022) provides full details of the risks linked to the Board objectives. A BAF Heat map provides a helpful summary picture.

New BAF Risks added in Q1	3	1740,1739,1756
BAF Risks rated 12-25 in Q1	20	
Closed BAF Risks in Q1	5	1600,1601,1348,1574,1448
Downgraded BAF Risks in Q1	1	1599

University Hospitals Dorset – Board Assurance Framework (BAF) Risks as at 11 July 2022

BAF Objectives 2022-23

1. To continually improve the quality of care so that services are safe, compassionate, timely and responsive, achieving consistently good outcomes and an excellent patient experience
2. To be a great place to work by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best
3. To ensure that all resources are used efficently to establish financially and environmentally sustainable services and deliver key operational standards and targets
4. To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people
5. To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community



Key:
Purple = ↑ risk, orange = ↓ risk, black ←→ risk (no movement from previous period), blue = new risk/added to this committee, grey = closed/no longer linked to Finance & Performance Committee

Jo Sims
Associate Director of Quality, Governance & Risk
July 2022

Options and decisions required:	For approval
Recommendations:	To approve the Board Assurance Framework 2022/23
Next steps:	Regular review in-year through the Board and its Committees.

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

University Hopsitals Dorset Annual Objectives 2022-23
Summary

Objectives 2022/23

1 To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience
2 To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best
3 To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets
4 To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people
5 To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
1.1	To deliver wide range of Patient Safety Quality Priorities, using a quality improvement (QI) approach:	Chief Strategy & Transformation Officer	Updated to reflect TMG priorities replacing Dorset list, updated to reflect national priority B	1600	If we do not deliver the Trust's QI and Innovation Strategy there is a risk that the Trust will not improve outcomes or deliver efficiencies in line with the Trust's values of being an improving organisation	Betts, Alan - Deputy Director of Transformation	Q1				0	⇩ Closed from RR 4	[05/05/2022] QI priorities agreed for 2022/23 at TMG - ongoing delivery of QI strategy with no new risks identified. **RISK CLOSED**	Transformation Committee	0
1.1.1	Deliver quality priority - managing the deteriorating patient	Chief Medical Officer	Carried over with extension to review managing deteriorating in ED	1605	Managing the deteriorating patient - if the Trust is unable to develop a unified policy and process for the monitoring, escalation and management of a deteriorating patient then there is a risk to patient safety and patient outcomes.	O'Donnell, Alyson - Chief Medical Officer	Q1	3	3	Moderate	9	⇩	[04/05/2022] Good progress on a number of workstreams with DIVA project, IV fluids and TEP management now live. Communication with ITU imminent and 2222 calls will go live in August when new doctors hand over Work continues on safe medical staffing model	Quality Committee Quality Governance Group	9
1.1.2	Deliver quality priority - standardised safety checklists	Chief Medical Officer	Carried over	1599	If unable to embed culture for use of safety checklist process for all interventional procedures undertaken across UHD then risk of never events occuring with potential harm to patients and regulatory action from CQC. Risk that variable application across UHD and lack of standardardisation across sites for same specialities, including staff training, will impact on compliance and culture .	O'Donnell, Alyson - Chief Medical Officer	Q1	3	3	Moderate	9	⇩	[04/05/2022] Work ongoing - to continue as a quality priority for Q1 2022-3 Working group continues to meet with policies, procedures and SOPs becoming increasingly aligned as single document	Quality Committee Quality Governance Group	6
1.1.3	Deliver quality priority for 2022/23 - acute kidney injury/dialysis management	Chief Medical Officer	New quality priority for 22/23												
1.1.4	Deliver quality priority for 2022/23 - blood glucose management	Chief Medical Officer	New quality priority for 22/23												
1.1.5	Deliver quality priority for 2022/23 - the deteriorating patient in ED	Chief Medical Officer	Carried over with extension to review managing deteriorating in ED	1605	Managing the deteriorating patient - if the Trust is unable to develop a unified policy and process for the monitoring, escalation and management of a deteriorating patient then there is a risk to patient safety and patient outcomes.	O'Donnell, Alyson - Chief Medical Officer	Q1	3	3	Moderate	9	⇩	[04/05/2022] Good progress on a number of workstreams with DIVA project, IV fluids and TEP management now live. Communication with ITU imminent and 2222 calls will go live in August when new doctors hand over Work continues on safe medical staffing model	Quality Committee Quality Governance Group	9
1.1.6	Deliver quality priority for 2022/23 - medical/pharmacy communication	Chief Medical Officer	New quality priority for 22/23												
1.1.7	Improve against Stroke pathway quality standards	Chief Operating Officer	New Board objective for 22/23	1468	Stroke Outreach Team Staffing. If there not an appropriate uplift to the staffing profile for UHD Stroke Outreach Team then there is a risk to patient safety	Gower, Morwenna - Stroke Service Manager	Q1	3	3	Moderate	9	⇔	[18/06/2021 Enhanced support meetings for stroke service remain in place. Indicative Q4 SSNAP B but worse for thrombolysis. Additional LTS within team impacting staff resilience further. Bank training opportunities being offered to cross site stroke staff for additional to contract shifts as no opportunities for secondment available. Interim Team Lead ending FTC 19.7.2021. Q4 Median time to specialist Nurse assessment from clock start : 27mins (SSNAP A). Q1 to date - 1hr and 2 minutes (SSNAP B). Q4 Median time to Brain imaging from clock start: 1hr 15mins.(SSNAP c) Q1 to date - 1hr 40 (SSNAP D) Q4 Median time to being admitted to the stroke unit from clock start: 3hrs 49. (SSNAP C) Q1 to date = 4hrs 23mins (SSNAP D) Deterioration in front door metrics which using evidence base for national recommendations suggests theses delays could lead to worsening worsening pt outcomes	Stroke Governance Group	2
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	New Board objective for 22/23	1277	Risk that Trauma Patients on non-trauma wards receive a reduce level of specialist input due to lack of trauma nursing, therapy and dedicated medical cover. Increased impact on ED performance standards due to lack of Trauma Capacity.	West, John - General Manager, Trauma and Orthopaedics	Q1	3	3	Moderate	9	⇔	[31/05/2022] no change to risk, trauma bed base now established on C2, B3, B4 and E3, ward staffing template review complete awaiting sign off	Trauma and Orthopaedics Governance Group	4
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	New Board objective for 22/23	1136	High level of qualified staff vacancies (24.6%) across the trauma wards, leading to risk to the quality of care to patients. Inability for the nursing bank office to provide substantive replacement staff for each vacant shift resulting in agency usage impacting available skill mix. ward nursing staff report increased workload and delays in care delivery.	West, John - General Manager, Trauma and Orthopaedics	Q1	2	3	Low	6	⇔	[03/05/2022] reviewed by Senior Matron - no change to risk or mitigations	Trauma and Orthopaedics Governance Group	3

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	New Board objective for 22/23	1439	Risk that lack of capacity to admit routine Orthopaedic Patients for their surgery creates inability to maintain or recover RTT position. This may lead to more complaints around compromising wellbeing of patients attributable to deteriorating access and waiting times. Operations may be cancelled when unable to maintain ringfenced bed base to meet GIRFT requirements.	West, John - General Manager, Trauma and Orthopaedics	Q1	2	5	Moderate	10	⇔	31/05/2022 whilst bed capacity has stabilised access to theatre template is restricted by theatre and anaesthetic staffing gaps. risk remains. [11/04/2022] full engagement with regional scheduling project with additional local service development eg. day case hip and knee replacement pathways.	Trauma and Orthopaedics Governance Group	6
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	New Board objective for 22/23	1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients - Risk of failure to achieve the NHFD standard that no more than 15% of patients have to wait longer than 36hrs post admission to undergo their surgery following a #NoF. Evidence shows that if patients wait more than 36hrs post injury for a #NoF they will have a worse outcome and longer recovery.	West, John - General Manager, Trauma and Orthopaedics	Q1	3	5	High	15	⇔	[14/06/2022 08:54:33 John West] 14/06/22 updated action plan attached. risk remains unchanged. [03/05/2022] daily trauma escalation meetings in place, Poole theatre template being reviewed by care group. current performance 30%NHFD and 50% of fit to surgery within 36h. risk remains unchanged. [11/04/2022] daily trauma escalation meetings in place, Poole theatre template being reviewed by care group. trauma summit and stakeholder meetings planned. current performance 30%NHFD and 50% of fit to surgery within 36h. risk remains unchanged.	Trauma and Orthopaedics Governance Group	2
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	New Board objective for 22/23	1207	T&O Medical Staffing Shortage at Junior and Middle Grade Level	West, John - General Manager, Trauma and Orthopaedics	Q1	3	3	Moderate	9	⇔	[11/04/2022] no change to risk, recurrent recruitment underway, work with HR to reduce/remove fixed term contracts where possible	Trauma and Orthopaedics Governance Group	4
1.2	Improve the safety and experience of emergency patients and their flow, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partner and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer	Updated to reflect national priority D	1131	Current challenges around patient flow and capacity due to increased demand, delays in external discharge and bed closures have become increasing difficult to manage and presents risk to patient safety	Sophie Jordan - Associate Director - Operations, Flow and Facilities	Q1	4	5	High	20	⇔	[10/06/2022] Progression with the ED Rapid Decompression plan and Hospital Flow Improvement Group. (Evidence attached) Monitored via weekly workstream meeting and with overall operational metrics. [09/05/2022] Risk rating remains the same. Continued pressure on flow due to high occupancy levels and numbers of patients Medically Ready for Discharge. Hospital Flow Improvement Group in place with 4 key workstreams focusing on improving flow medium to long term. A rapid ED Decompression Plan is in place to manage immediate risks. Both plans are reviewed weekly and report to TMG and OPG. [13/04/2022] UHD SDEC Workstream now part of the flow recovery programme with oversight of TMG Weekly SDEC Workstream meetings to support the areas in developing services required throughout the organisation. Bids for further funding being compiled. All routes of access being reviewed to ensure robust access to the services from within and outside the organisation. SDEC lead working as part of the system SDEC group to ensure equity of provision and access. Close working with SWAST, DHUFT and CCG to further develop services and access	Finance and Performance Committee	6
1.2	Improve the safety and experience of emergency patients and their flow, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partner and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer	Updated to reflect national priority D	1387	Demand & Capacity: Demand will exceed capacity for acute inpatient beds	Sophie Jordan - Associate Director - Operations, Flow and Facilities		4	5	High	20	⇔	[10/06/2022] Continued focus on the rapid decompression plan and Hospital Flow Improvement Group actions. [09/05/2022] Occupancy levels continue to remain above 95% for both sites, impacting on ED ambulance handover delays and increased number of 12 hour DTA breaches. Trust wide Flow Improvement Programme in place with Rapid decompression plan for immediate improvement. This is monitored weekly with support from ECIST. Bed modelling is in train, awaiting impact of SDEC mitigations for overall bed plan for 22-23	Finance and Performance Committee	6
1.2	Improve the safety and experience of emergency patients and their flow, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partner and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer	Updated to reflect national priority D	1053	Lack of capacity for elective & non elective activity and risk to patient harm due to LLOS and NRTR patients	McCubbin, Cherry - Associate Director Partnership, Integration & Discharge	Q1	4	5	High	20	⇔	[10/03/2022] Update - The position is unchanged from last update.	Finance and Performance Committee	6

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
1.2.1	Also improve the responsiveness and quality of Urgent and Emergency Care (UEC) as measured by a reduction in 12 hour waits in ED towards zero, minimisation of handover delays and same day emergency care outcomes supported by implementation of the UEC 10 Point Action Plan	Chief Operating Officer	Updated to reflect national priority D	1460	Ability to meet new UEC National Standards and related impact on patient safety, statutory compliance and reputation.	Higgins, Michelle - General Manager - Urgent and Emergency Care	Q1	4	5	High	20	⇔	[30/05/2022] some improvement in metrics however remains outside standards and patients waiting >12 hours in the departments and >60 minutes in Ambulances remains a challenge. RCA being undertaken for >12 DTA and >120 minute ambulance delays being reported through ED performance meeting and will be fed into Winter planning meeting from early June. Internal improvement schemes continue at pace. [03/05/2022] ED and UEC performance remains extremely challenged. Action plans in place supported by rapid decompression bi-weekly executive meeting. ED remains congested due to flow and ED process elements, with individual plans in place overseen by Flow Improvement Programme. Executive and senior leader focus through TMG and JLF [12/04/2022 17:08:04 Alex Lister] Unchanged. Significant challenges with ED performance. Exec support with actions. Bi WEEKLY coo LED meeting reporting to Regional Team - Current Recovery plan attached	Operations and Performance Group	6
1.3	To design and transfer outpatient services with a Digital First offer, improving access to care, diagnostics strategy delivery, reducing travel times, and through effective completion of care pathways	Chief Operating Officer		1464	Re-designing outpatient services for future demand Risk that the Trust fails to respond to the challenge of changing models of outpatient care in line with National trend information relating to population growth and aging population needs. Developing innovation and new models of care is essential to future-proof access to relevant clinical intervention and advice in a timely way.	Sarah Macklin	Q1	3	3	Moderate	9	⇔	[09/05/2022]- Final PA consulting report submitted to exec team for review await outcomes and action plan to support recommendations. The digital outpatient transformation programme of works is now under way in terms of Patient Portal/Bookwise/INTOUCH/digital transcription. Outcomes of these will be realised as they come on line during 2022. Patient portal will have several phases in terms of roll-out due to the integration complexity with eCAMIS, the project lead is currently working through the project plans with DrDoctor the chosen provider. INTOUCH self check in will see a July go-live date and Bookwise anticipated in June/beg July 22.	Finance and Performance Committee	4
2.1	To continue to engage with staff at all levels to ensure we maintain focus and realise the Health, Wellbeing and Covid-recovery needs and priorities of all our people, investing in appropriate provision of holistic interventions and resources. To engage with staff so that they feel valued and listened to and to strengthen our compassionate and inclusive culture, acting on staff culture champions recommendations and demonstrating success through the national staff survey	Chief People Officer	Updated to reflect national priority A, B and culture champions	1493	Absence, Burnout and PTSD - Risk of medium and lo	Carla Jones Deputy Director of Workforce & Organisational Development Deborah Matthews Director of Improvement and OD	Q1	4	3	Moderate	12	⇔	[31/05/2022] Action plans added to Datix including latest progress update. [11/04/2022] Referrals to OH remain high. Currently a 6/7 week wait for an appointment with an OH Nurse Adviser or OH Doctor due to low staffing levels and sickness absence within the team. All waiting referrals currently being reviewed and prioritised. Recruitment to the additional roles recently approved has commenced and one appointment made to date. Demand for psychological support & counselling service is high. The team remain under capacity due to staffing gaps and at present are unable to meet demand with referrals continuing to be redirected to the ICS Wellbeing Hub. A successful recruitment campaign has taken place to recruit Health & Wellbeing Practitioners to the bank and agreement has been obtained from the executive to extend the enhanced phased return to work (12 weeks) until end of March 2023, to support staff returning from periods of long term absence due to stress and mental health.	Workforce Strategy Committee	4
2.2	To support teams in coming together to operate as a single team across UHD sites, embedding our values and behaviours, policies and processes and to identify talent and raise performance and staff engagement across the Trust as measured by an improvement staff integration survey	Chief People Officer	Updated to reflect integration				Q1							0	

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
2.3	To deliver the Trust's People Strategy by developing effective and responsive People services, policies and practices for each stage of the employee cycle. This will include workforce planning recruitment and retention, training and education, employee relations, temporary workforce and workforce systems	Chief People Officer		1492	Resourcing Pressures - Staffing. Risk of significant resourcing pressures in the remainder of the Covid 19 pandemic and recovery period due to limited number of trained front line staff, likely increase in turnover as soon as the pandemic eases and limited pipeline of new recruits which is also impacted by the uncertainty around retaining EU employees and continuing to recruit from the EU.	Irene Mardon - Deputy Chief People Officer	Q1	4	3	Moderate	12	⇔	[31/05/2022] Action plans added 31/5 including progress updates. [12/05/2022] Risk description and controls updated. An action plan has been drafted for discussion at WODG on 18/5/22; once agreed this will be uploaded to the risk in Datix. [19/04/2022] Validation of the merged ESR data is being prioritised, with initial focus being on areas where workforce transformation or configuration is due more imminently. Data cleanse for Pathology is well under way with support from the HR Business Partner. Nursing Workforce have reviewed the Medical care group HCSW establishment for further cost centre updates. A large scale cleanse of Right to Work and Visa dates on ESR is also taking place, following historic changes to which fields and what data is recorded. Our Marketing and Social Media Officer has started work, paying particular attention to the regularly advertised volume posts such as HCSWs, refreshing our intranet/internet pages, and commencing work on recruitment videos. The Recruitment team continue to manage very high volumes of activity, with a number of vacancies still to be filled within both Medical and General recruitment teams, and a challenging market to recruit from.	Workforce Strategy Committee	4
2.4	To champion Equality, Diversity and Inclusion across UHD through positive action and promote initiatives which continue to improve results against workforce equality standards (eg WRES and WDES)	Chief People Officer	National priority A and patient safety just culture											0	
2.4.1	Implement the National Patient Safety Strategy requirement to develop a just culture across UHD as part of a ICS workforce plan	Chief People Officer	National patient safety strategy requirement and Quaity Account objective											0	
2.4.2	Define and agree measures to monitor implementation of inclusive leadership, equal opportunities in career development and endorsement of staff networks	Chief People Officer	New specific objective 2022/23											0	
3.1	Agree and deliver a sustainable budget, including delivery of the Trust Cost Improvement Programme. This includes realising the opportunities identified in the Getting It Right First Time (GIRFT) and Model Hospital benchmarking data	Chief Medical Office	National objective 1	1416	GIRFT and Model HospitalRisk of not achieving efficie	Helen Rushforth - Head of Productivity & Efficiency	Q1	4	4	High	16	⇔	[31/05/2022] Reviewed confirmed remains the same	Finance and Performance C	4
3.2	To deliver a Covid restoration programme that reduces the elective backlog, increases activity to pre-pandemic levels and returns waiting times and waiting patient numbers towards the national standards	Chief Nursing Officer	Updated to reflect national priority C	1383	Given the nature of the novel coronavirus, there is a risk that patients and/or staff could contract hospital acquired covid-19 infection as a result of inadequate or insufficient infection prevention and control processes and procedures, which may not be known due to evidence base available at the time of the pandemic	Bolton, Paul - Lead Nurse for Infection Prevention and Control	Q1	3	3	Moderate	9	⇔	[29/04/2022 Emergency and Urgent care demand has increased with significant occupancy pressures, remain on OPEL4 in internal critical incident. Tactical and Gold ask to review Covid-19 pathways and plans, to ensure capacity within the hospital in safely maximised (this was on an initial backdrop of a reduction in case rates and more patients admitted with incidental covid-19, but community cases increased significant) Pathways where reviewed to reduce blue capacity ward areas and manage Covid-19 in speciality developed in clinical wards - increase in incidental covid-19 being seen. Management of Covid-19 Contacts in bay SOP produced (which in turn increases the likehood of covid-19 contact) The organisation continues to have its controls (as listed) in place and oversight documented above and alongside: Implementation of National IPC guidance i.e. testing/staff/management Outbreak Management and oversight continues Regular learning from incidents shared, Fit Testing Process in place (policy due for ratification). IPC Cell meetings frequently including update on Epicell data Risk Reviewed. Data on hospital transmission to be reviewed	Quality Committee Infection, prevention & control group	6

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
3.2	To deliver a Covid restoration programme that reduces the elective backlog, increases activity to pre-pandemic levels and returns waiting times and waiting patient numbers towards the national standards	Chief Operating Officer	Updated to reflect national priority C	1342	The inability to provide the appropriate level of services for patients during the COVID-19 outbreak - There is potential for this outbreak to create a surge in activity with resultant pressure on existing services. Risk to personal health if staff contract Covid-19 Risk to the organisation relating to staffing gaps (medical, nursing, AHP, ancillary) due to social isolation requirements and sickness. Risk of Covid-19 positive patients presenting to main hospital services causing risk from spread of infection	Sophie Jordan - Associate Director - Operations, Flow and Facilities	Q1	4	4	High	16	⇔	[09/06/2022] Downward trend in the number of positive patients across both sites continues. Current admitted Covid-19 patients is 43. Staff absences due to Covid (isolating or symptomatic) are also reducing. [09/05/2022] New IPC guidance has been introduced allowing specialties to manage covid patients/contacts within individual areas with IPC team support to manage any potential outbreaks that require ward closures. This has released non covid bed capacity and enabled services to 'live with covid' and manage patients appropriately. 82 patients across both sites recorded today, which follows the downward trend for covid admissions. Under constant review by Tactical Group with Strategic oversight.	Quality Committee Infection, prevention & control group	6
3.2.1	Deliver a Covid restoration programme for elective patients	Chief Operating Officer	Updated to reflect national priority C	1074	Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2020/21 are not met There is a risk that there will be patient harm from delayed pathways, NHSI/E regulatory challenges and premium expenditure requirements if the RTT related targets for 2020/21 are not met, namely: 1) Total waiting list to be no greater than Jan 2020 2) No 52 week waiters 3) RTT delivers to agreed operational plan trajectory for 2020/21 4) Recognise RTT standard is 92% (national NHS constitution target) and should be delivered where possible	Judith May, Associate Director of Operational Performance, Assurance & Delivery	Q1	4	5	High	20	⇔	[09/06/2022] Risk description updated to reflect 2022/23 operational planning requirements. Capacity for patients in clinical priority groups 3 and 4 remains lower than demand. Use of additional insourced/outsourced ISP capacity continues to supplement internal capacity. 104+ week waits are reducing. Current risk at end June 2022 is 120. [20/04/2022] No significant change to risk. Numbers of 52/78 and 104 week waits continue to reduce and RTT performance stabilised however national standards not met. some specialities achieving 18 weeks. Clinical validation programme continues to ensure accurate waiting list and prioritisation of patients according to clinical need. Continue	Finance and Performance Committee	4
3.2.1	Deliver a Covid restoration programme for elective patients	Chief Operating Officer		1439	Orthopaedic operational pressures ,outlying patients and reduced ward footprint. Potential lack of capacity to admit routine Orthopaedic Patients for their surgery creates inability to maintain or recover RTT position. This may lead to more complaints around compromising wellbeing of patients attributable to deteriorating access and waiting times. Operations may be cancelled when unable to maintain ringfenced bed base to meet GIRFT requirements. Demand has not reduced to the level previously anticipated following the introduction of MSK triage in 2017 and referrals have steadily increased after an initial fall. Additions to waiting list now exceed removals by an average of 37 patients per month in the past year	John West - General Manager, Trauma Orthopaedics, Surgery PH Site	Q1	2	5	Moderate	10	⇔	[31/05/2022] whilst bed capacity has stabilised access to theatre template is restricted by theatre and anaesthetic staffing gaps. risk remains. [11/04/2022] full engagement with regional scheduling project with additional local service development eg. day case hip and knee replacement pathways.	Finance and Performance Committee, Operations and Performance Group	6
3.2.2	Covid restoration programme for cancer patients	Chief Operating Officer		1386	Cancer waits - Risk of patient harm from delayed pathways, risk to compliance with CWT standards. Risk may be increased if unable to recruit and retention of key clinical staff (oncologist and histopathologists) in particular in sub specialisation areas that rely on a single handed practitioner.	Judith May, Associate Director of Operational Performance, Assurance & Delivery	Q1	4	3	Moderate	12	⇔	[17/06/2022] ICS approach to PWC pathway reviews to be finalised 4th July at away day – update to be provided after this date [24/05/2022] Update from Stephen Bleakley: Wessex Cancer Alliance and NHSE have been approached for increased funding for aseptic pharmacy staffing. [11/04/2022 Structured pathway reviews for Breast, Gynae, Head & Neck, Colo, Prostate & Skin being undertaken by PwC. All timed pathways are being reviewed, admin processes being revisited, Demand & Capacity is being reworked, Business Information Structure & content being updated and implemented. Pathway and patient review carried out weekly at scheduled PTL breach meeting. Meetings are divided into risk areas for discussion - Operational management teams are in attendance therefore all risks are escalated in a timely manner. Holistic approach to pathway management introduced, looking at recurrent and adhoc capacity provision to mitigate delays to the pathway and reduce potential for patient harm. Monthly meetings scheduled with Operational Management and Diagnostic Service Management to review on an ongoing basis. [08/04/2022] Review of all Root Cause	Finance and Performance Committee	4

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
3.2.3	Deliver a Covid restoration programme for diagnostic patients	Chief Operating Officer		1348	Covid related pause to Dorset Bowel Cancer Screening Programme and potential diagnostic delay	Lister, Alex - Group Director of Operations (Medical Care Group)	Q1				0	⇩ Closed from RR 6	[03/05/2022] Diagnostic wait standard achieved for April at 100%. RBH rooms are now back open following ventilation work and all planned insourcing weekends delivered. No further actions required at this point. **RISK CLOSED** [19/04/2022] Diagnostic wait standard was not met in February 2022 (71%), however, since then the additional lists provided by insourcing weekends at Poole has mitigated the loss of capacity on the RBH site due to the ventilation work. Subsequently the diagnostic wait standard was met at 97% for March 2022. There is one further insourcing weekend scheduled at Poole in April and from beginning of May the RBH lists will return to the RBH	Finance and Performance Committee, Operations and Performance Group	
3.2.3	Deliver a Covid restoration programme for diagnostic patients	Chief Operating Officer		1574	Breast screening backlog - There is currently a significant backlog with 20,000 women waiting for breast screening in Dorset and just 3.9% of women eligible are being offered screening. If this continues women will present later with breast cancer as 7-10% of every 1000 patients screened have cancer detected early. The earlier the condition is found the better the prognosis and the less likely the patient is to need major surgery and treatments such as chemotherapy	Mandy Tanner - Radiology General Manager	Q1				0	⇩ Closed from RR 16	[24/06/2022 Predicted to reach recovery September 2022. Following external inspection in 2019 increase in staffing levels recommended but business cases not supported. No vacancies achieved without increase in staffing. **RISK CLOSED.** [24/05/2022 Discussed with GDoN and GDoO, likelihood reduced based on most recent staffing information. [13/05/2022] One new radiologist has joined the team. One Consultant radiologist retires in June. Locum, cover has been extended until end September whilst we advertise. Radiology manager has included Breast radiologists on a piece of work to inform a refreshed radiology UHD wide business case. [09/05/2022] Regarding our radiography staff, we will be fully staffed once additional radiographers join our Team this month. they will need to be trained. However, we are selling our 4th mobile unit this month which will support our training staff better as it will increase our workforce by 2 radiographers based at Poole. Staff will not be stretched over 6 sites just 5. Once trained we will be fully staffed.	Finance and Performance Committee, Operations and Performance Group	
3.2.4	Deliver a Covid restoration programme for emergency care patients	Chief Operating Officer	Updated to reflect national priority C	1429	Ambulance handover delays - If we cannot assess and move patients into ED clinical areas from the Ambulance queues within 15 minutes then there is a risk of harm to patients in the queue or community. See attached PDSA documents. There is also a risk to organisational performance standards and reputation	Lister, Alex - Group Director of Operations (Medical Care Group)	Q1	4	5	High	20	⇔	[30/05/2022] Reponses continues. RCAs commenced for >120 minute ambulance delays. Increased awareness of escalation processes. Revised DRAFT policy shared for comment and implementation. [03/05/2022] Ambulance handovers increase due to ED congestion and crowding. Bi weekly exec led rapid decompression meeting in place supported by Flow Programme. Focus of TMG and JLF to recovering Emergency Flow. Updated rapid decompression plan	Finance and Performance Committee, Operations and Performance Group	3
3.2.4	Deliver a Covid restoration programme for emergency care patients	Chief Operating Officer	Updated to reflect national priority C	1460	Urgent and Emergency Care (UEC) performance There is a potentional risk to patients waiting in excess of National Standards	Lister, Alex - Group Director of Operations (Medical Care Group)	Q1	4	5	High	20	⇔	[30/05/2022] some improvement in metrics however remains outside standards and patients waiting >12 hours in the departments and >60 minutes in Ambulances remains a challenge. RCA being undertaken for >12 DTA and >120 minute ambulance delays being reported through ED performance meeting and will be fed into Winter planning meeting from early June. Internal improvement schemes continue at pace. [03/05/2022] ED and UEC performance remains extremely challenged. Action plans in place supported by rapid decompression bi-weekly executive meeting.	Finance and Performance Committee, Operations and Performance Group	4
3.3	To update and deliver our Green UHD Strategy and Plan - including reducing our carbon footprint, improving air quality and make more sustainable use of resources	Chief Strategy & Transformation Officer	Updated to reflect 2022-23	1446	Sustainability Strategy If we do not deliver the Trust's Sustainability Strategy there is a risk that the Trust will not either measure or reduce it's carbon footprint	Edwin Davies - Associate Director Capital and Estates	Q1				0	⇩ Closed from RR 4	04/05/2022 **RISK CLOSED**, on trajectory for sustainability	Sustainability Committee	
4.1	To improve partnership and engagement with staff, governors, patients, local people and key stakeholders	Chief Strategy & Transformation Officer	Updated to reflect 2022-23											0	
4.1.1	Implement a communication and engagement plan, delivered over the year	Chief Strategy & Transformation Officer	New Board objective for 22/23											0	
4.1.2	Further develop our BU partnership and tangible benefits	Chief Strategy & Transformation Officer	Updated to reflect 2022-23	1601	If we do not continue to develop the partnership with Bournemouth University it may lead to a failure to fulfil our potential as University Hospital which may mean we don't continue to attract staff and research opportunities as a leading University Hospital	Betts, Alan - Deputy Director of Transformation	Q1				0	⇩ Closed from RR 4	[05/05/2022] BU Programme in year 2, recent presentations by BU and UHD at respective Boards, no new risks identified and systems and processes in place to continue to deliver BU partnership. **RISK CLOSED**	Transformation Committee	
4.1.3	Host the Dorset Innovation Hub on behalf of Dorset partner supporting spread of proven innovations	Chief Strategy & Transformation Officer												0	

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
4.2	Work with partners to address Health inequalities and improve population health management, preventing ill health and promoting health lifestyles	Chief Executive	New reflect national priority G	1603	The risk is establishing the Statutory ICS by April 2022 in a way that has effective governance and relationships that deliver against the 4 ICS objectives:- - improving population health and healthcare; - tackling unequal outcomes and access; - enhancing productivity and value for money; and - helping the NHS to support broader social/economic development) Failure to achieve the above leads to UHD being unable to fulfil its requirements and regulatory	Renaut, Richard - Chief Strategy and Transformation Officer	Q1	2	2	Low	4	⇔	[05/05/2022] ICS filling Executive Board posts with most expected to be complete by end May (Nursing post is the exception). Provider collaborative back on track with DHC becoming part of the collaborative, expect this to be in place by July per statutory requirement. Minor risk remains that ICS might not achieve its four objectives while organisational change is taking place	Board of Directors	2
5.1	Develop the reconfiguration plan to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for new estate and new models of care	Chief Strategy & Transformation Officer	Updated objective for 22/23	1602	Risk that In year delays to the critical path programme can lead to costs increasing by £0.5m a month. Complexity of the programme and external approvals required for capital expenditure generate the likelihood	Killen, Stephen - One Acute Network - Programme Director	Q1	4	2	Moderate	8	⇔	[01/04/2022] No further update	Transformation Committee	8
5.1	Develop the reconfiguration plan to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for new estate and new models of care	Chief Strategy & Transformation Officer	Updated objective for 22/23	1260	There is a risk that we are unable to maintain the Trust estate in line with Clinical and regulatory requirements. Risk to staff and patient safety and risk of regulatory action if statutory breaches identified. Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling	Edwin Davies - Associate Director Capital and Estates	Q1	4	3	Moderate	12	⇔	[28/06/2022] Updated action plan uploaded [13/06/2022] Progress continues at pace, Review undertaken, evidence of progress being made, risk still holding at 12. [29/04/2022 : progress continues at pace, however assurance required in order to consider further reduction in risk grading. Trust are appraised of the outcome of the fire risk assessments and work corrolated by site with any works required to enable project management to be effective All new fire extinguishers installed	Quality Committee	8
5.1.1	To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/23	Chief Finance Officer	Updated objective for 22/23	1594	Capital Programme Affordability (CDEL) - Risk that the agreed capital programme will not be affordable within the ICS capital allocation (CDEL) resulting in operational and quality/safety risks and a delay in the reconfiguration critical path	Papworth, Pete - Chief Finance Officer	Q1	4	3	Moderate	12	⇔	[27/05/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same	Finance & Performance Committee	6
5.1.1	To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/23	Chief Finance Officer	Updated objective for 22/23	1595	Medium Term Financial Sustainability -Risk that the Trust will fail to deliver a financial break-even position resulting in regulatory intervention, an unplanned reduction in cash and the inability to afford the agreed 6 year capital programme	Papworth, Pete - Chief Finance Officer	Q1	4	4	High	16	⇔	[27/05/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same	Finance & Performance Committee	6
5.1.1	To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/23	Chief Finance Officer	Updated objective for 22/23	1740	ICS at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit, a reduction in cash and regulatory intervention	Papworth, Pete - Chief Finance Officer	Q1	4	5	High	20	New	[27/05/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same	Finance & Performance Committee	8
5.1.1	To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/23	Chief Finance Officer	Updated objective for 22/23	1739	Financial Control Total 2022/23 - Trust at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit and a reduction in cash available to support the capital programme.	Papworth, Pete - Chief Finance Officer	Q1	4	5	High	20	New	[27/05/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same	Finance & Performance Committee	8
5.1.1	To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/23	Chief Finance Officer	Updated objective for 22/23	1604	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds	Killen, Stephen - Programme Director	Q1	4	5	High	20		[07/06/2022] Strategy & Transformation Risk Update - May 2022 - The risk score remains the same due to the enabling design fees being secured for the 2022/23 period. A planned approached is defined also for the 2022/2023 enabling schemes. No further funding has yet been confirmed. The trust therefore, continues at risk. The risk will be reviewed at ARC in June 2022.	Transforation Committee	8
5.2	Work with system partners in establishing the Dorset ICS and within that develop the Dorset provider collaborative	Chief Executive	Updated objective for 22/23	1603	The risk is establishing the Statutory ICS by April 2022 in a way that has effective governance and relationships that deliver against the 4 ICS objectives:- - improving population health and healthcare; - tackling unequal outcomes and access; - enhancing productivity and value for money; and - helping the NHS to support broader social/economic development) Failure to achieve the above leads to UHD being unable to fulfil its requirements and regulatory	Renaut, Richard - Chief Strategy and Transformation Officer	Q1	2	2	Low	4	⇔	[05/05/2022] ICS filling Executive Board posts with most expected to be complete by end May (Nursing post is the exception). Provider collaborative back on track with DHC becoming part of the collaborative, expect this to be in place by July per statutory requirement. Minor risk remains that ICS might not achieve its four objectives while organisational change is taking place	Board of Directors	2
5.3	Implement the UHD Digital Transformation Strategy	Chief Informatics & IT Officer	Update, national objective H	1298	There is a risk that we fail to maintain and develop the Trust IT services in line with clinical and operational requirements	Gill, Peter - Chief Information & IT Officer	Q1	5	2	Moderate	10	⇔	[12/05/2022] We have now formally started our rolling stock replacement programme as supported by the 2022/23 IT Capital programme. Staff recruitment has been successful and devices have been procured/received. The Informatics IPR shows that core infrastructure uptime has been maintained at or above the expected level (99.9% uptime) consistently for 8 consecutive	Information Governance Group	8

Ref	Specific Objective	Executive Lead	Status from 2021-22	Associated risks	Risk Title	Risk Lead	Quarter	Consequence	Likelihood	Severity	Rating	Movement	Last Update	Monitoring Group	Target risk rating
5.3	Implement the UHD Digital Transformation Strategy	Chief Medical Officer	Update, national objective H	1378	Lack of Electronic results acknowledgement system - A lack of an electronic results acknowledgement system for requested clinical tests is a risk to patient safety and could result in missed diagnosis and suboptimal treatment.	Sarah Hill - Assistant Director of IT Development	Q1	3	3	Moderate	9	⇔	[09/05/2022] Still not entirely resolved but much progress has been made on the last remaining issue. This being getting Radiology results in Poole UTC back via S1 [04/05/2022] Update requested on teams based notification progress Advent of LIMS ensuring better visibility but not an alert [04/04/2022] No further updates but no live issues of reported issues - those reported historical. Gaps in visibility of results between organisations improved with development of	Information Governance Group	4
5.3.1	Progress digital transformation and play an active part in the key Dorset transformation plans programmes	Chief Informatics & IT Officer	New specific objective 2022/23											0	
5.3.2	Progress a Digital Dorset Shared Service	Chief Informatics & IT Officer	New specific objective 2022/23	1434	Delays to the implementation of the Dorset Care Record	Hill, Sarah - Assistant Director IT Development	Q1	3	2	Low	6	⇔	[25/05/2022] Pathology testing scheduled for June / July 2022 My DCR engagement progressing - about 5 patients from UHD subscribed Document feed to DCR being reviewed Medical feed will not progress until EPMA is upgraded to FHIR compliant solution.	Information Governance Group	6
5.3.3	Procure and implement the Strategic Integrated Imaging Service: a digital diagnostics image sharing platform for Dorset	Chief Informatics & IT Officer	New specific objective 2022/23											0	
5.3.4	Create the Strategic Outline Case and Outline Business Case for the Dorset Electronic Patient Records system	Chief Informatics & IT Officer	New specific objective 2022/23	1756	There is a risk that the Graphnet CareCentric EPR degrades in its functionality and performance over the next 3 to 5 years	Hill, Sarah - Assistant Director IT Development	Q1	4	3	Moderate	12	⇔	New risk added	Information Governance Group	9
5.3.5	Ensure that the IT infrastructure and BAU support services are fit for purpose with minimal down-time and the technical layers are subject to a rolling stock replacement programme	Chief Informatics & IT Officer	New specific objective 2022/23	1273	Cyber Security Risks, Threats and Vulnerabilities- There are risks related to cyber security that, potentially, can affect the resilience of the Trust's IT systems and data. This could adversely affect all trust business.	Martin Davis, IT Security Manager	Q1	2	5	Moderate	10	⇔	[03/06/2022] The controls have marginally reduced in the last month due to the end of support for Windows 10 (version 1909). This is being addressed with a plan to enforce this upgrade across the UHD estate by 31 July 2022	Information Governance Group	6
5.3.5	Ensure that the IT infrastructure and BAU support services are fit for purpose with minimal down-time and the technical layers are subject to a rolling stock replacement programme	Chief Informatics & IT Officer	New specific objective 2022/23	1437	There is a risk of total outage of the computing services at RBCH if the single point of failure of electrical supply fails	Gill, Peter - Chief Information & IT Officer	Q1	2	3	Low	6	⇔	[12/05/2022] The resilience of the new eCAMIS physical servers has been re-assessed. From EMIS: "The CaMIS database / and application are replicated in real time from the Primary to the Secondary server. We used a modified version of our fail over plan to implement the new CaMIS boxes. So this gives a recent practical example proving that replication works. We have monitoring in place as well to check the status of replication. So if this ever fails for any reason this is treated as a priority to resolve. This is monitored 24/7 and would be picked up by our hosting team if it fails out of hours. So in short there is protection for the database/ application and this is robust and replicated in real time" There are unique services running on the second server which is not standard practice (as the two servers should be exactly the same). Both eCAMIS boxes are still in the same data centre (with the single power supply) and the second box needs to be moved to the second Data Centre (DC2) at RBH to provide better resilience. This needs to be scheduled with EMIS group following the Single PAS go live (and settling in). The Radiology PACS system remains fully in	Information Governance Group	1
5.3.6	Achieve a compliant Data Protection and Security Toolkit submission	Chief Informatics & IT Officer	New specific objective 2022/23	1591	Information Asset Management.There is a risk of data loss and/or service interruption as a result of the inadequate management of the large suite of Information Assets that contain Personal Identifiable Data.	Camilla Axtell - IG and Data Protection Officer	Q1	3	4	Moderate	12	⇔	[03/06/2022] The care group performance of IAO work has been escalated at the May 2022 Care Group Quarterly performance meetings. The Audit Committee and Board of Directors have been advised via Camilla's annual report that we are likely to be non-compliant to this aspect of the national Data Security and Protection Toolkit [06/04/2022] Around 80% compliance was achieved by end December 2021 but this has now slipped back as a result of the need for annual assurance for some of the requirements. TMG to be engaged to consider the appetite for performance management of this requirement in the current climate	0	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET
Meeting Date: 27 July 2022

Agenda item: 7.5

Subject:	Annual Complaints & Patient Experience Report

Prepared by:	Laura Northeast - Interim Head of Patient Experience Matthew Hodson - Deputy Chief Nurse
Presented by:	Matthew Hodson - Deputy Chief Nurse

Purpose of paper:	The purpose of this paper is to provide an annual report of the complaints and PALS learning and activity during 2021/22 for noting.
Background:	This report draws together the information provided in the quarterly complaints reports during 21/22 into an annual report.
Key points for members:	• The Trust procedures to manage concerns and complaints meet statutory requirements. • The complaints procedure was aligned 2021/22, adopting best practice from both sites. • UHD will continue to work with the PHSO as an early adopter of the new complaints framework, which includes a focus on Early Resolution of Complaints (ERC). • In Q4 the number of complaints resolved via early resolution has increased substantially. • The Trust has received 492 complaints, 121 early resolution complaints and 5214 PALS enquiries and concerns during 2021/22. • This is a reduction in the number of complaints received 2020/21 but has seen a significant increase in the cases managed in the PALS service.
Options and decisions required:	None required.
Recommendations:	To note the annual report.
Next steps:	Following review at the Trust board the report will be uploaded on the Intranet page.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	All
BAF/Corporate Risk Register: (if applicable)	-
CQC Reference:	Safe, caring, well-led & effective

Committees/Meetings at which the paper has been submitted:	**Date**
Quality Committee	25 July 2022

University Hospitals Dorset
NHS Foundation Trust

2021/2022

ANNUAL COMPLAINTS REPORT

2021/2022

ANNUAL COMPLAINTS REPORT

1. INTRODUCTION

1.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009), requires that all Trusts provide an annual report on the handling and consideration of complaints. The required inclusions to meet this statutory requirement are detailed in this report.

1.2 The Chief Executive is responsible for ensuring compliance with the arrangements made under these regulations. The responsibility for the handling and considering of complaints in accordance with these regulations is delegated, via the Chief Nurse, to the Head of Patient Experience.

1.3 This report describes how complaints have been managed at University Hospitals Dorset. The report details the number and nature of complaints received during the year and demonstrates the Trust's commitment to learning and improvement.

2. THE PROCESS FOR MANAGING CONCERNS AND COMPLAINTS

2.1 The legacy Trusts of UHD had two different approaches to complaint handling:
i) a decentralised model, where the core PALS and Complaints team managed the process and the Care Group teams on the Royal Bournemouth and Christchurch Hospitals (RBCH) site coordinated, investigated and wrote the written response to complaints about their service;
ii) a centralised model, where the corporate team at Poole Hospital considered the nature and severity of the complaint raised, worked with the complainant to consider options for early resolution and where required, offer impartiality in investigating and responding to complaints.

2.2 Both sites offered a combined complaint handling and PALS service, with one point of entry for service users and aim to provide a full, fair and honest response that also meets the expectations of the complainant. Both policies provided clear guidance for staff on the procedure and standards for the handling of complaints.

2.3 'Have Your Say' posters and leaflets are available across the Trust, reflecting the principles of PALS, the opportunity to give feedback, and information about making a complaint. All complainants are routinely offered independent support through complaint advocacy services.

2.4 Whilst considering the preferred model of complaint handling for UHD, the RBCH and PH policy and procedure for the management of complaints remained in place. Both policies meet the statutory NHS regulations for England, the responsibilities set out in the NHS Constitution and CQC regulations.

2.6 A preferred model of complaint handling, procedure and service delivery plans was developed during 2021/22, the model includes the following principles and standards:

- Meets the statutory and regulatory responsibilities.
- Provides a consistent, positive and proportionate experience for complainants.
- Aligns the legacy systems with minimal disruption to services.
- Promotes a culture of learning and ensures complaints are acted on to improve services.
- Achieves or working towards achieving best practice standards (Patient Association 2013; NHSE 2015; Healthwatch 2016; Parliamentary & Health Service Ombudsman, 2020).

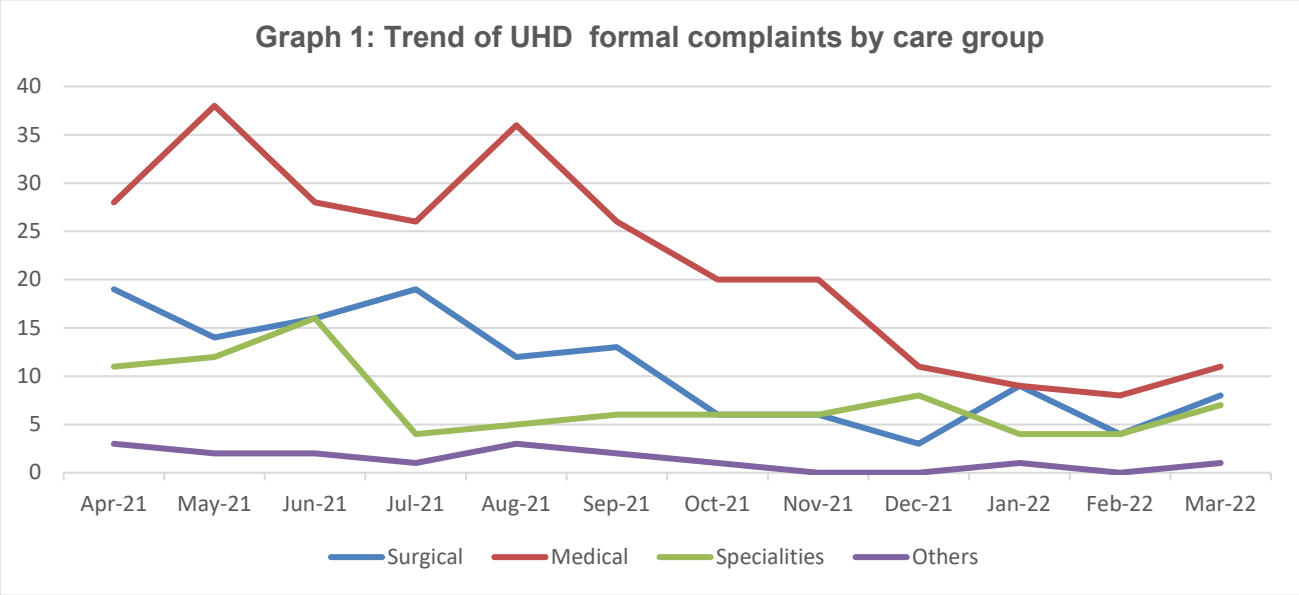
- Includes the new Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards Framework currently being piloted nationally. UHD is part of the early adopter group for this work.

The model that was approved in September 2021 for UHD to follow a hybrid model of the two previous models. This involves:

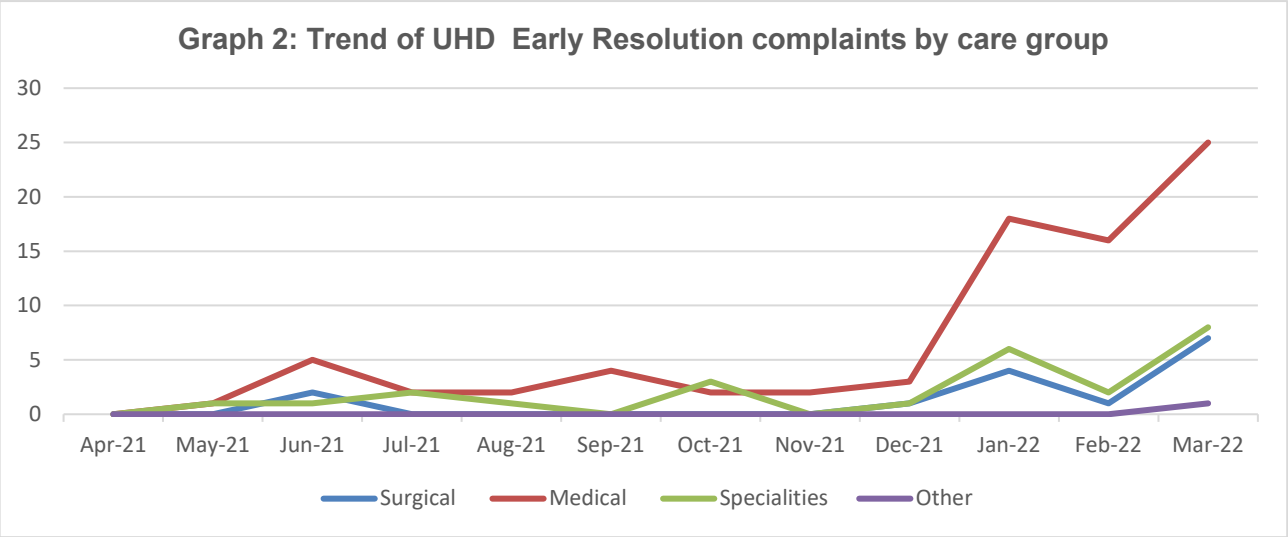
- Early Resolution complaints – complaints that are part of the complaint process but are resolved within 10 working days
- care group investigations and responses
- corporate investigations and complaints – these are the more complex and serious complaints.

3. COMPLAINTS RECEIVED

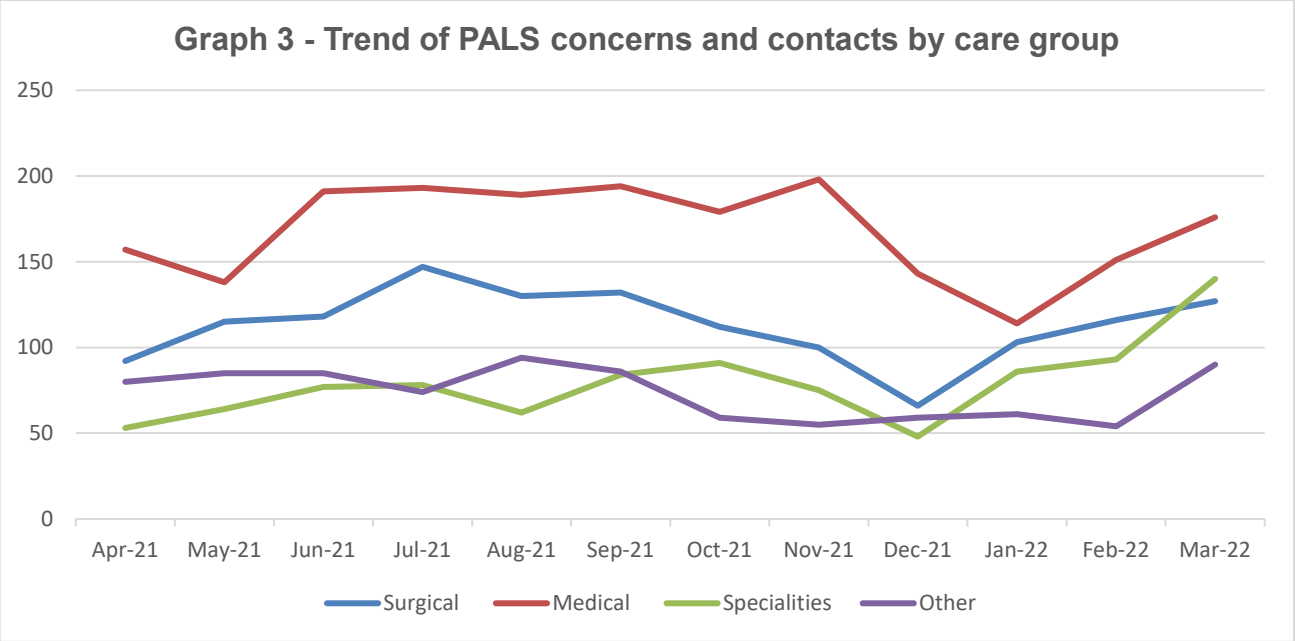
3.1 The Trust (incorporating single organisation data) received 492 complaints in 2021/2022. This is presented as a monthly trend, by care group, in graph 1.



3.2 In addition to the 492 complaints, the Trust also handled 121 early resolution complaints. This has been broken down to the care groups and is shown in Graph 2



3.3 A total of 5214 PALS concerns, and contacts were processed and responded to in this year. This is detailed in Graph 3.



3.6 The 5-year trend in complaints received can be seen in Graph 4. This showed an increasing number of complaints received, peaking at PH in 2018/19 and at RBCH in 2019/20. The decrease in 2020/2021 year can be attributed to the COVID-19 pandemic: the overall reduction in activity at the start on the pandemic; the national NHSE pause in complaint handling; and the considerable strong support for the NHS and its staff during this time. Graph 4 shows the introduction of the early resolution of complaints in Q4 of 21/22 not realised in the overall annual figures.

3.7 Table 2 shows the breakdown of persons making a complaint and their method of communication. The low 'In Person' mode of communication reflects the impact of the Covid-19 pandemic and temporary pause on receiving face-to-face PALS callers. The legacy of this may impact on the organisation of future service delivery.

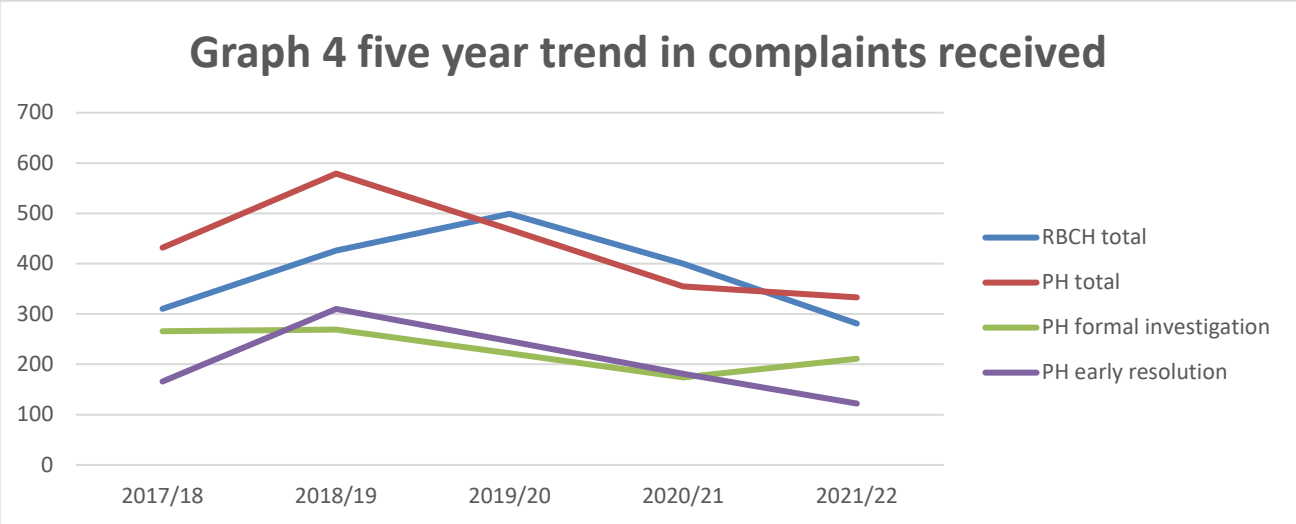
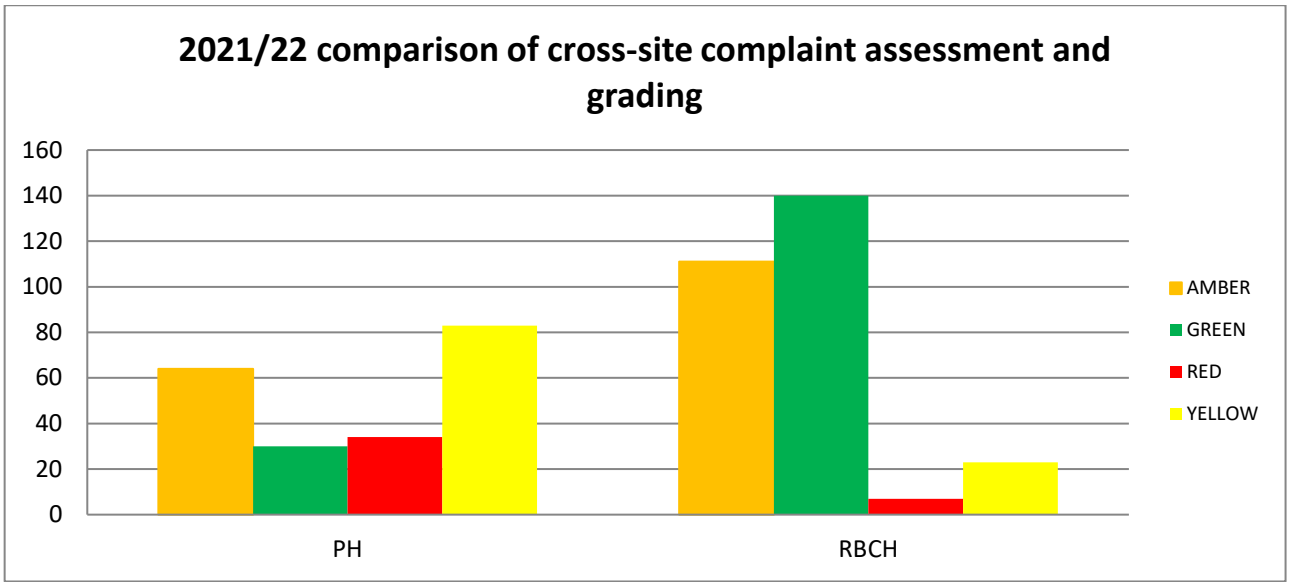


Table 2: Complainant profile and mode of communication, 2021/22

Person making the complaint			Mode of communication		
	RBCH	PH		RBCH	PH
Patient	90%	44%	Phone	10%	7%
Spouse	1%	13%	Email	70%	83%
Parent	0%	16%	In person	1%	0%
Relative/Carer	6%	16%	Letter	19%	9%

3.8 Graph 5 shows the breakdown of complaints received, by grade. The cross-site comparison reflects the different approaches to assessing complaints across our sites, rather than a significant difference in the severity of complaints received. RBCH used a risk assessment-based grading tool; PH used a more subjective account of care assessed against the CQC domains; and a high proportion of the lower graded complaints were resolved informally and therefore excluded from this data set.

3.9 A standardised UHD system of assessing and grading complaints has been adopted, that reflects the level of escalation and nature of investigation required for each level of complaint, this will be reflected in the 22/23 annual report. The Healthcare Assessment Tool (HCAT) was used from April 2021; this is a validated, reliable tool for analysing healthcare complaints about secondary care (Gillespie and Reader 2016).



Graph 5: Breakdown of complaints received, by grade

4 RESPONSIVENSS AND PERFORMANCE

4.1 Trust performance is monitored locally (Datix) and via national KO41a submissions, reported by NHS Digital.

4.2 National comparison of the number of complaints received at UHD can be seen in Table 3. The data suggests that UHD is not an outlier when compared with the number of complaints

received nationally, but when compared to peer group, who more consistently promote opportunities for early resolution, there is more work the Trust can do in this regard.

Table 3: National comparison of number of complaints received	Complaints received per 10,000 FCEs	Complaints received per 1,000 staff
All acute Trusts	37%	16.6%
University Hospital Dorset: RBCH site	35%	20%
University Hospital Dorset: PH site	29%	10%
University Hospital Southampton	17%	7%
Portsmouth Hospitals	27%	15%

4.3 Key performance targets are detailed, by site, in tables 4 and 5, including 100% compliance against the statutory three-working day acknowledgement target.

4.4 The process for agreeing target response times differed across sites. PH focused on achieving the timeframe as agreed with the complaint, whereas RBCH focused on the internal response-day target. This has been standardised as part of the new UHD policy and as such will be reflected in next year's report. From November 2021 the corporate complaints team was merged following consultation, and the processes aligned.

Table 4: Poole Hospital complaint handling performance	Q1	Q2	Q3	Q4	Yr end
Number of complaints received	71	50	46	44	211
% complaints acknowledged within 3 working days	89%	70%	65%	50%	71%
% response within timescale agreed with complainant*	100%	100%	100%	100%	100%
% response within 35 day internal target	11%	6%	4%	2%	7%
Number re-opened complaint investigations	2	3	1	0	6
Complaints under investigation by the PHSO	0	0	0	0	0
PHSO investigations closed (& upheld/partially upheld)	0	0	0	0	0

Table 5: RBCH complaint handling performance	Q1	Q2	Q3	Q4	Yr end
Number of complaints received	118	103	41	19	281
% complaints acknowledged within 3 working days	100%	100%	100%	95%	99%
% response within timescale agreed with complainant*	45%	31%	29%	47%	38%
% response within 35 day internal target	45%	31%	29%	47%	38%
Number re-opened complaint investigations	2	7	4	0	13
Complaints under investigation by the PHSO	0	0	0	0	0
PHSO investigations closed (& upheld/partially upheld)	0	0	0	0	0

*PH: response time included any subsequent extension to timeframe, if reasons explained and negotiated with complainant. RBCH: timeframe set at the outset.

4.5 The outcome of all closed complaints, by site, by quarter, is shown at Table 6. The data shows that UHD upholds fewer complaints when compared to the national average. Fewer upheld complaints may indicate fewer incidents where care fell below the expected standard, caution needs to be applied to this conclusion as it could also indicate that the Trust investigation potentially lacks openness and honesty. However, the PHSO looks at the way

the hospital complaint process investigations are conducted, in 2021/22 no complaints were investigated by the PHSO. The lower number of upheld complaints at UHD may in part be due to the number of complaints diffused through early resolution and therefore not included in this data set; but the data will continue to be monitored and reported.

Quarter	Hospital site	Table 6: Outcome of complaints investigated and resolved					
		Upheld	***National average***	**Partially Upheld**	***National average***	**Not upheld**	***National average***
Q1	**PH**	16 (22.5%)	*26.7%*	25 (35.2%)	*36.5%*	30 (42.2%)	*36.9%*
	RBCH	21 (17.7%)		49 (41.5%)		48 (40.6%)	
Q2	**PH**	9 (18%)	*27.1%*	21 (42%)	*36.4%*	20 (40%)	*36.5%*
	RBCH	16 (15.5%)		37 (35%)		50 (48.5)	
Q3	**PH**	6 (13.3%)	*27.5%*	21 (46.6%)	*38.4%*	18 (40%)	*34.1%*
	RBCH	7 (17%)		13 (31.7%)		22 (53.6%)	
Q4	**PH**	6 (13.6%)	*26%*	10 (22.7%)	*38.7%*	28 (63.6%)	*35.4%*
	RBCH	2 (10.5%)		5 (26.3%)		12 (63.1%)	

4.6 The number of reopened investigations and upheld/partially upheld PHSO investigations are measures of the quality of complaint handling. During 2020/21, the number of reopened investigations fall below the internal target of <10%.

5 THEMES AND LEARNING FROM COMPLAINTS

5.1 Learning from the detail of individual upheld complaints is monitored on Datix and reported via the quarterly patient experience report to the Nursing and Midwifery Forum and Quality Committee. The evaluation of learning and monitoring of improvements are reported in care group governance reports to the Quality Committee.

5.2 A high level summary of examples of learning can be found at Appendix A and are shared on the public website.

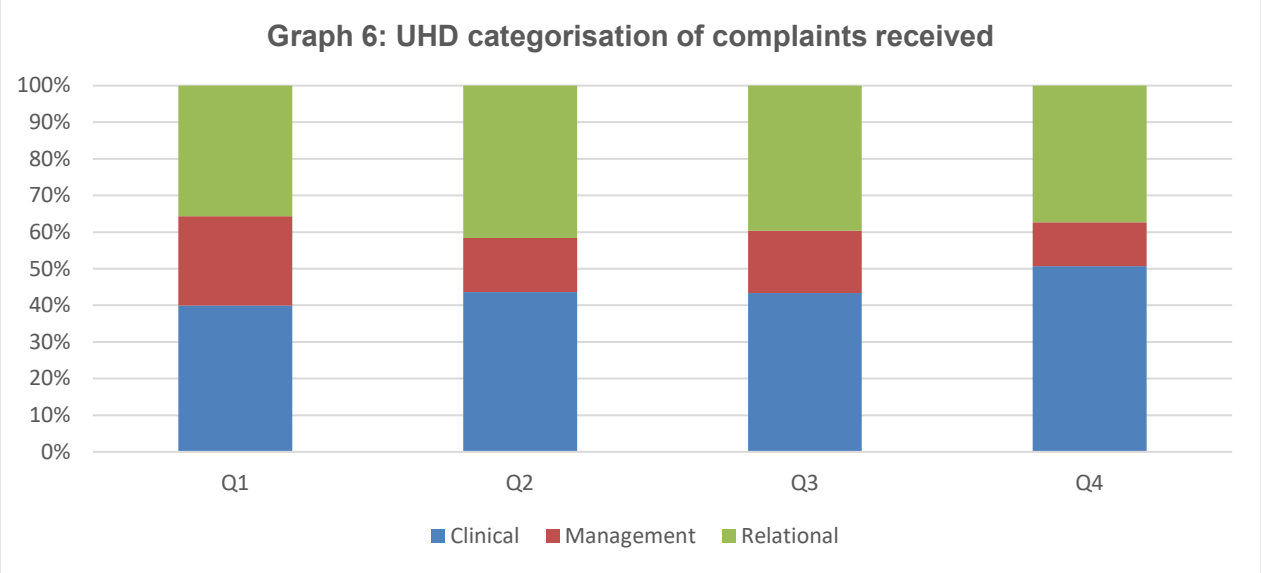
5.3 The data collected from complaints is analysed to help identify themes and emerging trends. The themes are extracted from the complaint narrative, taken from the perspective of the patient or their representative.

5.4 From 01 April 2021, the tool used for theming complaints was aligned and the grouping of complaint themes based on the HCAT tool; 3 over-arching categories, 9 themes and beneath this, over 50 sub-themes. A summary can be seen at Table 7.

CLINICAL	MANAGEMENT	RELATIONAL
•Quality •Safety •Effectiveness	•Environment •Systems & processes •Well led	•Communication/listening •Attitude •Dignity & respect

Table 7: UHD complaint theming: categories and themes

5.5 The data, by complaint category is shown by quarter in Graph 6 (to note: Q1 data is Poole Hospital only). The top 3 complaint themes, by category, by quarter are shown in Table 8 overleaf, identifying consistency in many of the top themes reported at Trust level. It is recognised that reporting themes and sub-themes by directorate or specialty will generate more relevant and useable data for tends, learning and improving. This detail will be available in the complaints dashboard, supported by the informatics team for 2022/23.



5.6 As can be seen in graph 6, the highest proportion of UHD complaints consistently fall into the clinical category; this is similar to the national picture. It should be noted that there are caveats regarding reliability of this comparison: it is collated from the KO41a data collection (community services and NHS hospitals); and secondly, the categories have been manually extrapolated and therefore subjective.

Table 8: 2020/21 TOP COMPLAINT THEMES, BY QUARTER		
Complaint category	**Quarter**	
CLINICAL **Quality** eg. Clinical standards **Safety** eg incidents, staff competencies **Effectiveness** eg procedural outcomes	Q1	• Clinical skills and conduct • Inadequate examination and monitoring • Outcomes and side effects
	Q2	• Inadequate examination and monitoring • Outcomes and side effects • Clinical skills and conduct
	Q3	• Inadequate examination and monitoring • Making and following care plans • Caring and compassion
	Q4	• Inadequate examination and monitoring • Substandard care; neglect – personal care • Caring and compassion
MANAGEMENT **Environment** eg facilities, equipment, staffing levels **Systems & processes** eg bureaucracy, waiting times, accessing services **Well led:** eg leadership and decision	Q1	• Delay – access (outpatient) • Delay – procedure or referral • Discharge
	Q2	• Documentation / records • Trust administration and bureaucracy • Delay – access (outpatient)
	Q3	• Discharge • Delay - other • Delay in procedure or referral
	Q4	• Trust administration and bureaucracy • Documentation and records • Accommodation and maintenance
RELATIONAL **Communication & listening** eg not acknowledging information given **Attitude** eg behaviour **Dignity& respect** eg caring and patient rights	Q1	• Communication absent • Caring and compassion • Communication breakdown
	Q2	• Communication breakdown • Disrespect • rights
	Q3	• Communication breakdown • Caring and compassion • Disrespect
	Q4	• Caring and compassion • Communication absent • Privacy and dignity

6 CONCLUSIONS & RECOMMENDATIONS

6.1 The Trust policy and procedures to manage concerns and complaints meet statutory requirements. The complaints procedure was aligned 2021/22, adopting best practice from both sites as well as phased implementation of national best practice recommendations, and the new PHSO complaints standards framework. UHD will continue to work with the PHSO as an early adopter of this framework.

6.2 Both sites offered a combined complaint handling and PALS service, with one point of entry for service users and other stakeholders. This is now aligned with a single UHD complaint and PALS service.

6.3 The Trust has received 492 complaints, 121 early resolution complaints and 5214 PALS enquiries and concerns during 2021/22. This is a reduction in the number of complaints received 2020/21, primarily due to the potential impact of the pandemic, however, there has been a significant increase in the cases managed in the PALS service.

6.4 A national comparison of complaints received (NHS Digital) shows that UHD is not an outlier with regards to the number of complaints received, but demonstrates some opportunity to increase the volume of early resolution complaints which has been realised in Q4 21/22.

6.5 The Trust underperformed against the statutory target for acknowledgement response time. This can, in part, be attributed to the increased clinical challenges of the pandemic, change in processes and major staffing vacancies in the corporate Patient Experience team. This will improve for the next financial year as staffing has improved with a change in leadership and management in the Patient Experience team alongside regular performance meetings with the care groups.

6.6 With the support of the informatics team, a new complaints dashboard has been produced to report complaint data by directorate and specialty, ensuring the data is more useful and can more easily be used to identify emerging trends. Weekly detailed reports are now sent to care group leads for discussion at weekly meetings.

6.7 Actions taken to improve the complainant experience have been put in place at because of a satisfaction survey.

Appendix A: 2021/22 examples of learning from upheld complaints

Further examples of learning from complaints:	
Complaint	**Acton/Learning**
I wanted to self-discharge after attending the Emergency Department with mental health problems and you stopped me from leaving	Implemented training for all Senior Nurses (Band 6 and 7) pertaining to capacity assessments by our psychiatric liaison team nurses. Improving our knowledge and skills in assessing capacity
Patient sent home from Endoscopy not having had the planned procedure as Covid-19 swab result unavailable. Patient questioned why they couldn't have swab re-taken at the Hospital before having the procedure.	Explained cancellations are always made following clinical direction from the Endoscopist on the day and are often multi-factorial. The Endoscopy Unit have now introduced a process to capture cancellation reasons which are then fed back to the patient when a cancellation in unavoidable, so they understand why
The phones are never answered on AMU	apologised, and explained the call volume on AMU has increased by 139% since Covid-19 and visiting restrictions were implemented. We have also added this to our Risk Register and commenced an improvement project
You were upset and concerned about the visiting restrictions on the maternity Unit. Your partner wasn't there to provide the support you needed; particularly so for new mums who have additional needs.	explained the requirement for restrictions to reduce the risk of spread of Covid-19, recognised the impact this has had. We have introduced a new system of visiting for new mums identified as needing additional help with physical or mental health needs
My wife was admitted to hospital with reduced Capacity. My wife has a Health and Welfare Lasting Power of Attorney with myself and two other attorney's. During admission a DNAR was applied, without the discussion with the LPOA. This was also included in the Care Plan on her discharge	Explanation that although the decision for a AAND form to be completed was appropriate, this should have not gone against the LPOA wishes and sincerest apologies given. Reassurances given that AAND form has been removed from patients medical records and further apologies given for the stress and upset caused
I asked to see my medical notes and blood results as an inpatient but was advised that I had to write to the hospital at a later date for access	We explained that the hospital records belong to the hospital and not the patient. Patient's do have a right to access their medical records, however they must do this by written request to the medico-legal department who will send the patient their own copy of their records.
I have not received results of the capsule endoscopy and do not know when I will	Reviewed information provided to patients on what happens after they have had their procedure and when they can expect to receive their results
My mother had no support, no one was there to help us through the End of Life process for my father	Sincerest apologies offered. Advised that Ward Sister has arranged to take part in an End of Life education pilot with the End of Life Specialist Nurse. This is a new service, giving the ward access and support to educate, review and offer

	feedback to help support patients through the End of Life journey
I did not receive any information about the request I had made for a letter regarding my ICD	Patient has been issued with a letter from his consultant regarding considerations to his care if he further presents to ED. This has also been added to the patient records as an alert for the staff awareness
My husband arrived home on Hospital transport following discharge still in a Hospital gown	We explained that we are often unaware of the time Hospital transport is going to arrive and there is not always time for them to wait for the patient to change, so in future we would give patients the option to change as soon as transport was booked
There was a lack of facilities for me to breastfeed my son when I attended for tests	Whilst staff tried to provide support, unfortunately there are currently no designated breastfeeding facilities. Plans are in place to build a designated area for breast feeding as part of the new Children's Unit
I was not informed that I had been discharged from the care of the Consultant	Apologised to for the lack of communication, a letter had been sent to the GP and not to them. This is being reviewed to ensure that communication is shared with the patient
My husband attended the Hospital for a colonoscopy only to be told that, as he had already had one earlier in the year, he did not need to have the procedure done again	The Endoscopy Bookings Team are working with our IT Teams on a project to make all of their referrals electronic which is expected to be completed next year; 2022 and it is hoped with these systems in place they can avoid a similar incident happening again
I am finding it very difficult to come to terms with the death of my father and struggling to grieve as a result. I was away when my father passed away at your hospital and I was unable to speak with him in the days that lead up to his death	Arranged for the family to meet with the Consultant who was caring for the patient to go through the patients notes, so the family could have an understanding of what the patients final days looked like
My diagnosis of AL amyloidosis could have been made in 2019 but you cancelled an appointment and did not reschedule it	The process has been changed in the Outpatients Department (OPD) where they are not able to cancel clinics unless the OPD team have been given rebook advice by the relevant speciality

Prepared by Laura Northeast
Interim Head of Patient Experience
June 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.6

Subject:	Mixed Sex Accommodation Declaration

Prepared by:	Dr Matthew Hodson, Deputy Chief Nursing Officer
Presented by:	Professor Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	To approve the UHD 2022 Mixed Sex Accommodation Declaration.
Background:	It is a Department of Health requirement that all providers of NHS-funded care confirm that they are compliant with the national ambition / definition: "*to eliminate mixed sex accommodation except where it is in the overall best interests of the patient or reflect the patient's choice*". It has been a requirement since April 2011, that eliminating mixed-sex accommodation declarations are visible on NHS-funded care organisation websites. Organisations are also expected to commit to publishing quality audits and data that relates to the mixed sex accommodation agenda.
Key points for members:	• Mixed sex accommodation refers not only to sleeping arrangements, but also to bathrooms or WCs as well as the need for patients to pass through areas specifically designated for the opposite sex, to reach their own facilities. • During the pandemic 2020/2021 the requirement for the Trust to report nationally our mixed sex accommodation was paused. National reporting has now recommenced • This declaration will also be subject to ongoing review as part of the work being undertaken by the LGBTQ+ Network regarding aligning our language as part of the wider NHS Rainbow Badge project.
Options and decisions required:	To agree the 2022 proposed statement as follows: University Hospitals Dorset NHS Foundation Trust remains committed to complying with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interests or reflects their personal choice, for example in critical care settings such as intensive care and other specialist care areas. We have the necessary facilities to provide sleeping areas and toilet and washing facilities that are for men or women only. This will mean different things in different hospitals. You could be:

	• in a same-sex ward, where the whole ward is occupied by either men or women only • in a single room, or • in a mixed ward, where men and women are cared for in separate bays or rooms with members of the same sex Toilet and washing facilities should be easy to get to, not a long way from your bed. You should not have to go through accommodation, toilet, or washing facilities used by the opposite sex, to get to your own. Gender neutral toileting facilities are also available throughout the trust. The trust implements this commitment in practice through the Same Sex Accommodation and Privacy and Dignity Policies. If our care should fall short of the required standard, we will identify this through our internal reporting process' and report it externally to our commissioners. Our mixed sex accommodation data will be regularly reviewed by our Quality Committee and reported to the Board annually as part of our ongoing commitment and our declaration of compliance. During the pandemic the national requirement for trusts to audit and report on mixed sex accommodation was paused. National reporting has now recommenced
Recommendations:	That the Board approves the 2022 mixed sex accommodation declaration.
Next steps:	Once approved, the Communications Team will update the Trust intranet page which highlights our declaration

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	**Strategic Objective 1**: To enhance emergency care and hospital flow, and continually improve the quality so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience.
BAF/Corporate Risk Register: (if applicable)	N/A
CQC Reference:	Responsive domain.

Committees/Meetings at which the paper has been submitted:	**Date**
Quality Committee	25/07/22

Mixed Sex Accommodation Declaration:

It is a department of Health requirement that all providers of NHS-funded care confirm that they are compliant with the national ambition / definition:

> *"to eliminate mixed sex accommodation except where it is in the overall best interests of the patient or reflect the patient's choice".*

It has been a requirement since April 2011, that eliminating mixed-sex accommodation declarations are visible on NHS-funded care organisation websites. Organisations are also expected to commit to publishing quality audits and data that relates to the mixed sex accommodation agenda.

For clarity, mixed sex accommodation refers not only to sleeping arrangements, but also to bathrooms or WCs as well as the need for patients to pass through areas specifically designated for the opposite sex, to reach their own facilities.

In 2020 during the pandemic the requirement for the Trust to report nationally our mixed sex accommodation was paused. National reporting has now recommenced.

The current statement on the UHD website published in August 2021 reads:

University Hospitals Dorset NHS Foundation Trust remains committed to complying with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interests or reflects their personal choice, for example in critical care settings such as intensive care and other specialist care areas.

We have the necessary facilities to provide sleeping areas and toilet and washing facilities that are for men or women only. This will mean different things in different hospitals. You could be:

- in a same-sex ward, where the whole ward is occupied by either men or women only
- in a single room, or
- in a mixed ward, where men and women are in separate bays or rooms

Toilet and washing facilities should be easy to get to, not a long way from your bed. You shouldn't have to go through accommodation, or toilet, or washing facilities used by the opposite sex, to get to your own. Gender neutral toileting facilities are also available throughout the trust.

The trust implements this commitment in practice through the Mixed Sex Accommodation and Privacy and Dignity Policies. If our care should fall short of the required standard, we will identify this through our internal reporting process' and report it externally to our commissioners. Our mixed sex accommodation data will be regularly reviewed by our Quality Committee and reported to the board annually as part of refreshing our declaration of compliance.

During the pandemic the national requirement for trusts to audit and report on mixed sex accommodation was paused. This has now recommenced

For 2022 it is proposed that this statement is as follows, with updates identified in italics from the 2021 declaration

University Hospitals Dorset NHS Foundation Trust remains committed to complying with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interests or reflects their personal choice, for example in critical care settings such as intensive care and other specialist care areas.

We have the necessary facilities to provide sleeping areas and toilet and washing facilities that are for men or women only. This will mean different things in different hospitals. You could be:

- in a same-sex ward, where the whole ward is occupied by either men or women only
- in a single room, or
- in a mixed ward, where men and women are in separate bays or rooms with ***members of the same sex***

Toilet and washing facilities should be easy to get to, not a long way from your bed. ***You should not*** have to go through accommodation, toilet, or washing facilities used by the opposite sex, to get to your own. Gender neutral toileting facilities are also available throughout the trust.

The trust implements this commitment in practice through the ***Same*** Sex Accommodation and Privacy and Dignity Policies. If our care should fall short of the required standard, we will identify this through our internal reporting process' and report it externally to our commissioners. Our mixed sex accommodation data will be regularly reviewed by our Quality Committee and reported to the Board annually ***as part of our ongoing commitment and our declaration of compliance.***

During the pandemic the national requirement for trusts to audit and report on mixed sex accommodation was paused. ***National reporting this has now recommenced***

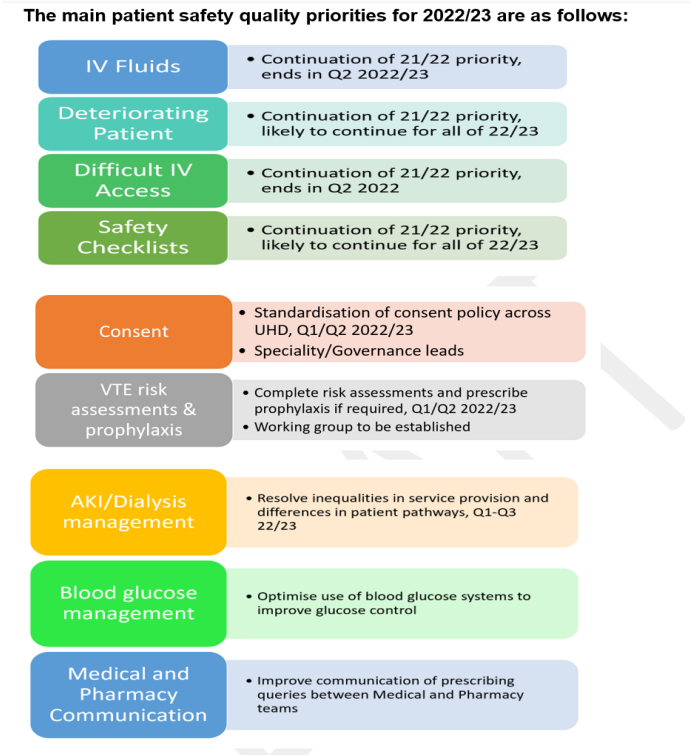
Prepared by:
Dr Matthew Hodson – Deputy Chief Nurse UHD July 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.7

Subject:	Quality Strategy 2022/2023
Prepared by:	Jo Sims, Associate Director Quality Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer
Purpose of paper:	To present the annual updates to the Trust Quality Strategy for approval by the Board of Directors.
Background:	The UHD Quality Strategy is reviewed and updated annually in accordance with the Trust's Document Control Policy and the Annual Quality Account.
Key points for members:	The revised Quality Strategy includes the following updates and additions: • Identification of the patient safety quality priorities for 2022/23 (as set out in the 21/22 Quality Account) 

	In addition, additional specific priorities for 22/23 have been set out in the Trust Quality Strategy. These cover the other three domains of patient safety, patient experience and clinical effectiveness. • Continuing to participate in the work across the ICS to develop and adopt agreed principles and policies to support a Just Culture. • Continue to improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups. • Support transition from the National Reporting and Learning System and STEIS to the new national Patient Safety Incident Management System (PSIMS). • Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework as and when published (proposed July 22) • Work with Workforce leads and colleagues across the system to consider the best approach to implementation of the new national Patient Safety Syllabus as and when training materials become available. • The appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system. • Develop and implement a UHD Clinical Audit plan for 22/23 • Further develop ward to board reporting and expansion of existing quality metrics • Appendix A updated governance chart
Options and decisions required:	The Board are asked to approve the Quality Strategy.
Recommendations:	For the Board to approve the Quality Strategy.
Next steps:	

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register		
Strategic Objective:	All	
BAF/Corporate Risk Register: (if applicable)	N/A	
CQC Reference:	Well Led	
Committees/Meetings at which the paper has been submitted:		**Date**
Quality Committee		25/07/22

University Hospitals Dorset
NHS Foundation Trust

Quality Strategy
2022 - 2023

Approval Committee	Version	Issue Date	Review Date	Document Author
Quality Committee	3	June 2022	April 2023	Associate Director Quality Governance & Risk

Version Control

Version	Date	Author	Section	Principal Amendment Changes
2	June 2021	JS	6, 12	Revised objectives and quality priorities for 2021/22
3	June 2022	JS	6, 12	Revised objectives and quality priorities for 2022/23

Contents

Figures

Appendices

Introduction

A quality strategy details the aims, objectives, time-scales, responsibilities and monitoring processes of how to achieve the Trust strategic goals for patient safety, patient outcome and patient experience.

The overall aim of the Quality Strategy is to ensure that there is a robust quality framework in place which will assure the Board of Directors that the organisation has the ability to provide safe, high quality care, is compliant with the CQC regulations, and continues to strive for further quality improvements.

High quality care is at the centre of everything we do and maintaining and improving the quality of patient care remains the top priority for the trust. This vision is underpinned by the Trust's values and is delivered through five key strategic objectives:

We recognise that our most valuable asset is our staff and the Quality Strategy dovetails into other important strategic documents such as the trust Annual plan, Risk Management Strategy and People Strategy. Together these documents set out our commitment to improve the quality of learning, education and training. Central to this is developing the collective leadership for quality improvement and a culture that enables individuals and teams to flourish.

> *'Improvements in the quality of care do not occur by chance. They come from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels'*
>
> The Kings Fund [1]

This strategy takes into account the key changes taking place across the NHS as part of Covid recovery and the development of Integrated Care Systems. It incorporates the plans set out in the National Patient Safety Strategy and the increasing use of digital and IT technology to enhance patient safety and patient care.

The strategy for 2022/23 also recognises the pressure that the NHS and NHS staff have been under over the past 12 months and therefore seeks to identify realistic targets and timescales for aspirations and developments.

Background

In 2008, a national review of quality by Lord Darzi, led to the widespread implementation of his recommendations to achieve 'High Quality Care for All' (2008). The report set out an ambition for quality to be at the heart of everything we do and determined that in the NHS quality includes the following dimensions:

- Patient safety.
- Patient experience.
- Patient Outcomes.

The Darzi report was followed by the Government's commitment to quality through legislation (the Health and Social Care Act, 2008). To ensure organisations operate within this legislation, the Care Quality Commission (CQC) was established as the official regulator of the NH. Measures of quality are also explicitly set down in the recent governmental white paper entitled 'Equity and Excellence for All' (Department of Health (DoH) 2010) and its associated document 'The NHS Outcomes Framework' (DoH 2010). The Francis Reports 2010 and 2013 also cite the importance of clear vision and transparent operating partnered with a duty of candour to ensure quality is embedded and appropriately risk assessed in any process within the Trust.

The Trust Quality Strategy supports all of the above guidance and recommendations. The strategy also meets the new National Patient Safety Strategy objectives (published February 2021) and the National Quality Board "Shared Commitment to Quality" published in April 2021.

Roles and Responsibilities for Quality Governance

Whilst frontline individuals and clinical teams are responsible for delivering high quality care, it is the responsibility of the Board of Directors to create a culture within the organisation that enables clinicians and clinical teams to work at their best.

The overall responsibility for delivery of the quality agenda rests with the Chief Executive. This responsibility is delegated to the Chief Nursing Officer, in conjunction with the Chief Medical Officer, who has executive responsibility for ensuring that risk management, patient safety, quality

and patient experience is delivered throughout the organisation and remains a Trust priority and an integral part of the Trust policies and procedures.

Figure 1. Leadership of Quality

All Executive, Non-Executive Directors and Senior Leaders in the trust engage with front line staff, patients and carers through a variety of forums to enable them to contextualise the information they receive and become familiar with the care environment and clinical practice including:

- Filmed patient stories and Care Conversations.
- Meet the Executive/Ask “Aly Communications
- Board presentations and reports (inc. Freedom to Speak Up Guardian reports, Organisational Development, Change Champions, Patient Partners)
- Staff briefing sessions
- Open days and engagement events.

Measurement of our performance

Quality Governance describes the structures and processes in place to provide adequate leadership and scrutiny of quality to ensure high quality care is delivered and risks are

understood and managed at all levels of the organisation. Our comprehensive reporting frameworks for the Board and its subcommittees promote transparent and open reporting and are underpinned by directorate structures that provide identification and early resolution of problems.

We measure our quality performance using a broad range of indicators (Figure 2). These indicators are triangulated through Trust, Care Group and Directorate governance meetings and Ward to Board reporting.

Figure 2. Sources of data for measurement of quality

Patient and family feedback including patient surveys, focus groups, complaints, complements	Quality outcome measures including Getting it Right First Time (GIRFT)	Measures of the reliability of critical safety processes
National and local audit	NICE Compliance	Capacity to respond to and learn from safety, quality and risk information
Data on staff satisfaction, culture, values and behaviours	Learning from deaths including structured case note reviews (emortality), learning from inquests, Claims and Medical Examiner reviews	Ward Accreditation and Quality reporting
Compliance with fundamental standards of care and CQC key lines of enquiry	Incident reports and reporting culture. Evidence of learning and improvement	Learning from Claims

Scrutiny of our services

Reporting our performance

Mechanisms are in place to provide two way transfer of information from the front line staff up to the board and back again.

The trust has an established governance structure (Appendix A).

Quality reporting through these structures supports to review, analysis and delivery of key metrics related to patient experience, safety and effectiveness of services up to the board of directors.

All Performance and Quality reporting in the new organisation will be based on the CQC key lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led). Board and Board subcommittee reporting will support wider quality assurance processes such as peer review, annual self-assessment and internal and external audit.

Information in the Board Integrated Performance Report and Quality Committee reports will routinely include:

- Locally defined priorities and performance against them
- National requirements and performance against them
- Exception reporting and risk based narrative commentary
- Trends – current and future risk, assurance and quality issues
- Internal comparisons and external benchmarks
- Directorate, specialty, ward level data where appropriate
- Quantitative and qualitative data
- Patient stories
- Statistical interpretation and analysis

Specific metrics will include:

Monitoring Committee/Group	CQC Key line of Enquiry	Quality Metrics
Board of Directors Integrated Performance Report (IPR)	Safe	Patient Safety Incidents (LERNS) Never Events Pressure Ulcers Falls Incident Reporting (NRLS) Medication Incidents Hospital acquired Infections
	Caring	Complaints FFT Section 42s (Safeguarding)
	Effective	Mortality
	Responsive	eNurse Assessment compliance (falls, Tissue Viability, Nutrition) Patient Moves
	Well Led	Risks 12+ Red Flags Patient safety alerts
Quality Committee	Safe	Patient safety Incidents – LERNS Never Events, Staff Accidents

Monitoring Committee/Group	CQC Key line of Enquiry	Quality Metrics
		Medication Incidents Hospital Acquired Infections,
	Caring	Complaints Patient Feedback Safeguarding (Adults and Children)
	Effective	Mortality (HSMR, SHMI, learning from deaths and Medical examiner reviews) NICE compliance Clinical audits
	Responsive	eNA Red flags
	Well led	Mandatory training Risk register Board Assurance Framework Learning from Inquests and Claims CQC Insight Reports Staff survey results – safety culture
Quality Governance Group		As above and: LERNS Restraint Incidents Inquests Claims Risks
Directorate Risk and Governance Groups		As above – Key metrics to be included as standard agenda items (as set out in the Trust Risk Management Strategy).
Ward Meetings	Safe	Patient safety Incidents Staff Accidents Medication Incidents Hospital Acquired Infections, Saving Lives KPIs, Hand hygiene
	Caring	Privacy and dignity, single sex accommodation
	Effective	eNA, eObs,
	Responsive	Complaints, Patient moves, outliers, delayed transfers,
	Well led	Risks 12+, Essential Core skills, Staffing and skill mix,

External

Externally, the Trust is reviewed by a range of external organisations and stakeholders. These include:

- CQC – review of compliance against the CQC regulatory framework and Key Lines of Enquiry (KLOE) via announced and unannounced reviews and inspections.
- NHSI – review of compliance against NHS Improvements Well-led Framework
- Clinical Commissioning Groups – review of compliance against National and local quality schedules
- Local Healthwatch – review and publically comment on the Trust Annual Quality Report
- Council of Governors – routine monitoring of patient safety, patient experience and patient outcome measures, risks and performance
- Local Health Overview and Scrutiny Committees -review and public comment on the Trust Annual Quality Report
- External Auditors (Internal and External Audit) - review and public comment on the Trust Annual Quality Report, completion of annual Internal Audit plan.
- Dorset Quality Surveillance Group as part of the Integrated Care System.

Sharing progress with patients and the public occurs through the Trust Member Newsletter, meetings and open days. The Annual Quality Account reports on the quality of trust services including progress with our quality priorities.

Our quality priorities

The relationship between our values, strategic objectives and quality priorities are expressed within the Quality Wheel [5] (Appendix B)

The trust's quality priorities are arranged within the domains of quality; safety, patient experience and clinical effectiveness (clinical outcomes). Additionally we recognise the fundamental role that our staff play in delivering high quality care and our people strategy therefore forms the fourth domain.

Individual priorities within each domain are derived from the national guidance and triangulation of internal data from a variety of sources including patient feedback, external stakeholders, regulators, governors and incident reports.

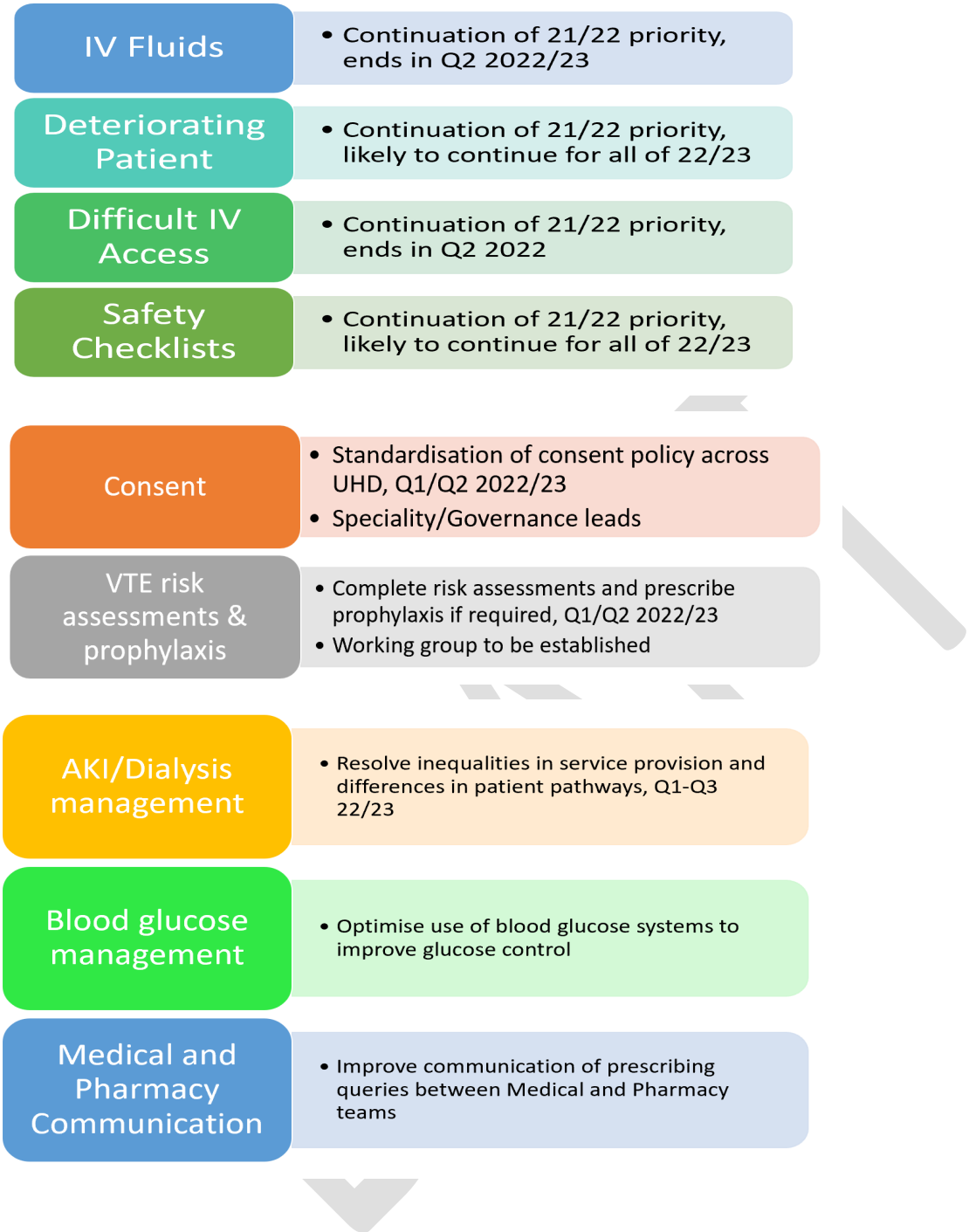
In order to identify priorities for quality improvement in 2022/23 we have used a wide range of information sources to help determine our approach. These include:

- *gathering the views of patients, public and carers via real-time feedback and patient surveys*
- *collating information from claims, complaints, medical examiner reviews and incident reports, including no harm events*
- *using the results of clinical audits, external reviews and inspections to tell us how we are doing in relation to patient care, experience and safety*
- *using the Getting it Right First Time (GIRFT) and CQC insight Tool analyses*
- *listening to staff feedback during Action Learning weeks*
- *considering the views of our commissioners as part of our shared quality and performance meetings and their feedback following formal announced and unannounced inspections*
- *listening to what staff have told us in staff briefings and "Ask the Exec" sessions*
- *listening to what governors have told us following their engagement with the public, patients and members*
- *canvassing the views of patients and staff through our organisational development and quality improvement work.*

We have also considered the results of the national staff survey to help us decide where we need to focus our quality improvement efforts and actions. We have also taken on board the national picture for patient safety and collaborated with Clinical Commissioning Groups (CCG), local and national Patient Safety Specialist networks as part of our patient safety strategy work.

Our overall aim is to continue to improve the quality of care we provide to our patients ensuring that it is safe, compassionate and effective, whilst ensuring that it is informed by, and adheres to best practice and national guidelines. We will drive continued improvements in patient experience, outcome and care across the whole Trust using a standard quality improvement (QI) methodology. We will continue to support and develop our staff so they are able to realise their potential and further develop a Trust culture that encourages engagement, welcomes feedback and is open and transparent in its communication with staff, patients and the public.

The main patient safety quality priorities for 2022/23 are as follows:



In addition, additional specific priorities for 22/23 have been set out in the Trust Quality Strategy. These cover the other three domains of patient safety, patient experience and clinical effectiveness.

Patient Safety

Our main priorities for patient safety for 2022/23 continue to directly link to the key requirements of the National Patient Strategy including:

- Continuing to participate in the work across the ICS to develop and adopt agreed principles and policies to support a Just Culture.
- Continue to improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups.
- Support transition from the National Reporting and Learning System and STEIS to the new national Patient Safety Incident Management System (PSIMS).
- Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework as and when published (proposed July 22)
- Work with Workforce leads and colleagues across the system to consider the best approach to implementation of the new national Patient Safety Syllabus as and when training materials become available.

Patient Experience

Our main patient experience objective for 2022/23 is to work with colleagues across the system to implement the requirements of the NHS Patient Safety Partners Framework including:

- The appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system.

Clinical Effectiveness

At University Hospitals Dorset NHS Foundation Trust, to reduce variation and ensure the best possible clinical outcomes, we strive to ensure our patients are provided the most effective evidence-based care. The Trust participates in a robust clinical audit and clinical outcomes programme and over the forthcoming years our quality priorities are to:

- Develop and implement a UHD Clinical Audit plan for 22/23
- Further develop ward to board reporting and expansion of existing quality metrics

Progress against these priorities will be monitored by the Board of Directors, Quality Committee and the Council of Governors Quality Strategy Group.

Keeping on track and strategy delivery

Each of the three pillars of quality; Patient Safety, Patient Experience, Clinical Outcomes/Clinical Effectiveness are monitored through the respective reporting groups in the trust governance framework (Appendix A). Through these groups specific measurable objectives will be set and monitored. This strategy overall will be reviewed annually by the Trust wide the Quality Committee.

The Chief Nursing Officer and Chief Medical Officer will monitor the process for governing quality locally to ensure it is being complied with in respect of this strategy. This will be reported at the Care Group and Directorate governance meetings.

Aspects of quality and governance implementation will be subject to monitoring through the annual internal audit review and Annual Quality Account.

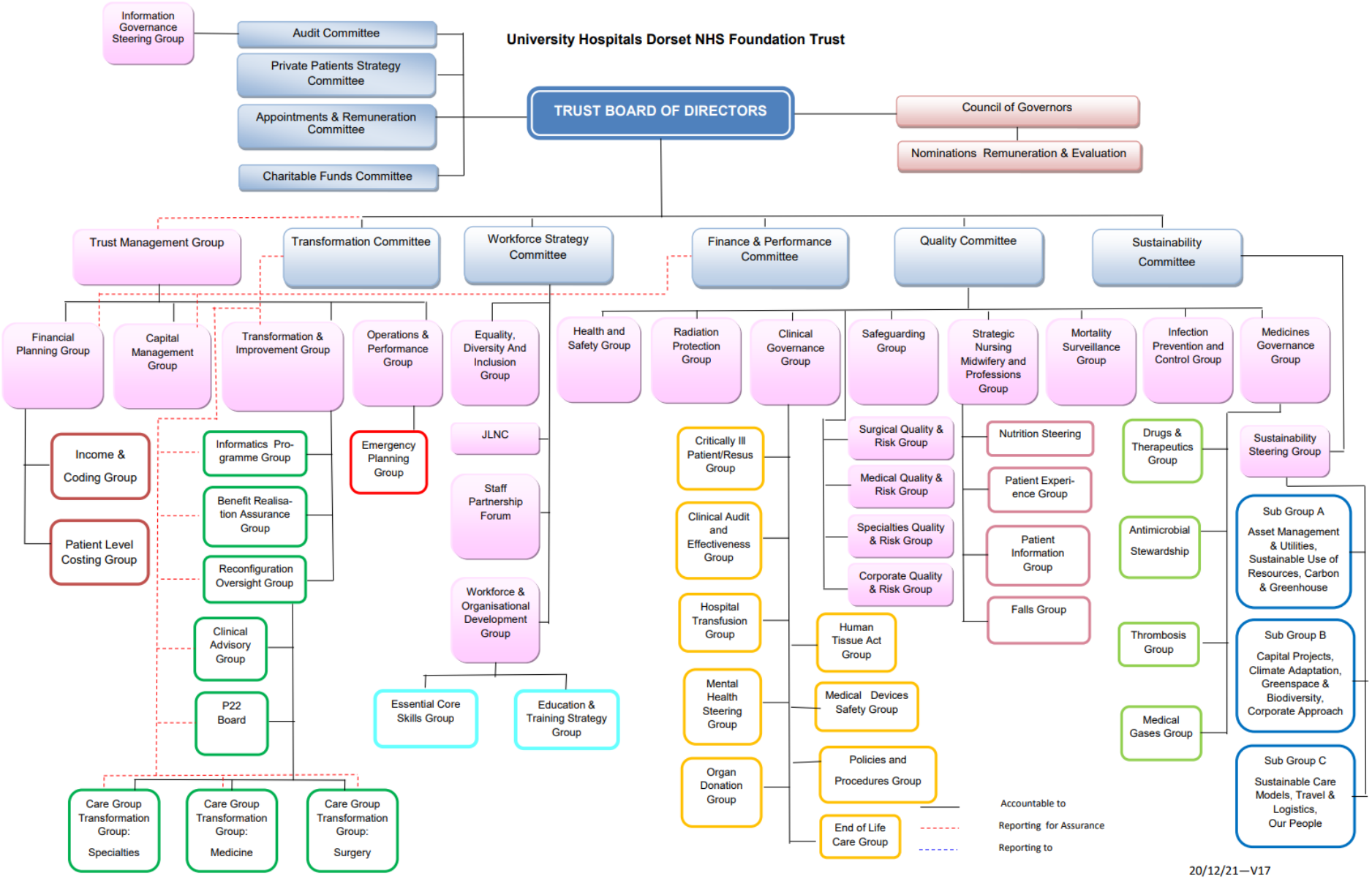
References

- The Kings Fund (2016) Improving Quality in the English NHS: A strategy for action.
- Department of Health (2008) High Quality Care for All. NHS next stage review final report.
- Department of Health (2014) Five Year Forward View.
- NHS Improvement (2016) Implementing the Five Year Forward View.
- NHS Long Term Plan (2019) #longtermplan www.longtermplan.nhs.uk
- The NHS Patient Safety Strategy – safer culture, safer systems, safer patients. July 2019
- NHS Patient Safety Strategy:2021 update. Published February 2021
- National Quality Board – A shared commitment to quality for those working in health and care systems. April 21
    - National Quality Board (2011) Quality Governance in the NHS – a guide for provider boards.
    - National Advisory Group on the safety of patients in England (2013) A promise to learn- a commitment to act: Improving the safety of patients in England. (The Berwick Report).

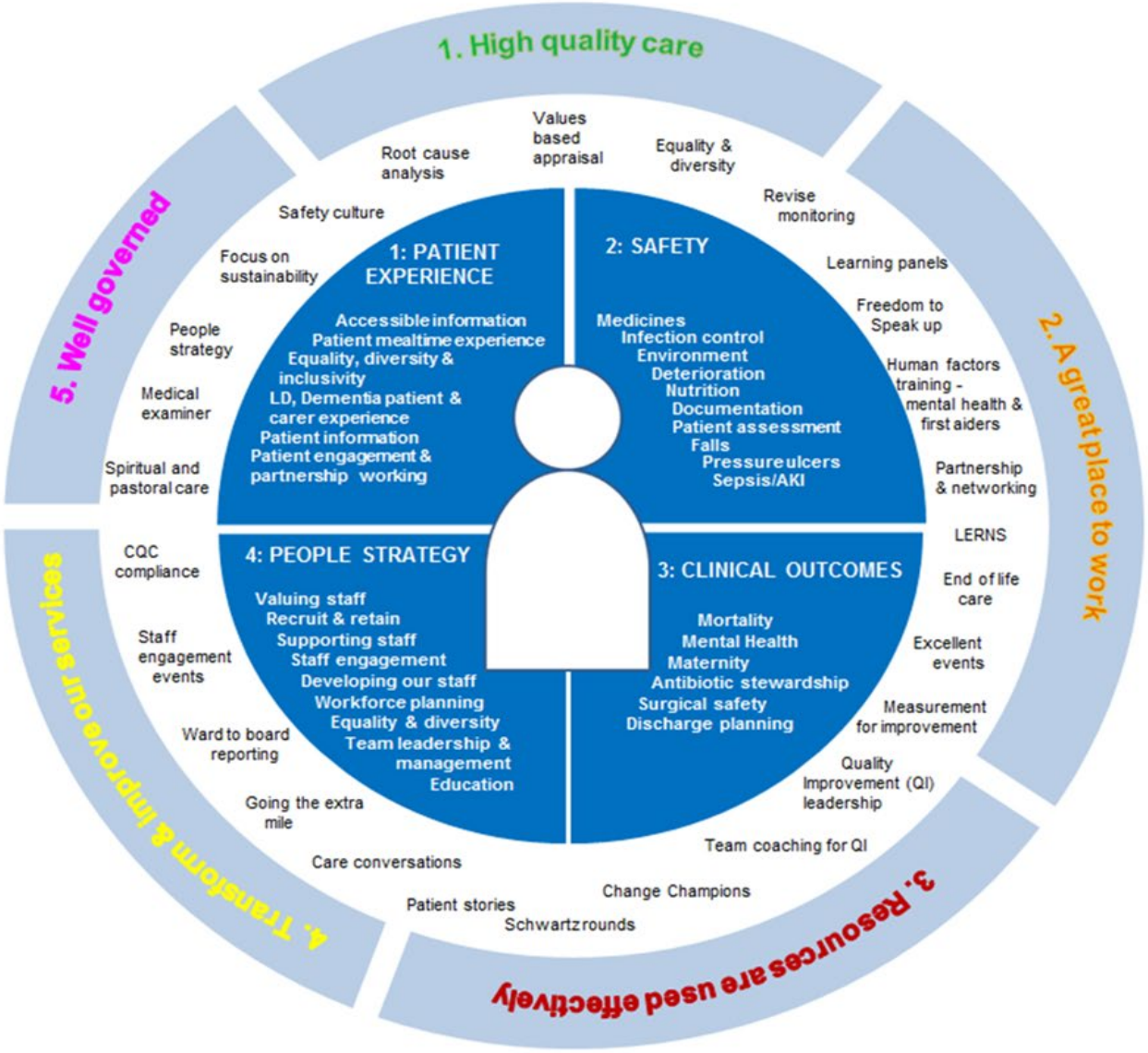
Equality Impact Assessment

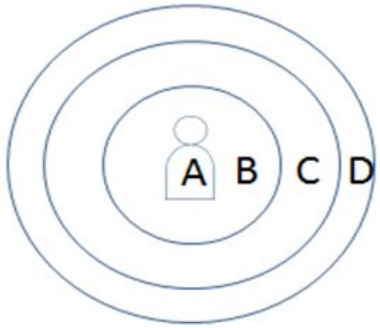
1. Title of document	**Quality Strategy 2022/23**	
2. Date of EIA	June 22	
3. Date for review	June 23	
4. Directorate/Specialty	Quality and Risk	
5. Does the document/service affect one group less or more favorably than another on the basis of:		
	Yes/No	**Rationale**
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	N	
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	N	
• Gender reassignment – the process of transitioning from one gender to another.		
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	N	
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.	N	
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	N	
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	N	
• Sex – a man or a woman.	N	
• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	N	
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N	
8. If the answers to any of the above questions is 'yes' then:	**Yes**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.		
Adjust the policy to remove disadvantage identified or better promote equality.		

Appendix A


University Hospitals Dorset NHS Foundation Trust
TRUST BOARD OF DIRECTORS
Council of Governors
Nominations Remuneration & Evaluation
Information Governance Steering Group
Audit Committee
Private Patients Strategy Committee
Appointments & Remuneration Committee
Charitable Funds Committee
Trust Management Group
Transformation Committee
Workforce Strategy Committee
Finance & Performance Committee
Quality Committee
Sustainability Committee
Financial Planning Group
Capital Management Group
Transformation & Improvement Group
Operations & Performance Group
Equality, Diversity And Inclusion Group
Health and Safety Group
Radiation Protection Group
Clinical Governance Group
Safeguarding Group
Strategic Nursing Midwifery and Professions Group
Mortality Surveillance Group
Infection Prevention and Control Group
Medicines Governance Group
Income & Coding Group
Patient Level Costing Group
Informatics Pro-gramme Group
Benefit Realisa-tion Assurance Group
Reconfiguration Oversight Group
Clinical Advisory Group
P22 Board
Emergency Planning Group
JLNC
Staff Partnership Forum
Workforce & Organisational Development Group
Essential Core Skills Group
Education & Training Strategy Group
Critically Ill Patient/Resus Group
Clinical Audit and Effectiveness Group
Hospital Transfusion Group
Mental Health Steering Group
Organ Donation Group
Surgical Quality & Risk Group
Medical Quality & Risk Group
Specialties Quality & Risk Group
Corporate Quality & Risk Group
Human Tissue Act Group
Medical Devices Safety Group
Policies and Procedures Group
End of Life Care Group
Nutrition Steering
Patient Experi-ence Group
Patient Information Group
Falls Group
Drugs & Therapeutics Group
Antimicrobial Stewardship
Thrombosis Group
Medical Gases Group
Sustainability Steering Group
Sub Group A
Asset Management & Utilities, Sustainable Use of Resources, Carbon & Greenhouse
Sub Group B
Capital Projects, Climate Adaptation, Greenspace & Biodiversity, Corporate Approach
Sub Group C
Sustainable Care Models, Travel & Logistics, Our People
Care Group Transformation Group: Specialties
Care Group Transformation Group: Medicine
Care Group Transformation Group: Surgery
Accountable to
Reporting for Assurance
Reporting to
20/12/21—V17

Appendix B – Quality Wheel





A. Approach philosophy
B. Pillars of Quality – focus of priorities
C. Workstreams and processes
D. Strategic goals

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.8

Subject:	Risk Management Strategy
Prepared by:	Jo Sims, Associate Director Quality Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer
Purpose of paper:	To present the annual updates to the Trust Risk Management Strategy for approval.
Background:	The UHD Risk Management Strategy is reviewed and updated annually in accordance with the Trust Document Control Policy,
Key points for members:	The revised Risk Management Strategy includes the following updates and additions: • Refresh risk appetite in line with 2022/23 board objectives • Add (4.0) specific risk management objectives for 2022/23 in line with national and local priorities • Appendix A updated governance chart • Appendix E refresh to provide additional information on risk matrix definitions • Section (5.0) additional guidance on risk controls • Section (7.7) additional clarity on the role of the Executive sponsor of a risk rated 12-25 • Section 8.23 additional clarity on risk escalation to Care Group Board and Quality Committee. These amendments are minor changes.
Options and decisions required:	To approve the Risk Management Strategy
Recommendations:	To approve the Risk Management Strategy
Next steps:	

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register		
Strategic Objective:	All	
BAF/Corporate Risk Register: (if applicable)	N/A	
CQC Reference:	Well Led	
Committees/Meetings at which the paper has been submitted:		**Date**
Quality Committee		25/07/22

University Hospitals Dorset
NHS Foundation Trust

Risk Management Strategy and Policy

When using this document please ensure that the version you are using is the most up to date either by checking on the Trust intranet or if the review date has passed, please contact the author.

'Out of date policy documents must not be relied upon'.

Approval Committee	Version	Issue Date	Review Date	Document Author
Shadow Interim Board	1	1st Oct 2020	1 Oct 2021	Head of Governance & Risk
Board of Director's	2	July 2021	July 2022	Head of Governance & Risk
Board of Director's	3	July 2022	July 2023	Head of Risk Management

Version Control

Version	Date	Author	Section	Principal Amendment Changes
2	16/07/2021	JH	2	Refreshed and in line with 21/22 Trust objectives. Risk escalation thresholds articulated
			5	Amendment to the definitions of roles
			6.1	Amendment to the responsibilities within the Trust's Governance Structure
			6.11	• Review of the BAF six monthly (Q2 and Q4) • New risks are presented to the committee by an in depth report by the executive sponsor or relevant Care Group Director (or designated deputy).
			6.10-20	Addition - Sustainability Committee
			6.21-22	Addition - Transformation Committee
			6.23 onward	'Quality Governance Group 'Title amended and report requirements in line with Risk Appetite statement
			7	Responsibilities and Scheme of Delegation for Risk Management Titles amended Role of Risk Manager added
			8.16	Reference to and link to the Risk Register Toolkit
			8.17-24	• Further clarity re: escalation, agreement and sign off prior to notification to Trust Board • Onward management and update of 12+ risk
			Appendix B	Update to the BAF report template
			Appendix C	• Added cover sheet template • Update to Risk Report template • Remove Risk matrix from subsequent appendix as repeated
			Appendix F	• Content table and link to Risk Register Toolkit
3	06/07/2022	JH		• Refresh risk appetite in line with 2022/23 board objectives • Add (4.0) specific risk management objectives for 2022/23 in line with national and local priorities • Appendix A updated governance chart • Appendix E refresh to provide additional information on risk matrix definitions • Section (5.0) additional guidance on risk controls • Section (7.7) additional clarity on the role of the Executive sponsor of a risk rated 12-25 • Section 8.23 additional clarity on risk escalation to Care Group Board and Quality Committee.

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8.	Risk Management Committee Structure	
9.	Risk Management Processes	
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11.	Process for Monitoring Compliance with this Policy	
12.	Approval, Implementation and Review	
13.	References	
14.	Links to Risk Register Toolkit	
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A.	Clinical governance and Risk Management Committee Structure	
B.	Board Assurance Report Templates	
C.	Risk Report to Board Cover Sheet template	
D.	Risk Report to Quality Committee/Board Template (inc of Matrix for Risk Register Assessment)	
E.	Risk Matrix for Patient Safety Risk – Risk Level descriptors	
F.	Template report for Trust Clinical Governance Group	
G.	Directorate Clinical Governance/ RAGG Meeting Agenda Template and Meeting Agenda Guide	
H.	Risk Register Toolkit - content and link	
	EQUALITY IMPACT ASSESSMENT (EIA) SCREENING FORM	

1. Executive Summary

University Hospitals Dorset Hospitals NHS Foundation Trust aims to provide excellent person-centred emergency and planned care to the people we serve. The Board recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify and contextualise risk, ensuring that the Trust understands the risks it is prepared to accept in pursuing the Trust's aims and objectives. This strategy sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds, and states how the delivery of the Trust's Risk Management Strategy will be achieved.

The Trust has key aims that the risk management strategy supports in the delivery of;

- Devolved decision making and accountability for the management of risk throughout the organisation; from the point of delivery to the Board.
- Promoting a culture of assurance, monitoring, and improvement, ensuring risks to the delivery of Trust strategic objectives are well understood.
- Supporting patients, carers, and other stakeholders through the management of risks to patient safety, patient experience, and service delivery.
- Refining processes and systems to ensure engagement in risk management is efficient and effective, enabling good decision making through robust reporting to relevant decision-making groups and scrutiny groups.
- Supporting the Trust Board, commissioners, and other key stakeholders in receiving and providing assurance that the Trust understands its risk profile and is working to mitigate key risks in appropriate and timely ways.

The overall aim of the Trust is to achieve a culture where risk management and safety is everyone's business, that there is open and honest recording of risks and a culture that encourages organisation wide learning and risks are continuously identified, assessed and minimised. A culture of ownership and responsibility for risk management is fostered and supported throughout the organisation.

The Trust Board of directors recognise that Risk Management is an integral part of the Trust's quality, governance, and performance management processes. The Board, with support from its committees will ensure a robust system of risk management is effectively maintained, and champion a culture whereby risk management is embedded across the Trust through policy, strategy, and plans (business planning, policy documentation, strategies, etc. should all explicitly reference risks they are seeking to manage)

Effective Risk Management is the responsibility of every member of staff, either permanent, temporary or to those contracted working within, or for, the Trust. Further; we require that organisations with whom we contract services to provide risk, assurance, and performance information.

The strategy covers all aspects of risk including clinical risk, staff related risk, environmental risk, corporate risk and financial risk. The principles and procedures described within this document and the Trust Risk Assessment and Risk Register Guidance are applicable for all types of risk.

This Risk Management Strategy is underpinned by policy and toolkits guiding staff on the day to day delivery of effective risk management processes. Policy guidance is provided as part of this combined Risk Management Strategy & Policy document.

The Strategy refers to two key documents for managing risk at a strategic level these are:

- The Board Assurance Framework (BAF) – The BAF is a key mechanism to reinforce the strategic focus of the board and better manage risk. It is used to help the organisation capture, report and monitor key risks to the strategic objectives, implement corrective action and report to Board on progress. It is designed to provide assurance that the organisation is delivering on its objectives and draw attention to areas of concern. The BAF also helps the organisation to assess the controls it has in place to mitigate the risks and review the assurances to check the controls are effective.

- The Risk Register – The Trust uses a risk register to record, prioritise and monitor risks across the organisation. Details of this process can be found in the section 8 of this strategy & policy. Risks that are scored in excess of the Trust appetite are presented to the Executive Directors and Committees in accordance with the relevant Governance Cycles.

Both the BAF and the Risk Register are managed through the Trust's Risk Management system (web-based); DATIX.

A copy of the strategy will be made available to all staff and external stakeholders via the Trust website and intranet.

2. Risk Appetite

Definition of Risk Appetite

The Trust's agreed risk appetite is the level of risk that the Trust Board have agreed to be acceptable or unacceptable. This is expressed against a range of risk categories. This informs the levels of risk that should be escalated to senior management, the levels of risk that teams are empowered to manage themselves, and the level of risk that they Board are willing to accept in seeking to deliver the Trust's strategic Objectives.

Risk appetite is defined as "the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time" (HMT Orange book definition 2005).

Why is risk appetite important?

The resources available for managing risk are finite and so the aim is to respond reasonably and proportionately to risk priorities in accordance with an evaluation of the risks. The Board of Directors recognise that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options.

The Trust's aim, therefore, is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the culture of the organisation and becomes an integral part of the Trust's objectives, plans, practices and management systems.

Risk Appetite Statement

- All risks rated 12-25 will be escalated to the Board of Directors and risk status reviewed monthly.
- All risks rated 12-25 will be reported to the Audit Committee and risk controls and action plans discussed quarterly.

In addition:

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
To be a great place to work, by creating a positive, open and inclusive culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.	The Trust sees protecting our staff and their physical and mental wellbeing as key priority. Our staff are vital in keeping patients safe and delivering the organisation's aims. We are committed to recruiting and retaining staff to deliver high quality care and will support this through training and supervision. We will not tolerate unprofessional conduct, bullying and harassment, or any activity that contradicts our values.	• Risks relating to **Workforce** will be reported to the Quality Committee if they score 12 or more • Risks relating to **Workforce** will be reported to the Workforce Strategy Committee if they score 8 or more. • Risks relating to **Workforce** will be reviewed at Care Group Board if they score 8 or more. • Risks relating to **Workforce** will be reviewed at Directorate Governance if they score 4 or more. • Risks relating to **Workforce** will be reported to the Workforce and Organisational Development Group if they score 4 or more
	We are strongly averse to risks that might threaten staff members' health, safety and wellbeing, or team morale and cohesion, as well as risks to compliance with frameworks provided by national bodies.	• Risks relating to **Health & Safety** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Health and Safety** will be reviewed at Care Group Board if they score 8 or more. • All **Health and Safety** risks will be reviewed at the Trust Health and Safety group if they score 4 or more
	The Trust is committed to developing its leadership and organisational talent through values based appraisal and agreed personal development objectives. The Trust is committed to investment in developing leaders and nurturing organisational talent through programmes of change and transformation. The Trust has a tolerant appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.	• Risks relating to **Training and Development** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Training and Development** will be reported to the Workforce Committee if they score 8 or more. • Risks relating to **Training and Development** will be reported to Care Group Board if they score 8 or more. • Risks relating to **Training and Development** will be reported to the Workforce and Organisational Development Group if they score 4 or more.

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets.	We will strive to deliver our services within the budgets modelled in our financial plans. However, budgetary constraints will be exceeded if required to mitigate risks to patient safety. All such financial responses will ensure optimal value for money.	• Risks relating to **Finance** will be reported to the Quality Committee if they score 12 or more • Risks relating to **Finance** will be reported to the Finance and Performance Committee if they score 8 or more. • Risks relating to **Finance** will be reviewed at Care Group Board if they score 8 or more • Risks relating to **Finance** will be reviewed at Directorate Governance if they score 4 or more
	This trust is committed to delivering a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and emergency care	• Risks relating to **Performance** will be reported to the Quality Committee if they score 12 or more • Risks relating to **Performance** will be reported to the Finance and Performance Committee if they score 8 or more. • Risks relating to **Performance** will be reported to the Operations and Performance Group if they score 4 or more • Risks relating to **Performance** will be reviewed at Care Group Board if they score 8 or more • Risks relating to **Performance** will be reviewed at Directorate Governance if they score 4 or more
	The Trust will agree and publish the multi-year Green Plan, to measure, and reduce our carbon footprint, improve air quality and make more sustainable use of resources as part of a multi-year sustainability strategy.	• Risks relating to **Sustainability** will be reported to the Quality Committee if they score 12 or more • Risks relating to **Sustainability** will be reported to the Sustainability Committee if they score 8 or more.
To continually improve the quality of care so that services are safe, compassionate, timely and responsive- achieving consistently good outcomes and an excellent patient experience	Delivery of high quality, safe, services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an ongoing commitment to being a learning organisation. The Trust will not accept risks which compromise the delivery of high quality and safe services which jeopardise	• Risks relating to **Patient Safety** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Patient Safety** will be reported to the Quality Governance Group if they score 8 or more. • All risks relating to **Patient Safety** will be reviewed at Care Group Board if they score 8 or more. • Risks relating to **Patient Safety** will be reviewed at Directorate Governance if they score 4 or more

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
	compliance with its statutory duties for quality and safety.	
	It can be in the best interests of patients to accept some risk in order to achieve the best outcomes from individual patient care, treatment and therapeutic goals. It is also recognised that as part of informed consent patients may decide to opt out of treatment recommended. We will accept this risk and support our staff to work in collaboration with people who use our services to develop appropriate documented care plans based on assessment of need, efficacy, choice and clinical risk.	• Risks relating to **Clinical Effectiveness** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Clinical Effectiveness** will be reviewed at Quality Governance Group if they score 8 or more. • Risks relating to **Clinical Effectiveness** will be reviewed at the Clinical Audit and Effectiveness Group if they score 4 or more. • Risks relating to **Clinical Effectiveness** will be reviewed at Care Group Board if they score 8 or more. • Risks relating to **Clinical Effectiveness** will be reviewed at Directorate Governance if they score 4 or more.
To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.	We have a strong commitment to engage in co-production to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services.	• Risks relating to **Patient Engagement** will be reported to the Quality Committee if they score 12 or more • Risks relating to **Patient Engagement** will be reviewed at Care Group Board if they score 8 or more. • Risks relating to **Patient Engagement** will be reviewed at Directorate Governance if they score 4 or more.
	The Trust will continue to utilise information technology to transform clinical processes to achieve the maximum benefit from these investments, improve efficiency and improve the working lives of staff. We strive to implement digital channels to help patients, families, and carers connect better with the Trust. We will avoid risks to the achievement of our information technology aims; development & integration of infrastructure across the Trust	• Risks relating to **Infrastructure and Information Technology** will be reported to the Quality Committee if they score 12 or more • Risks relating to **Infrastructure and Information Technology** will be reported to the Quality Improvement and Digital Transformation Group if they score 8 or more • Risks relating to **Infrastructure and Information Technology** will be reported to the Informatics Programme Group if they score 4 or more • Risks relating to **Infrastructure and Information Technology** will be reviewed at Care Group Board if they score 8 or more. Risks relating to **Information Governance will** be reviewed at Directorate Governance if they score 4 or more.

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
	The Trust will continue to invest heavily in our estate to ensure it is fit for purpose to deliver safe and effective care.	
	The Trust will strive to ensure that the protecting of information, critical to the delivery of the work of the Trust in support of patient care, ensures public confidence, and maintains the positive reputation of the Trust	• Risks relating to **Information Governance** will be reported to the Quality Committee if they score 12 or more • Risks relating to **Information Governance** will be reported at Information Governance Steering Group if they score 8 or more. • Risks relating to **Information Governance** will be reviewed at Care Group Board if they score 8 or more. • Risks relating to **Information Governance** will be reviewed at Directorate Governance if they score 4 or more.
To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	The Trust will only consider service redesign and divestment risks in services we are commissioned to provide where there is assurance that patient safety and clinical care will be maintained or improved.	• Risks relating to **Service Design and Transformation** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Service Design and Transformation** will be reported to the Transformation and Innovation Committee if they score 8 or more.
	The Trust will continue to support innovation as it is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The Trust has an encouraging appetite to risk where benefits, improvement and value for money are demonstrated	• Risks relating to **Innovation** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Innovation** will be reported to the Transformation Committee if they score 8 or more

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
	This Trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the Trust's current and future services. The Trust has a risk seeking appetite for developing these partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties. This Trust will make every effort to meet the expectations of stakeholders and the standards that applicable regulators have set, unless there is significant evidence to challenge veracity or benefit.	• Risks relating to **Stakeholder Relationships** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Stakeholder Relationships** will be reported to the Transformation and Innovation Committee if they score 8 or more

3. Background

The business of healthcare is, by its very nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing University Hospitals Dorset NHS Foundation Trust's Board of Directors with assurance on the framework for clinical quality and corporate governance.

The Trust has identified standard processes and procedures for the identification, assessment and appropriate management of risks at all levels of the organisation describing:

- the process for assessing all types of risk
- the process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation using a single risk register, held and accessed via a web-based system (Datix)
- risk appetite
- risk controls and assurances
- management responsibility for different levels of risk within the organisation
- risk monitoring, escalation and mitigation.

4. Risk Management Objectives

The Trust's Board aims to take all reasonable steps in the management of risks to ensure that the organisation's vision, values and objectives are achieved.

The Trust manages risks by:

- Undertaking an annual assessment of the organisation's objectives and identifying the principal risks to achieving those objectives (Board Assurance Framework risks)
- Regular monitoring of the effectiveness of the Board Assurance Framework by the Trust's Board and the Audit Committee
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified and the controls in place to mitigate them e.g. internal and external audit, commissioned independent reviews, Care Quality Commission (CQC) reports and other external/peer review inspections
- Regular monitoring and review of the risk register and risk appetite ensuring the risks are managed effectively and at the appropriate level within the organisation and escalated where appropriate
- Integrating risk management into business planning, quality improvement and cost improvement planning processes, ensuring that objectives that are set across the organisation with plans to manage risk in accordance with quality impact assessment and risk assessment procedures.

Specific Objectives 2022 – 2024:

Our main priorities for 2022/23 continue to directly link to the key requirements of the National Patient Strategy including:

- Continuing to participate in the work across the ICS to develop and adopt agreed principles and policies to support a Just Culture.
- Continue to improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups.
- Support transition from the National Reporting and Learning System and STEIS to the new national Patient Safety Incident Management System (PSIMS).
- Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework as and when published (proposed July 22)
- Work with Workforce leads and colleagues across the system to consider the best approach to implementation of the new national Patient Safety Syllabus as and when training materials become available.
- Embed consistent risk escalation and risk review processes to reflect the risk profile of University Hospitals Dorset NHS Foundation Trust and in line with the Trust Risk appetite.
- Support a consistent approach to the articulation and assessment of risks in line with of University Hospitals Dorset NHS Foundation Trust's risk appetite.
- Maintain and develop the risk management system (Datix across) the Trust to ensure engagement in the effective management of risks from Ward to Board.

- Further develop thematic reviews via the Risk Management system (Datix dashboards) for risks, incidents and issues, complaints, claims and inquests to enable triangulation of quality information at Ward, Directorate, Care Group and Trust level.
- Promote and support the review of risks, risk ratings and risk action plans as a standard agenda item at all governance meetings

5. Definitions of Risk

Risk can be defined as the combination of the probability of an event and its consequences. The following risk definition is used by the Trust:

"The chance of something happening that will have an adverse effect on an objective."

Risk can relate to:

- **A threat** – an event or circumstance which could cause harm or loss, or affect the ability of the organisation to achieve its objectives.
- **An opportunity** – the organisation must take some risks in order to obtain a benefit; to innovate, grow and improve.

Based on this definition, consistent statement of risks can be framed as an 'if … 'then' statement, for example: ***If*** *we continue to or fail to do something* ***then*** *the result will be…..*

Strategic risks are significant risks that have the potential to impact across the organisation. These are captured and reported via the Board Assurance Framework.

Operational risks are risks that exceed the Trust's stated risk appetite. These risks are identified across the Trust, scored, managed, and escalated as appropriate, and reported to the Trust Board and sub-Committees.

Likelihood & Consequence reflect the probability of a risk occurring, and potential impact caused to the Trust if the risk were to occur. Both likelihood and consequence are scored between 1 and 5 and are discussed in detail in the Risk Matrices provided as ***Appendix 2***.

Risk Score; risks are scored against impact and likelihood. This provides a risk a score of between 1 and 25 that reflects the prioritisation that the risk should receive. Risks are scored in three stages;

- **Initial Risk Score;** this score reflects the impact and likelihood of the risk, once, and at the point of assessment and articulation of the risk reflecting the prior management/actions that have been undertaken and the reflecting the identified gaps in controls at that time
- **Current Score;** this score reflects the current state of the risk, bearing in mind the controls in place to mitigate against both impact and likelihood. This score will reflect the progress to delivery of controls and the gaps that may increase or decrease during the life of a risk. This assessment and potential to re-grade will be considered and amended as appropriate at each risk review.

Note: at the point of submission to the risk register initial and current risk score will be the same

- **Target Score;** this risk score reflects the future state of the risk, when gaps in controls have been addressed and any outstanding actions completed.

Risk controls: the **measures** by which an organisation can assess and assure itself regarding the progress of mitigation, minimisation, or elimination of risks or the need for escalation.

- can be directed towards **reducing** the severity of the risk were it to occur or reducing the likelihood of the risk occurring. Typical examples are; compliance with national or local policy or guidance, performance metrics and staff training/competency frameworks.
- details the systems, processes, or information which demonstrate that controls are in place and are **effective**. The most common forms of assurance include clinical, internal, and external audit, and regulator inspections**.**

Actions; any identified gaps in controls should prompt an action to close the identified gap. Actions should be specific, nominate clear owners, and provide a date for completion. E.g. to develop an policy or a training programme

Review; all risks are to be reviewed and a progress update added in line with current risk score and risk appetite. The standards set are as follows:

Current Risk score	**Frequency of review (minimum)**	**Threshold for compliance reporting**
12 and above	Once a month	35 days
8-11	Every 2 months	70 days
4-7	Every 3 months	105 days
1-3	Every 6 months	200 days

Risk Assessor: the risk Assessor is responsible for ensuring that the risk is assessed and progress updates added to the risk record in line with the requirement for review and that any need to materially amend or upgrade the risk is escalated to the Risk Owner

Risk Owner; the risk owner takes oversight of the accuracy and timely review of the risk record. The risk owner is ultimately responsible for the risk, the control framework, and ongoing management and grading of the risk.

Risk Register; all identified risks are recorded on the Trust risk register. This is a dynamic and responsive collection of risks that the Trust faces across clinical and corporate areas. This is managed on the DATIX system; access to which can be register can be requested through the Quality Governance Team.

Board Assurance framework (BAF) is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains details internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.

6. Organisational and Management Arrangements

6.1 The Trust's Governance Structure is provided as ***Appendix A.***
In the addition to the overview by the subject matter Committees and Groups (as indicated in the Risk Appetite Statement). The following Committees and Groups hold explicit responsibility for the review, challenge, action, and escalation of risks as appropriate:

- The Trust Board
- Trust Quality Committees
- Trust Clinical Governance Group
- Care Group Boards
- Directorate Governance

6.2 The Trust Board: The Trust Board of Directors set the strategic direction of the Trust which includes setting strategic objectives and ensuring that patient and staff safety is prioritised, and that effective and robust risk management systems are in place throughout the organisation.

6.3 The Board of Directors develop, monitor and manage the Board Assurance Framework which records the strategic risks to the Trust that may affect the achievement of the Trust's strategic objectives. The Board Assurance Framework, in full, is reviewed 6 monthly by the Board of Directors.

6.4 The Trust's Risk Register will be overseen by the Trust's Risk Management Department. All new risks rated 12 or above will be reported and reviewed monthly by the Board; an in-depth presentation by the risk's Executive Lead may be requested by the Board.

6.5 The Board receive a monthly summary of all risks rated 12 and above, an Integrated Performance Report and a LERN review (External & Board level investigations) report which highlight potential areas of concern such as financial risks, and risks to quality and safety or patient experience.

6.6 **Audit Committee:** The Audit Committee is a committee of the Board of Directors, chaired by a non-executive director, which ensures effective evidence and assurance of internal control, including Risk Management, is in place throughout the Trust. It provides the Board with independent and objective review and monitoring of:

- the effectiveness of the systems in place for the management of risk;
- compliance with the law and regulations covering the NHS
- the internal financial control system
- delivery of the Board Assurance Framework.

6.7 The Audit Committee reviews the full Board Assurance Framework quarterly and receives a report on all 12-25 risks at each meeting. Risks escalated to this committee will be reviewed monthly and new escalated risks will be accompanied by an in-depth report by the Executive sponsor or risk owner/handler.

6.8 Internal auditors assist the committee by providing a clear statement of assurance regarding the adequacy and effectiveness of internal controls.

6.9 **Quality Committee:** The Quality Committee is a committee of the board of directors and is chaired by a non-executive director. The committee receives detailed quality, safety and performance reports including Serious Incident reports so that it can ensure that patient safety and quality of services meet registrations and compliance requirements.

6.10 The Committee reviews the BAF six monthly (Q2 and Q4) and any risks escalated to it on a monthly basis prior to the risk register report being presented to Board. New risks are presented to the committee by an in-depth report by the executive sponsor or relevant Care Group Director (or designated deputy).

6.11 **Finance and Performance Committee:** The Finance and Performance Committee is a committee of the Trust Board and is chaired by a Non-Executive Director.

6.12 The Finance and Performance Committee provides the Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's finance and investments in the context of delivering the Trust's strategy, the underpinning financial plan and associated clinical activity data. The Committee has over-arching responsibility for financial risk on behalf of the Board.

6.13 The Committee reviews the relevant section of the BAF and those risks escalated to it on a quarterly basis.

6.14 **Workforce and Strategy Committee:** The Workforce Strategy Committee is a committee of the Trust Board and is chaired by a Non-Executive Director.

6.15 The Committee provides the Board with assurance concerning all aspects of strategic and operational workforce and organisational development relating to the provision of care and services. It also provides assurance to the Board that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of high quality, safe patient care.

6.16 The committee provides assurance that, where there are workforce or organisational development risks and issues that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way.

6.17 The Committee reviews the relevant section of the BAF and those risks escalated to it on a quarterly basis.

6.18 **Sustainability Committee** provides the Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's multi-year Green Plan and reduction of the Trust's carbon footprint. The Committee has over-arching responsibility for sustainability risks on behalf of the Board.

6.19 The Committee reviews the relevant section of the BAF and those risks escalated to it on a quarterly basis.

6.20 **Transformation Committee** provides the Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's transformation and service improvements in line with the Dorset ICS Long Term Plan. The Committee has over-arching responsibility for sustainability risks on behalf of the Board.

6.21 The Committee reviews the relevant section of the BAF and those risks escalated to it on a quarterly basis

6.22 **Trust Management Group:** The Trust Management Group (TMG) is the lead operational group for the Trust chaired by the Chief Executive and includes the Executive Directors, and Clinical Directors. It is responsible for the delivering the Trust's strategic objectives, operational management, service planning and delivery and advising the Board of Directors. TMG receives a risk report (12-25 rated risks) as a standing agenda item at each formal meeting.

6.23 **Clinical Governance Group (CGG):** The Trust Clinical Governance Group meets monthly. The group will receive a monthly report on all risks rate 12 and patient safety risks rated 8 -12. The Group will receive by exception risk reports from sub-groups and directorate at least quarterly.

6.24 The group will ensure that the Trust Risk Register is maintained and updated on a regular basis in line with the Trusts' Risk Management Strategy, and that the Care Quality Commission standards for quality and safety and other related National Guidance are maintained.

7. Responsibilities and Scheme of Delegation for Risk Management

7.1 The Trust's risk management framework requires engagement from all staff throughout the Trust, including contractors and temporary staff. All are expected to participate in the risk management process. Individual staff and groups have specific responsibilities and accountability around risk management which are detailed below.

7.2 The **Chief Executive Officer** has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory

requirements and adhering to guidance issued by the Department of Health and Social Care and Care Quality Commission in respect of governance.

7.3 The **Chief Medical Officer** and **Chief Nursing Officer** have joint delegated responsibility for managing the strategic development and implementation of organisational risk management and clinical governance. The Chief Nursing Officer has specific responsibility for acting as to the Board lead for monitoring compliance with the Care Quality Commission. The Chief Medical Officer is the Trust Caldicott Guardian.

7.4 The **Chief Finance Officer** has delegated responsibility for ensuring that the Trust complies with NHS England and Monitor's requirements for financial risk management.

7.5 The **Chief People Officer** has delegated responsibility for all aspects of human resource risk management, Health and Safety and for the co-ordination and implementation of the Trust's strategy for occupational health services.

7.6 The **Director of Infection Prevention and Control** has responsibility for advising the Board on all risk issues relating to the prevention, management and control of infection.

7.7 **Executive Directors**: The Trust has identified Executive Director leads for each of the main areas of risk. The Executive Directors with delegated responsibility sit on the Quality Committee with responsibility for risk management.

Executive Directors agreeing (as part of formal escalation process) to act as Lead Executive for risks are responsible for monitoring compliance and supporting the management, progress and further escalation of risks on the Trust's risk register that are relevant to their delegated roles and responsibilities. Executive Director leads are responsible for ensuring that reported risks are updated in accordance with the Trust Risk Management strategy and risk appetite and for ensuring the adequacy of any agreed controls and action plan to mitigate or reduce identified risks.

New risks are presented to the Quality Committee by the executive sponsor or relevant Care Group Director (or designated deputy). New risks are presented to the Board of Directors by the executive sponsor

Executive Directors are responsible for providing assurance to the Quality Committee and Board in regard to sponsored risks and may be requested to provide an 'deep dive' regarding the risks for which they are designated Lead Executive.

7.8 **Non-Executive Director Leads:** The Trust has identified Non-Executive Director leads for risk. The Non- Executive Directors with delegated responsibility sit on the Quality Committee.

7.9 **Care Group Directors, Deputies and Heads of Nursing and Professions:** have the following responsibilities in relation to risk management.

- Review with the Directorate Governance Group leads, Directorate Manager and Matrons the directorate risk register, integrated performance report, CQC action plan and other associate quality reports
- Review, with the directorate management teams, patient experience results (Friends and Family Test, patient comment cards, national surveys, complaints) for the Care Group and drive improvements
- Approve, monitor and ensure delivery of the directorate clinical audit plan and monitor compliance
- Provide a Care Group Quality report to the Quality Committee and escalation of any areas of risk or concern. Provide a report on any mitigating actions, recommendations/ or learning points.
- Ensure quality patient safety, patient outcomes and patient experience is a standard agenda item at all directorate governance and risk meetings and is a core objective for all managers across the Care Group
- Ensure robust and appropriate data quality throughout the directorate to enable effective clinical, quality management and financial information.
- Ensure that the directorate meets statutory and Trust reporting and investigation timescales in respect to LERN reviews (formerly Serious Incidents)
- Ensure all escalated new risks are consistent with Trust approach to the articulation and assessment of risks and that they have a current action plan
- Ensure that any risks agreed at Directorate Governance as rated 12 and above are for considered, reviewed for acceptance at Care Group Board (via the Care Group Board meeting or Chair's decision) and in keeping with the Trust's Risk appetite
- Ensure that risks agreed as rated 12 or above have a designated (formally requested and agreed) Executive Lead and, via the Head if Risk, secure addition to the monthly Risk report to the Quality committee for 'recommendation to accept' to Board
- To support the leads for clinical governance in carrying out their roles

7.10 **Directorate Clinical Governance/Lead Clinician (Clinical Governance Group representative):**

- Responsible for representing their directorate on the Clinical Governance Group (CGG)
- Attending at least 75% of the Clinical Governance Group meetings and ensuring that a designated deputy attends in their absence
- Monitoring the directorate quality and clinical governance agenda (to include the routine review of the directorate quality dashboard, ward scorecard, patient experience results, LERNs, complaints and risks)
- Providing a formal quarterly report to the Clinical Governance Group. Directorate leads are required to report on any significant clinical governance or risk issues for CGG attention and for dissemination any important learning points from the directorate review of serious incidents, root cause analysis reports, complaints, clinical audits, mortality reviews or external inspections/reports.
- Attending at least 75% of the directorate governance meetings.
- Responsible for ensuring their directorate retains an effective directorate risk register.

- Ensure all pending or new risks are consistent with Trust approach to the articulation and assessment of risks and that they have a current action plan
- Discussing any risks rated 12 or above to the attention of the Directorate Clinical Director and Directorate management team (via the Directorate Governance meeting or Chair's decision) as required.
- Presenting the learning and monitor completion of actions in relation to LERN reviews (formerly Serious Incident investigations) undertaken by the directorate to CGG.

7.11 **Directorate Managers, Senior Matrons and Matrons** responsibilities for risk management include:

- To ensure that the directorate has a robust structure for the management of quality, clinical governance and risk, and that this is communicated and applied across all areas of the directorate
- Ensuring that any risks agreed at Directorate Governance as rated 12 and above are escalated for consideration, review and acceptance at Care Group Board (via the Care Group Board meeting or Chair's decision)
- To ensure that robust structures are in place for complaints handling, incident reporting and management, risk assessment and audit that comply with Trust policy.
- To ensure that lessons learned, and best practice are disseminated across the directorate and Trust
- To ensure that the directorate clinical governance and risk meetings are multidisciplinary and cover directorate wide activity and responsibilities. Ensuring that the following are reviewed at least monthly:
  - Complaints
  - Incident records
  - LERN reviews (including action plans)
  - Clinical Audits
  - NICE
  - Risk register
  - Patient experience results (FFT, patient surveys, patient comment card results)
  - Mortality
- Ensuring compliance with statutory and Trust reporting and investigation timescales in respect to all learning events
- To attend Scoping meetings and LERN Review Learning Panels for the directorate as required
- Ensure quality metrics and quality impact assessments are included in all business cases and cost improvement, sustainability and transformation plans

7.12 **Managers / Heads of Department / Ward Sisters,** are responsible the management of local risks. This is done by adhering to the following roles and responsibilities:

- Carrying out local risk assessments and escalating these at directorate level
- Ensuring the all learning events are reported, recorded investigated and acted upon within their designated area(s) and scope of responsibility in accordance with Trust policy

- Disseminating information on the Trust's Risk Management Strategy (and associated policies and procedures) within their designated area(s) of responsibility, via local induction, appraisal and mandatory training
- Ensuring that all staff are made aware of the risks and associated risk control plans within their work environment and their individual responsibilities via the processes above
- Ensuring that all staff have appropriate information, instruction and training to enable them to work safely. Those responsibilities extend to anyone affected by the Trust's operations including sub-contractors, members of the public, visitors etc.

7.13 **Staff,** every member of staff (including contractors and agency staff) must be aware of the Trust Risk Management Strategy & Policy and their individual responsibilities with regards to maintaining safety. All staff have a responsibility for risk management and a commitment to identifying and minimising risks. In particular, key responsibilities are to:

- Escalate perceived risks to team leaders and line managers,
- Understand and support the controls in place in work areas to mitigate risks,
- Report Learning Events (including incident, concerns, near misses) in accordance with the Trust's Learning Events policy and bring this to the attention of their line manager
- Act safely in accordance with training, policy guidance, and good practice,
- Comply with Trust policies, procedures and guidelines in place to protect the health, safety and welfare of anyone affected by the Trust activities
- Neither intentionally nor recklessly interfere with or misuse any work equipment provided for the protection of safety and health
- Be aware of emergency procedures (e.g. resuscitation, evacuation, fire and major incident procedures) relevant to their roles and work area(s)
- Attend mandatory training and any other risk management training deemed necessary for their role and/or area of work
- Comply with professional guidelines (as applicable to their role and profession) and acting in accordance with such guidelines and codes of practice

7.14 **Associate Director for Quality Governance and Risk is responsible for;**

- Supporting the Chief Nursing Officer and Chief Medical Officer in the strategic leadership for quality governance and risk management for the Trust ensuring the Trust has a robust framework which meets the requirements of NHS Improvement, NHS England, the Care Quality Commission and the CCG to deliver year on year improvements in patient care.
- Collaborating with the Chief Nursing Officer, for the development of the Trust's Quality Strategy and implementation throughout the organisation.
- Overseeing the incident reporting and investigation process and ensure appropriate systems in place to cascade learning.
- Overseeing the Trust Risk Management Strategy, risk register process and the Board Assurance Framework processes

- Working with the Chief Medical Officer and Chief Nursing Officer to ensure that quality and clinical governance systems and processes are integrated across the Trust and appropriately aligned with the Care Group/Directorates
- Collaboration with the Chief Medical Officer to implement a framework for learning from deaths, in line with national best practice, to include implementation of a mortality review process and a Medical examiner system across the Trust.
- Collaboration with the Chief Medical Officer ensure that robust processes are in place to management NHS Resolution (clinical and non-clinical) claims and coroner inquests.

7.14 **Head of Risk Management**, is responsible for;

- The development of strategic plans, policies, procedures and statement of purpose documents with regard to risk management.
- Development, support and oversight of the implementation of the risk functions and of the Risk Management Strategy
- Provision of training, information and support to clinical and corporate teams
- Ensuring relevant risks are reported to external agencies such as commissioners through appropriate oversight groups.
- Responsibility for ensuring systems and processes relating to clinical risk management are embedded throughout the Trust, including clinical incident reporting and investigations; ensuring lessons learnt from LERNS are shared throughout the governance structure; reviewing risk assessments to identify risks which are prevalent across the organisation.
- Ensuring the risk management system and associated processes are maintained and updated in line with Organisational requirements and the Trust Risk Appetite.
- Undertaking consultations with the Executives and Non-executive Directors to inform the review of the Trust Risk Appetite statement.
- Provide, through oversight, a 'check and challenge' process for all risks on the register with the risk owners through a systematic and documented process.
- Support the Associate Director for Quality Governance and Risk in regard to :
  - the incident reporting and investigation process and ensure appropriate systems in place to cascade learning.
  - the Trust Risk Management Strategy, risk register process and Board Assurance Framework processes

7.15 Risk Management Processes

8.1 The Trust's process for risk management is intended to provide a structured method for the identification, management, and escalation of risks. A toolkit is provided on the Trust intranet and the Quality and Risk Team are a key contact for support.

8.2 The primary tool that the Trust uses for managing its identified risks is the Risk Register. This can be described as a record of all risks identified, both clinical and non-clinical, that might impact on the Trust's delivery of its objectives.

8.3 The Trust Risk Register is accessed through the DATIX system, similarly to the management of incidents.

8.4 **Risk Identification;** Risks will be identified in many ways and prompted by both internal and external events. The Trust aims to be proactive in its identification of risk The Trust has a range of risk assessment tools to identify risk and potential risks associated with its activities. Examples include; risk assessments (clinical and non-clinical), audit (clinical and non-clinical), impact assessments, CQC inspections and monitoring visits, complaints and concerns, LERNs and LERN Reviews, etc.

8.5 Risks should be titled with a brief summary of the risk, and can be framed as an 'if … 'then' statement, for example: If we continue to or fail to do something then the result will be…..

8.6 The description of the risk should be succinct and summarises the causes of the risk, and the consequences/outcome if the risk were to occur. Providing this context will help to align controls and actions to specific causes and consequences.

8.7 **Risk Assessment;** The Trust uses a standardised approach to risk assessment that ensures consistency across the organisation. Risks are assessed based on the impact that the risk might have if it were to occur, and the likelihood of the risk occurring. The impact can be based on a variety of factors including; financial implications, the number of service users affected and the severity of harm, or the impact on staff morale and wellbeing.

8.8 The Trust uses a standard 5x5 risk scoring matrix for assessing the impact and likelihood of the risk. The matrix has been adopted as part of a pan-Dorset Risk Management framework.

	Likelihood Score				
	1	2	3	4	5
Impact Score	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Figure 2. 5 X 5 risk scoring matrix.

Risk rating 1-4 Very low
4-6 Low
8-12 Moderate
15-25 High

8.9 Each risk will be assessed as below:

- **Initial**, this score reflects the impact and likelihood of the risk, once, and at the point of assessment and articulation of the risk reflecting the prior management/actions

that have been undertaken and the reflecting the identified gaps in controls at that time

- **Current**, this score will reflect the progress to delivery of controls and the gaps in controls that may increase or decrease during the life of a risk. This assessment and potential to re-grade will be considered and amended as appropriate at each risk review.
    - Note: at the point of submission to the risk register initial and current risk score will be the same
- **Target**, the risk score that should be achieved through implementing actions, bringing the risk in line with articulated appetite and tolerance. This should include a date by which the target score will be achieved.

8.10 Risk scores are not intended to be precise mathematical measures of risk but are a useful tool to help in the prioritisation of control measures for the treatment of risk. The scoring system allows the levels of risk to be easily identified and therefore prioritised.

8.11 Controls to manage the risk should be described to provide detail on the management systems and processes the Trust have in place to manage its risks. Examples include policy guidance, staff training, appropriate skill mixes and staff numbers, etc.

8.12 Actions should be recorded to provide detail on further work planned to mitigate the risk. These should align to gaps in controls or controls that are understood to be ineffective. Actions should be specific, measurable, achievable, relevant, and time-specific

8.13 An element of the risk assessment process is to agree the course of action. This should be in line with the Trust's Risk Appetite. Courses of action can be summarised as either to;

- **Treat** – identify new actions that will, once completed, become controls and further mitigate the risk
- **Tolerate** – agree that the control framework in place is appropriate and reflective of the seriousness of the risk, and that no further action is necessary
- **Transfer** – move the risk away from the organisation through, for example, outsourcing activity.
- **Terminate** – agree that the risk cannot be practically mitigated further, but is in excess of risk appetite, and therefore to consider terminating the activity that produces the risk.

8.14 Risks are recorded onto the Risk Register; a crucial part of the Trust Risk Management Strategy. The register is a management tool that enables the organisation to be aware of its risk profile. The register is a dynamic living document which is populated through the organisations risk assessment and evaluation processes. This enables risks to be quantified and ranked and shared at the appropriate levels.

8.15 The risk register is primarily an internal management tool to support Care Groups / Directorates in managing their risks, whilst offering an opportunity to escalate particular risks to the Trust Executive and senior management.

8.16 The Trust has one electronic risk register accessed through the risk management system (Datix). Risk assessments can be completed with reference to the Risk Register toolkit found on the intranet.
Link below: https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/risk-register-toolkit

8.17 **All new risks** must be reviewed and signed off by the relevant Governance,Clinical or Operational Departmental Lead and:

- **Risks rated 8** and above must be signed off by the relevant Directorate Management Team.
- **Risks rated 12** and above require the review and agreement from the Care Group Directors and communication to the relevant Executive Lead.

This ensures the consistent escalation of appropriate risks to Quality Committee for sign off and notification to Board of Directors. As below:

Risk Score	Decision to Accept or Close a Risk	Exec Lead	Risk Owner	Risk Assessor
V.Low 1-3	Directorate Governance	If Board Assurance Framework Risk otherwise not applicable	Clinical or Operational Departmental Lead	Departmental /Specialty Lead
Low 4-6	Directorate Governance	If Board Assurance Framework Risk otherwise not applicable	Clinical or Operational Departmental Lead	Departmental /Specialty Lead
Moderate 8-10	Care Group Governance	If Board Assurance Framework Risk otherwise not applicable	Care Group Director	Directorate General Manager/ Senior Matron/ Clinical or Governance Leads
Moderate 12	Reviewed and accepted at Quality Committee Reviewed at Quality Governance Group Noted at Trust Board	All risks	Deputy Exec	Care Group Director/ Operational/ Governance Lead. Or Subject Matter Lead Or Trust Operational Lead
High 15 -25	Reviewed and accepted at Quality Committee Reviewed at Quality Governance Group Noted at Trust Board	All risks	Deputy Exec	Care Group Director/ Operational/ Governance Lead. Or Subject Matter Lead Or Trust Operational Lead

8.18 All new 12 and above risks are presented to the Quality Committee for recommendation for agreement and notified to the Board of Directors

8.19 Those risks which exceed the Trust's risk appetite will be submitted to the Board sub committees and the Board as appropriate.

8.20 Whilst all specialties and wards have local level responsibility for reviewing and managing their risks, the Care Groups/Directorates have an overarching responsibility to ensure that all relevant risks within their area are monitored, managed and escalated appropriately. This will include:

- A review of scores, controls, and action plans for risks recorded on the risk register
- A challenge of the risks recorded as an accurate reflection of the area's risk profile
- Agreement of escalation of risks in excess of the Trust's risk appetite.
- A review of mitigated risks with completed action plans, with a view to closing these risks down.

8.21 Directorate and Care Group Leads are responsible for keeping their risk register up to date and for highlighting any risks graded 12 or above for acceptance onto the Trust Risk Register.

Current Risk score	**Frequency of review (minimum)**	**Threshold for compliance reporting**
12 and above	Once a month	35 days
8-11	Every 2 months	70 days
4-7	Every 3 months	105 days
1-3	Every 6 months	200 days

8.22 Risk register 'hygiene' will be maintained by ensuring that;

- all risks graded as Very Low and Low that have met their target risk grading are closed,
- all risks currently graded as Moderate that have met their target risk grading are reviewed at Care Group Boards for consideration of closure as a tolerated risk,
- risks graded as Very Low and Low that have not been reviewed for a year are closed unless statutory reason for extended planned review date
- risks designated 'in holding' status are reviewed and become accepted onto the risk register within 60 days or are considered for rejection or closure.

8.23 To ensure effective escalation and management of risks, the risk assessor must inform the Directorate manager and Care Group leads when a new risk exceeding risk appetite (i.e. graded 12 or above) is submitted for acceptance onto the 'live' directorate risk register.

In turn the Care Group Directors must request the relevant Executive Director to confirm that they will act as Executive Lead (please see Table below). This will ensure that the risk narrative and controls identified are agreed and that any action plan can be supported by the Care Group and by an Executive Lead. The process is

not aimed to inhibit directorates raising risks but will ensure risks are clearly articulated, have appropriate Care Group and Board level discussion, approval and support at the earliest opportunity.

8.24

12+ Risk Theme	Executive Lead	Monitoring Committee
Workforce	Chief People Officer	As per Risk Appetite Statement
Health & Safety	Chief People Officer	
Training and Development	Chief People Officer	
Stakeholder Relationships	Chief Strategy and Transformation Officer	
Finance	Chief Finance Officer	
Performance	Chief Operating Officer	
Sustainability	Chief Strategy and Transformation Officer	
Patient Safety	Chief Medical Officer Or Chief Nursing Officer	
Clinical Effectiveness	Chief Nursing Officer	
Patient Engagement	Chief Nursing Officer	
Infrastructure and Information Technology	Chief Information and IT Officer	
Information Governance	Chief Information and IT Officer	
Service Design and Transformation	Chief Strategy and Transformation Officer	

8.25 The Risk Owner and Risk Assessor will be responsible for providing a monthly update on risk status of those risks graded 12 or above to the Quality Committee, TMB and Board of Directors, with the oversight and support of the designated Executive Lead.

8.26 Executive Leads to Board Assurance Framework risks on the Trust Risk Register will be asked to complete a separate quarterly report on compliance to the Audit Committee.

8.27 **External Visits, Inspections and Accreditations**, The Audit Committee is responsible for ensuring the Trust prepares and adopts a proactive approach to the recommendations / requirements arising from external agency visits, inspections and accreditations. Relevant sub-committees are expected to report on areas of non-compliance, populating the Trust Risk Register as appropriate.

9.0 Training

9.1 The Trust Board recognises that training is central to the successful implementation of this strategy and to staff understanding their roles and responsibilities for risk management across the organisation.

9.2 Risk management training not mandatory for all staff. Those in leadership or management positions and those with explicit responsibility for risk management should receive risk management training. This training is provided by the Quality and Risk Team on a bimonthly basis. Full details are available on the Trust intranet.

9.3 It is expected that all staff will familiarise themselves with this Strategy & policy document and be able to identify, communicate, and escalate risks in their areas.

10. Process for Monitoring Compliance with this Policy

Criteria	Method of Monitoring	When	Method of following up non compliance	Follow up of action plan by	Criteria
The Risk Strategy has a process for Board or high-level committee to review the organisation wide risk register	Annual review by Internal Audit of risk Management functions and Assurance Framework	Annually	Results of Audits reviewed and shared with Quality Committee (QC)	Internal Audit	Internal Audit Report –Audit Committee
The Risk Strategy has a process for management of risk locally, which reflects the Trust risk management strategy	Directorate Internal Audit Reports (rotational) Looking at whether risk management processes function appropriately at local level.	Annually	Results of audit reviewed and shared with QC and Audit Committee chairs, action plans to address non-compliance requested	Internal Audit	Internal Audit Report –Audit Committee
	Review of results of Annual Governance Audit tool, identifying whether staff are made aware of processes for risk management.	Annually	Results reviewed by Health and Safety Group and action plans re non-compliance requested	Health and Safety Group	Annual review of results and action plans by Health and Safety Group

The Risk Strategy has a process for Board or high-level committee to review the Trust's Board Assurance Framework	Review by Audit Committee of Trust's Board Assurance Framework, looking at whether risk management processes function appropriately	Quarterly	Results of review, by exception, shared with QC and Board of Directors chairs, action plans to address non-compliance requested	Audit Committee	Quarterly review and escalation by exception

11. Approval, Implementation and Review

11.2 Once approved, the strategy will be placed on the Trust intranet.

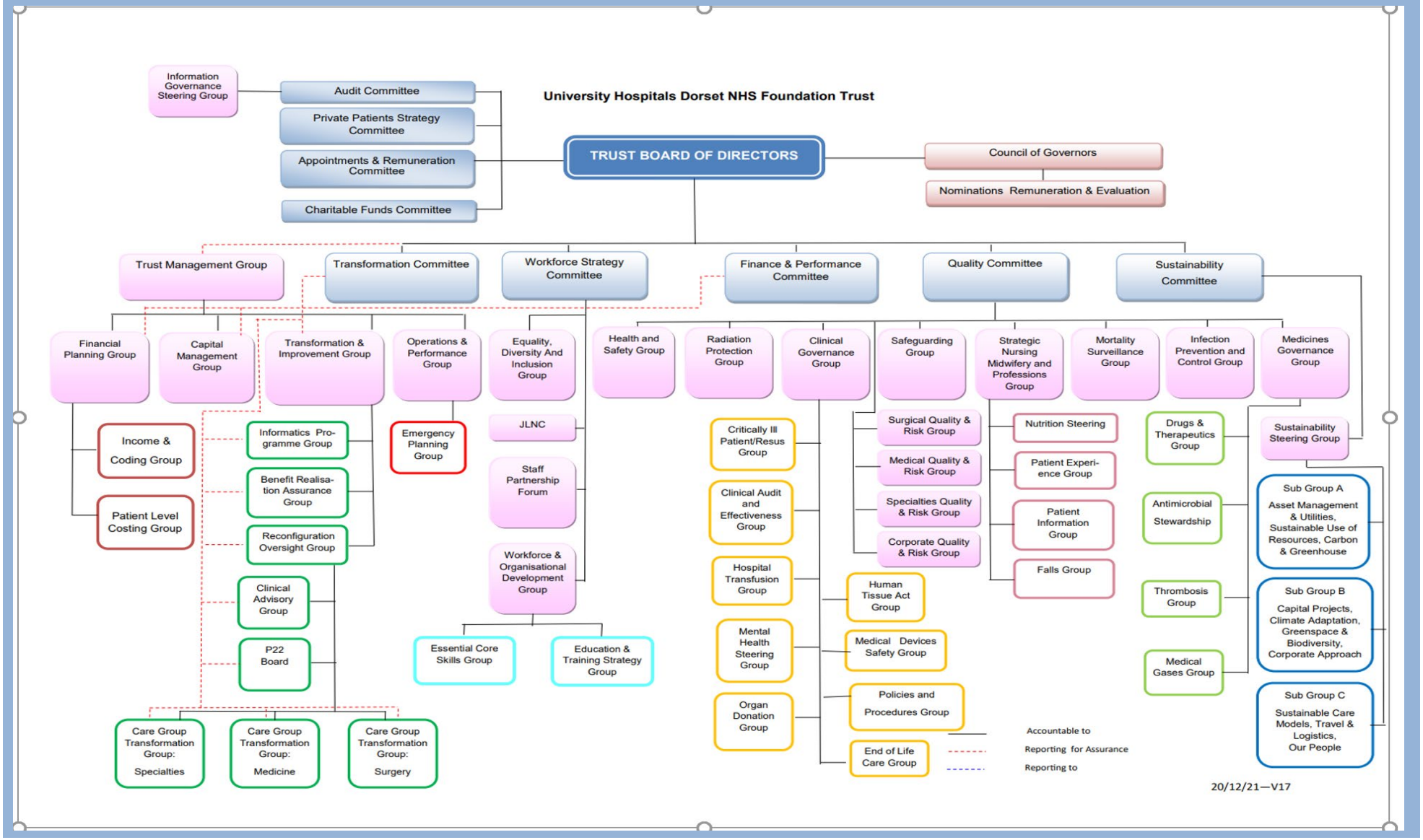
11.3 The Board is responsible for reviewing the strategy annually and updating it as necessary.

12. References

- Risk Register Toolkit (inc. Escalation and agreement of risks rated 12-25)
- Risk matrix
- Risk Grading descriptors

https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/risk-register-toolkit

Appendix A: Trust Governance Structure

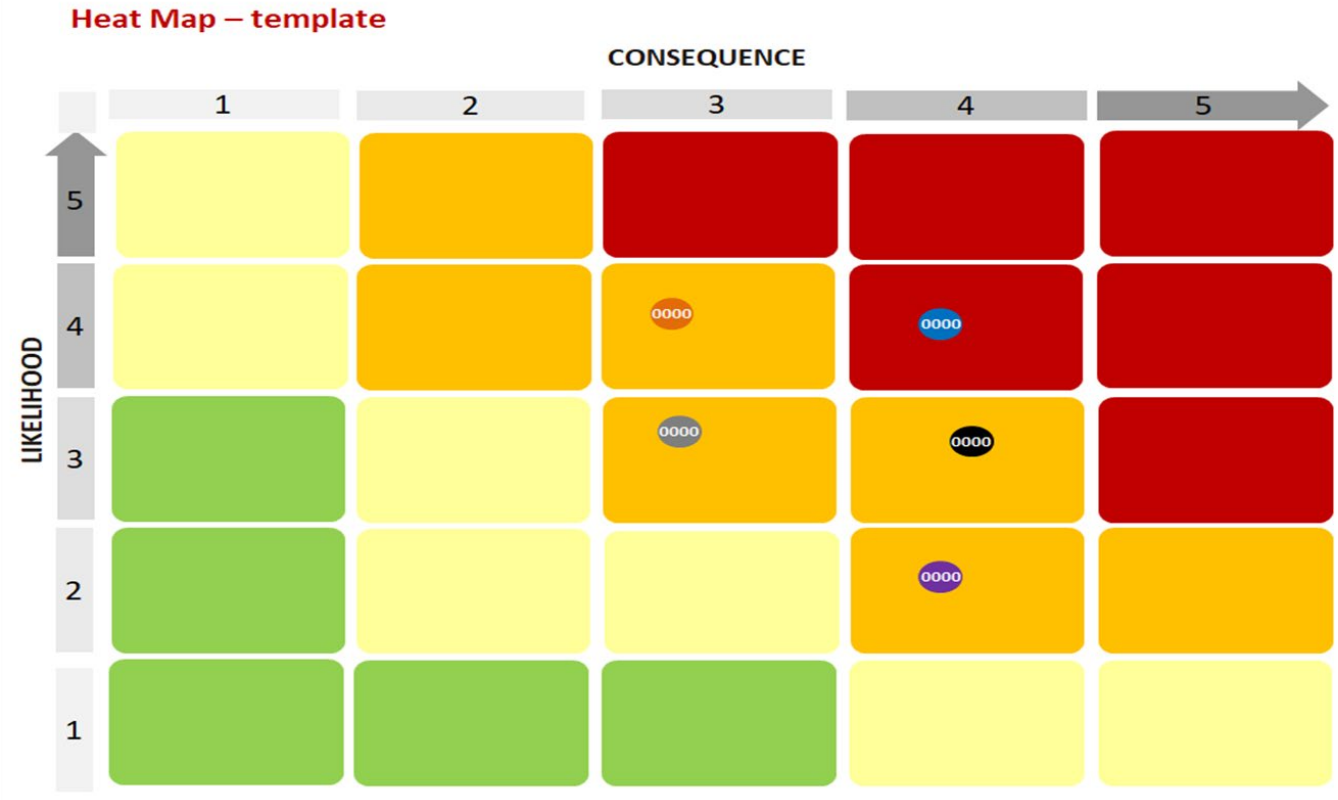


Appendix B: Board Assurance Framework Report Templates

1. BOARD ASSURANCE FRAMEWORK REPORT

Part A Board Assurance Framework Heat Map Overview

- **Purple** background indicates risk increased
- **Orange** background indicators risk decreased
- **Black** background indicates risk remained the same as previous quarter
- **Blue** background indicates new risk
- **Grey** background indicates risk has closed/reduced or equal to risk rating of 8 during the quarter and will be removed at the next quarter review



Principle objective	Specific Objective	Risk ID	Title	Risk description	Executive Lead	Risk Owner	Consequence (current)	Likelihood (current)	Risk level (current)	Current progress	Monitoring Committee	Risk level (Target)

Appendix C Cover Sheet content - Quality Committee/Board Template

Key points for members:

Current risks rated at 12 and above on the risk register	
Risk(s) increased to 12 and above for review	
Reduced, closed or refreshed risk(s)rated at 12 and above to note	
Potential new risks for review	

To note - Current 12+ Risks increased in month			
Risk no:	Title	Risk Owner	Risk Trend

To note - Current 12+ Risks decreased in month			
Risk no:	Title	Risk Owner	Risk Trend

New risks provisionally rated 12 and above for consideration				
Risk no:	Title	Proposed Grading	Exec Lead	Papers

Risks increased to 12 and above for consideration					
Risk no:	Title	Proposed Grading	Update	Exec Lead	Papers

Closed, Reduced or suspended Risks previously rated at 12 - to note			
Risk no:	Title	Decrease in Grading	Progress update

Risks graded 12+ - Compliance with review timescales - to note			
No: of risks under review	Number of Risks compliant with Risk Appetite timescales	% of Risks Compliant with Risk Appetite timescales	Month on month position

University Hospitals Dorset
NHS Foundation Trust

Risk Report

The Quality Committee will review the Trust's significant risks at each meeting, generating actions appropriate following each review.

The Executive Director responsible for each area of risk will take responsibility for presenting to the Committee the current controls and mitigating actions in place.

The Committee is responsible for bringing significant risk issues to the attention of the Board of Directors for acceptance or for agreement of further actions for mitigation

For the period to end *** (as on **/**/****)**

Risk Register

SUMMARY

The report details new, current and closed risks rated at 12 and above, in month.
A risk rating is undertaken using an NHS standard five by five matrix according to their severity consequence and likelihood, as per the Trust's Risk Management Strategy and Risk Assessment Toolkit.
There are:

Current risks rated at 12 and above on the risk register	
Risk(s) increased to 12 and above for review	
Reduced, closed or suspended risk(s)rated at 12 and above to note	
Potential new risks for review	

DEFINITIONS

Movement in month - Key:

★	New Risk	⇩	A decrease in risk score
⇔	The score remains the same	⇧	A rise in risk score

Risk Review Compliance All risks should be reviewed and a progress update added in line with current risk score as set out in the Risk Management Strategy. I.e.

Current Risk score	**Frequency of review (minimum)**
12 and above	Once a month
8 to11	Every 2 months
4 to 7	Every 3 months
1 to 3	Every 6 months

Risk Rating Status

Initial	The risk rating identified at the time the risk was entered onto the Trust risk register as an approved risk
Current	The risk rating at the time of reporting (for the purposes of the QC, TMG and Board reports this is the 10th of the month)
Target	This is the rating value when all identified mitigations and actions have been fully implemented. This risk rating should be in line with the risk appetite for the type of risk identified

Risk Matrix and Risk Scores

See Appendix A and B

The summary details for all proposed new risks rated at 12 and above are highlighted in the tables (2 and 3) below. The Executive Directors or Risk Leads for each of the proposed new risks will provide a full report to Quality Committee as required

1. **Trust Risk Appetite – 12+ Risks Ranked by grading and associated Executive Lead** (Risk review compliance and risk action plan status)

Ref	**Title**	**Care Group or equivalent**	**Risk Rating**	**Executive lead**	**Risk review Compliance** (see definitions for timescales)	**Risk action plan status**

2. New risks rated 12 and above: to be reviewed at Quality Committee

Site	Ref	Risk Rating	Risk Details. (as described on Datix)	Lead(s)	Date opened	Status

3. Current risks increased to 12 and above rating in month

Site	Ref	Risk Rating	Details	Update	Risk Owner	Lead Executive	Date placed on risk register	Last review date	Risk trend

4. Current Risks rated at 12 and above

Site	Ref	Risk Rating	Details	Update from last review	Risk Owner	Lead Executive	Monitoring Committee	Date risk accepted as a 12+ risk	Last review date	Risk trend
Informatics/Digital Transformation										
Covid										
Equipment /Estates Risks										
Workforce Risks										
Transformation Risks										
Finance Risks										

5. Closed, Reduced or suspended Risks previously rated at 12

Site	Ref	Risk Rating	Details	Update	Risk Owner	Date risk accepted as a 12+ risk	Last review date	Date closed or reduced

One Acute Network - Current Risks

A high level summary of the risk picture is shown below:-

Programme	Risks at 12+	New	Comments
TOTAL			

*****Summary statement

6. Risk Heat Map

Current Risk Grading		Likelihood				
		No harm (1)	Minor (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Severity	Almost Certain (5)					
	Likely (4)					
	Possible (3)					
	Unlikely (2)					
	Rare (1)					

Current Risk score by month – rolling year (at the point of report date – taken as preceding month)

Current Risk Score– UDH total	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	May 22
Very Low (1-3)												
Low(4-6)												
Moderate(8-10)												
Moderate(12)												
High (15 -25)												
Total number of risks under review												

7. Compliance and Risk Appetite

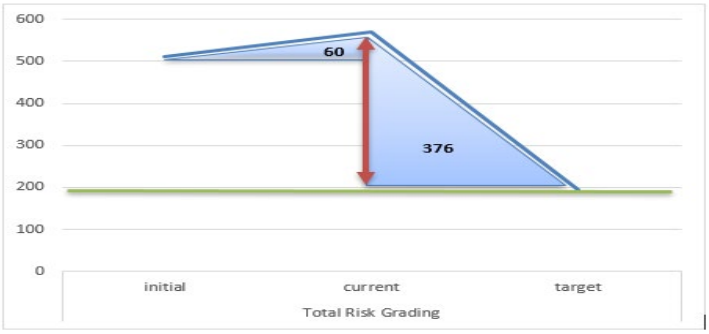
Summary of compliance:

Current Risk Grading	*No: of risks under review*	*Number of Risks compliant with Risk Appetite timescales*	*% of Risks Compliant with Risk Appetite timescales*	*Month on month position*
12 and above				
8 to11				
4 to 7				
1 to 3				
Total				

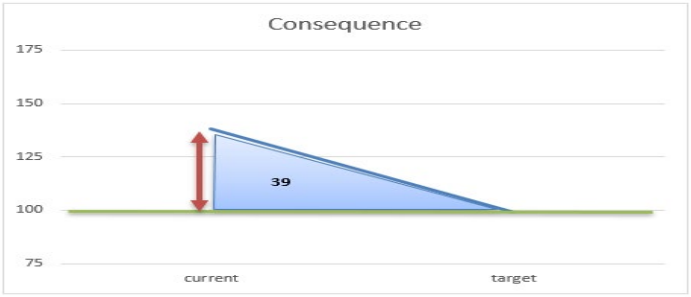
Risk Appetite:

Ref	Title	Rating (current)	Risk level (current)	Rating (Target)	Target Level

Total Risk grading:



Consequence:



Likelihood:

To note: the shaded areas represents the number of grading 'points' between Current grading or rating and attaining Target grading or rating

8. Recommendations

The Committee is asked to:

- Receive and consider reports from the Executive Lead for any new risks graded 12+.
- Review the adequacy of the risk rating, controls and mitigations and confirm if the new 12+ risks should be presented to the Board of Directors for acceptance.
- Review the adequacy of any current risks graded 12+ and consider any additional risks graded 12+for inclusion on the Trust Risk Register

Appendix E Model risk Matrix for Patient Safety Risk – Risk Level descriptors

Risk Grading	Likelihood x Consequence		Summary Descriptor (reference to patient safety domain only)
1	1	1	Less than annual occurrence of minimal injury that requires minimal intervention
2	1	2	Less than annual occurrence of evidence that overall treatment or service is suboptimal with minor implications for patient safety
	2	1	May occur annually but less than monthly - minimal injury that requires minimal intervention
3	1	3	Less than annual occurrence of evidence of significant harm to more than 50% of the patient cohort
	3	1	Every month there is evidence of minimal injury that requires minimal intervention
4	1	4	Less than annual occurrence of evidenced major injury leading to long-term incapacity/disability
	2	2	May occur annually but less than monthly and result in evidence that overall treatment or service is suboptimal with minor implications for patient safety
	4	1	Evidence of weekly occurrence that a treatment/service has significantly reduced resulting minimal injury that requires minimal intervention
5	1	5	Less than annual occurrence of evidenced issues that impacts on a large number of patients, increased probability of death or irreversible health effects occurring
	5	1	Daily evidence of minimal injury that requires minimal intervention
6	2	3	Less than annual occurrence of evidence of significant harm to more than 50% of the patient cohort
	3	2	Every month there is evidence that overall treatment or service is suboptimal with minor implications for patient safety
8	2	4	May occur annually but less than monthly and result in evidenced major injury leading to long-term incapacity/disability
	4	2	Evidence of weekly occurrence that a treatment/service has significantly reduced resulting in evidence that overall treatment or service is suboptimal with minor implications for patient safety
9	3	3	Every month there is evidence of significant harm to more than 50% of the patient cohort
10	2	5	May occur annually but less than monthly and impacts on a large number of patients, increased probability of death or irreversible health effects occurring
	5	2	Evidence of daily occurrence that overall treatment or service is suboptimal with minor implications for patient safety
12	4	3	Evidence of weekly occurrence that a treatment/service has significantly reduced resulting in significant harm to more than 50% of the patient cohort
	3	4	Every month there is evidence of major injury leading to long-term incapacity/disability

15	5	3	Evidence of daily occurrence that a treatment/service has significantly reduced with resulting harm to more than 50% of patient cohort
	3	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced monthly
16	4	4	Weekly evidence of major injury leading to long-term incapacity/disability
20	5	4	Daily evidence of major injury leading to long-term incapacity/disability
	4	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced weekly
25	5	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced daily

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Consequence score (severity levels) and examples of descriptors				
1	**2**	**3**	**4**	**5**
Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
• Minimal injury requiring no/minimal intervention or treatment. • Peripheral element of treatment or service suboptimal • Informal complaint/inquiry	• Overall treatment or service suboptimal • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved • Breech of statutory legislation • Elements of public expectation not being met • Loss of 0.1–0.25 per cent of budget • Claim less than £10,000 • Loss/interruption of >8 hours • Minor impact on environment	• Treatment or service has significantly reduced effectiveness • Repeated failure to meet statutory or contractual standards • Major patient safety implications if findings are not acted on • Challenging external recommendations/ improvement notice • 5–10 per cent over project budget • Local media coverage – long-term reduction in public confidence • Loss of 0.25–0.5 per cent of budget	• Major injury leading to long-term incapacity/disability • Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ independent review • Low performance rating • Uncertain delivery of key objective/service due to lack of staff • Enforcement action • Multiple breeches in statutory duty • Improvement notices • National media coverage with <3 days service well below reasonable public expectation • Non-compliance with national 10–25 per cent over project budget • Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million	• An issue which impacts on a large number of patients, increased probability of death of irreversible health effects • Gross failure to meet national standards • Multiple breeches in statutory or regulatory duty • Prosecution • National media coverage with >3 days service well below reasonable public expectation. • Incident leading >25 per cent over project budget • Non-delivery of key objective/ Loss of >1 per cent of budget • Loss of contract / payment by results • Claim(s) >£1 million • Permanent loss of service or facility • Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
	Not expected to occur for years	Expected to occur at least annually	Expected to Occur monthly	Expected to occur weekly	Expected to occur daily

Appendix F: Sub-Committee or Directorate Quarterly Risk and Assurance Report to Clinical Governance Group (CGG)

Name of sub-committee/ Directorate		**Dates of meetings in last quarter**	
Chairperson		**Date of CGG meeting**	

Risk / Assurance Report The Sub-group wishes to report the following significant risk issues and / or breaches in assurance Action Plans, Risks, Learning points risk controls, audit reports to the Clinical Governance Group

For discussion and action at the Clinical Governance Group: (Please keep this as concise as possible, sticking to the main points for discussion).no more than 3 pages.	
Key Learning and Points for Information & dissemination: (Please use this space/area for dissemination of information to the group).	
Action I Feedback CGG feedback on the Directorate/Sub-group report is provided in the meeting notes and action tracker	

Appendix G:
Directorate Clinical Governance/ RAGG Meetings Agenda Template

[DIRECTORATE] RISK AND GOVERNANCE GROUP MEETING
[Date]
[Venue]

AGENDA

1.0 APOLOGIES FOR ABSENCE

2.0 MINUTES OF THE MEETING HELD ON [DATE]

3.0 MATTERS ARISING

4.0 QUALITY STRATEGY: SAFE

a) Incident Reports (Datix)
b) Serious Incidents (SI)
c) Risk Register – DATIX Web
d) Claims
e) Infection Control
f) Safeguarding

5.0 QUALITY STRATEGY: EFFECTIVE

a) Clinical Audit
b) NICE (as applicable)
c) Mortality reviews (as applicable)
d) Care Quality Commission Action Plans (as applicable)
e) Policies and Procedures
f) Research and Development Activity
g) Quality improvement

6.0 QUALITY STRATEGY: PATIENT EXPERIENCE

a) Complaints
b) FFT/ Patient Engagement activity

7.0 QUALITY MEASURES FRAMEWORK

a) Quality Dashboard

8.0 STAFF

a) Essential Core skills/ Mandatory Training
b) Appraisal

9.0 FEEDBACK, DISSEMINATION AND ESCALATION

a) Quality Governance Group (CGG) Top 10
b) Care Group

10.0 DATE, TIME AND VENUE OF NEXT MEETING

Directorate Clinical Governance/ RAGG Meetings Agenda Guide

AGENDA GUIDANCE

The standardised agenda has been developed in line with the organisations Quality Strategy and aims to provide assistance on the topics that should be discussed at Risk and Governance meetings throughout the Trust. The following is guidance on what information should be discussed under each agenda item.

QUALITY STRATEGY: SAFE

a. Incident Reports (Datix)

A progress report on all new patient safety incidents e.g. new reports in month, RCA progress and action plan approval, follow up on action plan implementation, outstanding/open reports and any trends that have been identified.

b. Serious Incidents (SI)

A progress report around all new SI's reported and any SI investigations on going. Review SI investigation timescales and discuss Duty of Candour requirements. Discuss any actions that need to be implemented and any learning that can be taken and disseminated throughout the care group.

c. Risk Register

Discuss items currently on the Risk Register and review progress of associated action plans. Review the risk rating for any new risks and ensure escalation of risks rated moderate or high to the Care Group lead. During / after each meeting the "Progress Review" section for each risk should be updated on the DATIX Web risk register to confirm that the risk and mitigation action plan has been reviewed

d. Claims

Discuss all new claims received. Any actions that require to be implemented and any learning that can be taken and disseminated throughout the care group.

e. Infection Control

Discuss compliance with infection control, e.g. MRSA, Cdiff, IC Audits, Hand hygiene etc.

f. Safeguarding

Discuss all new and ongoing safeguarding issues.

QUALITY STRATEGY: EFFECTIVE

a. Clinical Audit

Discuss any clinical audit projects that are underway or which require to be progressed. Review the results of any completed Clinical Audits on the Directorate Audit plan – Do the results raise a risk issue, what improvement actions are required, do the results need wider dissemination?

b. NICE guidelines

Discuss any new, outstanding or relevant NICE guidelines and undertake actions/baseline assessment required. Review completed baseline assessments for relevant guidance for the Directorate, if non or partially compliant does this need to be on the Directorate risk register? Is an action plan required? Do issues need escalation?

c. Mortality reviews / Learning from deaths
Discuss mortality review data.
Discuss any actions and learning points from case note/mortality reviews completed

d. Care Quality Commission *Discuss issues and action plans relating to CQC that are relevant to the Directorate/Care group.*

e. Policies and Procedures
Discuss all relevant Policies and Procedures ensuring that all are in date.

f. Research and Development Activity
Discuss (by exception) any significant research and development activity within the care group.

g. Quality improvement programmes
Discuss any quality improvement programmes on-going within the care group or going on within other areas that may be useful to implement.

QUALITY STRATEGY: PATIENT EXPERIENCE

h. Discuss all new complaints received. Review any on-going complaints investigations to ensure required timescale will be met. Any actions that require to be implemented and any learning that can be taken and disseminated throughout the care group.

i. FFT / Patient Surveys

Monitor all of the above by exception. Highlight areas of good practice and action areas of concern.

QUALITY MEASURES FRAMEWORK:

j. Quality Dashboard
Discuss Quality data for directorate data where applicable.

STAFF:

a. Essential Core skills/ Mandatory Training
b. Appraisal

FEEDBACK, DISSEMINATION AND ESCALATION

a. Quality Governance Group
b. Trust Executive Group
c. Care Group

Information discussed at the above groups should be disseminated through local governance structures and any issues that required escalation should be feedback to the above groups.

Appendix H: Risk Register Toolkit - content and link

https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/risk-register-toolkit

- Trust Risk Appetite & Statement
- Role of the Risk Register
- Acceptance onto the 'Live' Risk Register
- Risk Submission
- 12 + risk escalation
- Reviewing a risk
- Risk Closure
- Running reports
- Appendix A : Flow chart: Escalation and agreement of risks rated 12 and above
- Appendix B : Grading the Risk and Risk Matrix / Descriptors

EQUALITY IMPACT ASSESSMENT (EIA) SCREENING FORM

1. Title of document/service for assessment	Risk Management Strategy
2. Date of assessment	
3. Date for review	
4. Directorate/Service	
5. Approval Committee	

	Yes/No	**Rationale**
6. Does the document/service affect one group less or more favourably than another on the basis of:		
• Race	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Gender (including transgender)	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Religion or belief	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Sexual orientation, to include heterosexual, lesbian, gay and bisexual people	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Age	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Disability – learning disabilities, physical disabilities, sensory impairment and mental health issues	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Marriage and Civil Partnership	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Pregnancy and Maternity	No	Policy applies to all staff groups and adverse incidents are treated uniformly
7. Does this document affect an individual's human rights?	No	Policy applies to all staff groups and adverse incidents are treated uniformly
8. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	No	Policy applies to all staff groups and adverse incidents are treated uniformly

9. If the answers to any of the above questions is 'yes' then:	**Tick**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid		
Adjust the policy to remove disadvantage identified or better promote equality		
If neither of the above possible, submit to Diversity Committee for review.		

10. Screener(s)

Print name……

11. Date Policy approved by Committee	

12. Upon completion of the screening and approval by Committee, this document should be uploaded to Papertrail.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.9

Subject:	Trust Annual Security Update

Prepared by:	Dave Bennett and Malcolm Keith - A.S.M.S.
Presented by:	Mark Mould – Chief Operating Officer

Purpose of paper:	To provide an update on the Annual Security Report (2021-22) to the Hospital Board of Directors. To highlight the current risk rating relating to Trust security and actions being taken and the link to the staff survey responses.
Background:	1. An annual Security Report is a requirement under Service Condition 24 of the NHS Standard Contract. 2. The Trust has in place a Security Management Group (SMG) that reports to the Health & Safety Group chaired by the Chief People Officer who have considered the report in **Appendix A.** 3. Under the UHD Trust, there are several items that are held on the Risk Register linked to Security and increased Violence and Aggression. Top level is: 'Mental Health behaviors in physical healthcare environments' which scores at 15 (1502) and additional linked subset risks (1767,1502,1142). 4. The staff survey results 20/21 has been considered in agreeing the Security work programme for 22/23
Key points for Board members:	The Trust is required to audit against the *Violence Prevention Reduction Standards.* These are new standards nationally and no existing reference is currently in place to benchmark what good looks like. BDO (the Trust auditors) have been asked to review how compliance may be monitored and how UHD compares to peers. Initial feedback is that the Trust making substantial progress ahead of other Trusts, but further work is required. This new tool has identified that currently the Trust is 73.8% compliant with the standard.

		Compliant					
Section	**Elements**	**Y**	**N**	R	A	G	Check Total
PLAN	**14**	**12**	**2**	0	2	12	14
DO	**11**	**6**	**5**	1	4	6	11
CHECK	**12**	**10**	**2**	1	1	10	12
ACT	**5**	**3**	**2**	5	3	12	20
	42	**31**	**11**	**7**	**10**	**40**	**57**

	A task and finish group has been established to verify, challenge, support and update initial findings as proposed by the Trust Accredited Security Managers. The annual security report and Trust staff survey have identified key themes where the Trust will focus on development and improvements: • A yearly comparison on previous year's security incidents has shown an increase of reported incidents from 880 to 1064 but a reduction in quarter 4 21/22 compared to 20/21 (253 v 220) • While overall incidents have increased, the severity of the Incident indicates that the higher-level severity remains relatively low (<10%) in comparison to overall number of incidents raised but something that will remain a focus in 22/23. • Staff survey – The Trust's national report includes results on security related questions o a very low incident percentage on: 'Personal experience of physical violence from colleagues' at 2% & 'Personal experience of physical violence from managers' at 1%, which is consistent to previous years. o the reported incidence rises for the other two questions: 'Personal experience of physical violence from patients/service users' at 13% & 'When you have experienced physical violence at work did you report it' at 32%, which is consistent to previous years. o The staff survey has identified several areas that have high frequencies of incidents. SMG will monitor hot spots and support Care Group/Departmental actions plans. **Actions taken** • Introduction of a Staff Support group, which is multidisciplinary, led by a mix of clinical and non-clinical colleagues, including representatives from Health & Safety, Estates, Nursing, Comms, Risk and Staff side teams. *Note: This group was set up to rapidly set out how to improve the links and findings from the staff survey, leading task and finish groups on how to interpret the Violence Prevention Reduction Standards (VPRS) initiatives. The aim is to improve site movement logistics, also how we communicate improvements, so staff know what has changed. Three key areas to date: Incident Recording for staff, VPRS task group, staff/visitor site movement. This will report back to Health and Safety group.* • 21/22 saw additional investment of time and resource into Education and Training to support staff in dealing with incidents of Violence & Aggression that may be starting to influence the reported incidents alongside the other actions in place. • All restraints across UHD where a restraint is recorded are now post event reviewed and recorded by site and incident type. • A single provider is now in place for out of hours dedicated security attendance and a parity of service provision for both main acute sites to support and protect staff. • A pilot to introduce Body Worn Cameras produced positive initial feedback with a case to be submitted post trial for funding and implementation. There is evidence of these being used at other Trusts already and the team will be templating existing Standard Operating Procedure (SOPs) (in full) to implement • CCTV - UHD required by the Human Tissue Authorities (HTA) Standards to make improvements to mortuary access, after national case highlighted shortcomings.

	• A review of CCTV/Door access led to the following actions; o Additional access control to several doors o Increased CCTV internal to mortuary areas o Emergency Department/Urgent Treatment Centre CCTV Review - 2 main sites o Reduction in staff allocated with access rights to the Mortuary o Introduction of escorted access for non-Mortuary staff
Options and decisions required:	For information – see full H&S security report in additional reading appendix A
Recommendation:	The Board of Directors (BoD) are requested to receive and review the Annual Security Report and work plans being undertaken.
Next steps:	The report and associated work plans will be monitored via the SMG this year as part of governance checks.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	1. To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they can realise their potential and give of their best. 2. To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets. 3. To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience.
BAF/Corporate Risk Register: (if applicable)	Security was logged as risk 1767 (V&A directed towards staff and support) has now been replaced with 1502 by Risk team and risk 1511 (Emergency Department) effective security provision) has been closed in last financial year.
CQC Reference:	All domains

Committees/Meetings at which the paper has been submitted:	**Date**
Health & Safety Group	July 22
Security Management Group (SMG)	July 22
Trust Board	July 22

Health & Safety Group
Security Briefing Paper: (Data April 21 to March 22)

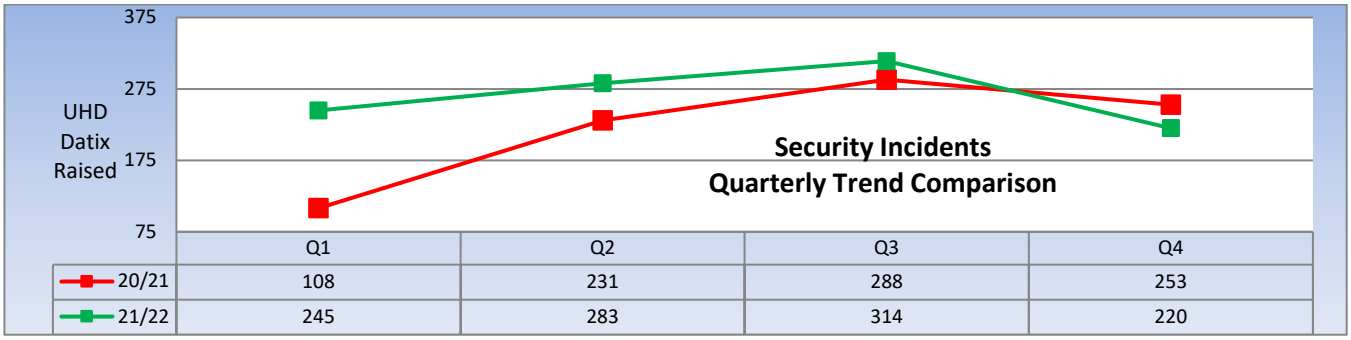
1. Introduction

The purpose of this paper is to update the Health & Safety Group on security related incidents for April 2021 – March 22 and to provide updates on UHD initiatives completed or in progress over the year. The report has been prepared using data collated from the Datix Web reporting system. Data correct as of 28th March 2022 and will have been ratified through the Security Management Group (SMG).

Risk Register - Security was logged as risk 1767 (Risk to Portering Support – level 8) and risk 1511 (ED effective security provision) and is currently under review now as Allied security (dedicated ED security provision) are in place across both main sites.

2. Yearly Comparisons

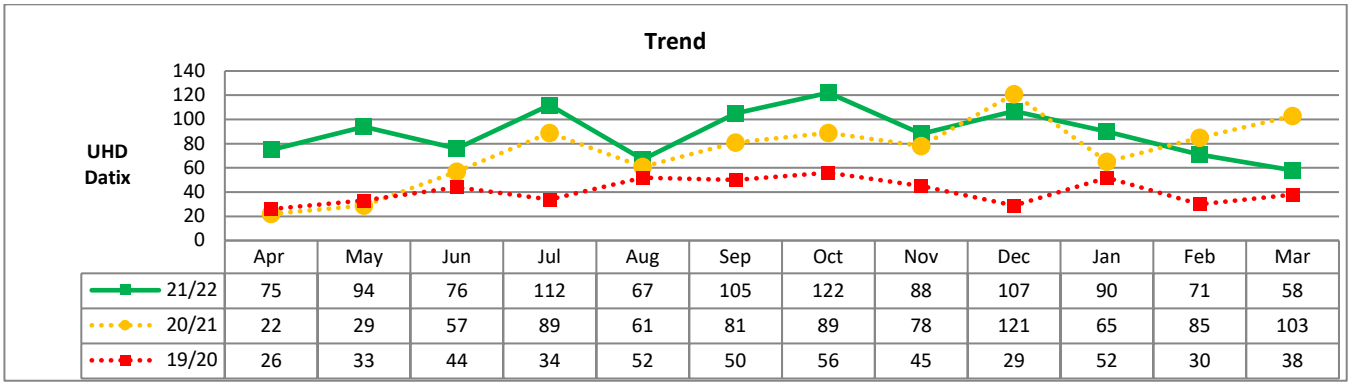
Trend Analysis – comparison



	Q1	Q2	Q3	Q4
20/21	108	231	288	253
21/22	245	283	314	220

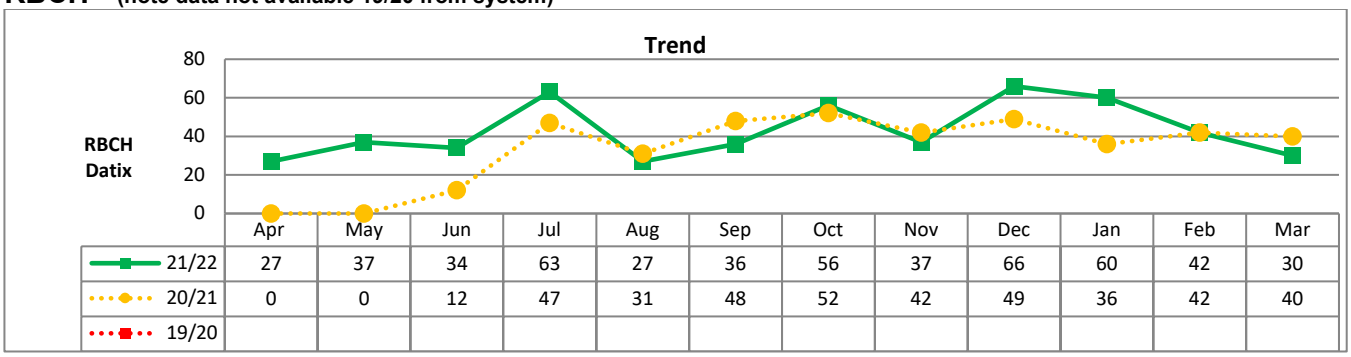
Trend indicated a gradual increase in the number of incidents reported showing a peak during Q3. Q4 returning to lower than those expected numbers when compared to 2020 – 21.

UHD



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
21/22	75	94	76	112	67	105	122	88	107	90	71	58
20/21	22	29	57	89	61	81	89	78	121	65	85	103
19/20	26	33	44	34	52	50	56	45	29	52	30	38

RBCH * (note data not available 19/20 from system)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
21/22	27	37	34	63	27	36	56	37	66	60	42	30
20/21	0	0	12	47	31	48	52	42	49	36	42	40
19/20												

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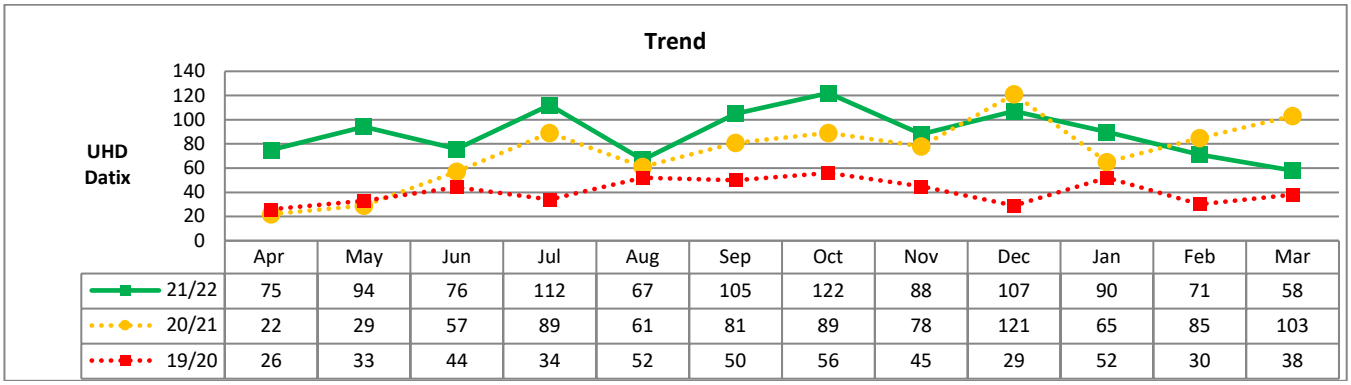
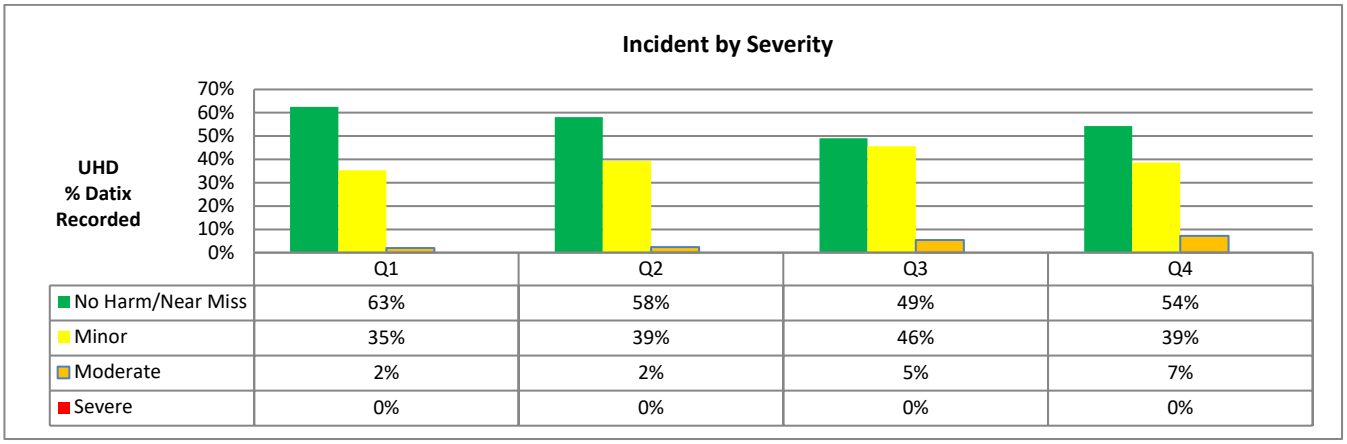


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
21/22	75	94	76	112	67	105	122	88	107	90	71	58
20/21	22	29	57	89	61	81	89	78	121	65	85	103
19/20	26	33	44	34	52	50	56	45	29	52	30	38

There was a noticeable decrease in both the level of reports towards year end, this may be attributed to the level of activity, which was reduced due to the impact of Covid and lower footfall. Improvements also noted with the additional investment of time and resource into Education and Training to support staff in dealing with incidents of Violence & Aggression.

3. Security Related Incidents (Behavioural) – Severity



	Q1	Q2	Q3	Q4
No Harm/Near Miss	63%	58%	49%	54%
Minor	35%	39%	46%	39%
Moderate	2%	2%	5%	7%
Severe	0%	0%	0%	0%

Report indicates that the higher-level severity remains relatively low in comparison to overall number of incidents raised.

Restraint

There was a total of 264 incidents across UHD where a restraint was recorded. The tables below indicated where a restraint was recorded by site and incident type.

Note any restraint is post event reviewed so represent significant resource implications on top of the actual incident and these are registered under Datix in various formats.

RBH

Bournemouth Site	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	4	2	4	7	2	5	2	5	11	3	1	7	53
Patient Restraint Processes	0	0	2	5	2	6	7	2	7	9	4	2	46
Uncooperative/Stubborn patient Behaviour	2	0	0	0	2	0	4	3	4	3	4	0	22
Missing Patient (absconded/abducted patient)	1	1	0	1	2	0	0	0	0	1	1	0	7
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure	0	2	1	0	0	0	1	0	0	1	0	0	5
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	0	0	0	1	0	2	0	1	1	0	0	0	5
Self-harming Behaviour	0	0	0	2	0	0	0	0	0	0	1	0	3
Patient refusal of diagnostic/therapeutic recommendations/interventions	0	1	0	0	0	0	0	0	0	0	0	0	1
Persons Performing Unauthorised Acts	0	1	0	0	0	0	0	0	0	0	0	0	1
Total	7	7	7	16	8	13	14	11	23	17	11	9	143

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Poole Site	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
Patient Restraint Processes	13	1	3	1	2	1	1	4	5	2	3	4	40
Inappropriate/Aggressive Behaviour towards Staff by a Patient	1	5	3	3	3	1	5	2	4	0	4	1	31
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure	0	0	0	4	4	0	4	3	2	2	0	1	20
Uncooperative/Stubborn patient Behaviour	0	0	0	1	2	2	0	1	4	1	2	0	13
Self-harming Behaviour	0	1	0	1	2	1	1	0	0	3	0	0	9
Missing Patient (absconded/abducted patient)	0	0	0	0	2	0	1	0	0	1	0	0	4
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	0	0	0	0	1	0	0	1	0	0	0	0	2
Use/Possession of Prohibited/Stolen Goods	0	0	0	0	0	0	1	0	0	0	0	0	1
Total	14	7	6	10	16	5	13	11	15	9	9	6	121

All incidents of restraint reported are followed up by Risk Management, under the post restraint review process. The introduction of Post Restraint Investigation Meeting (PRIM) has proved successful in ensuring restraints are investigated for appropriateness, legal frame works and learning outcomes.

Trauma Risk Investigation Meeting (TRIM) whilst relatively new is seen as an extremely useful tool in the support of staff who have been exposed to upsetting circumstance.

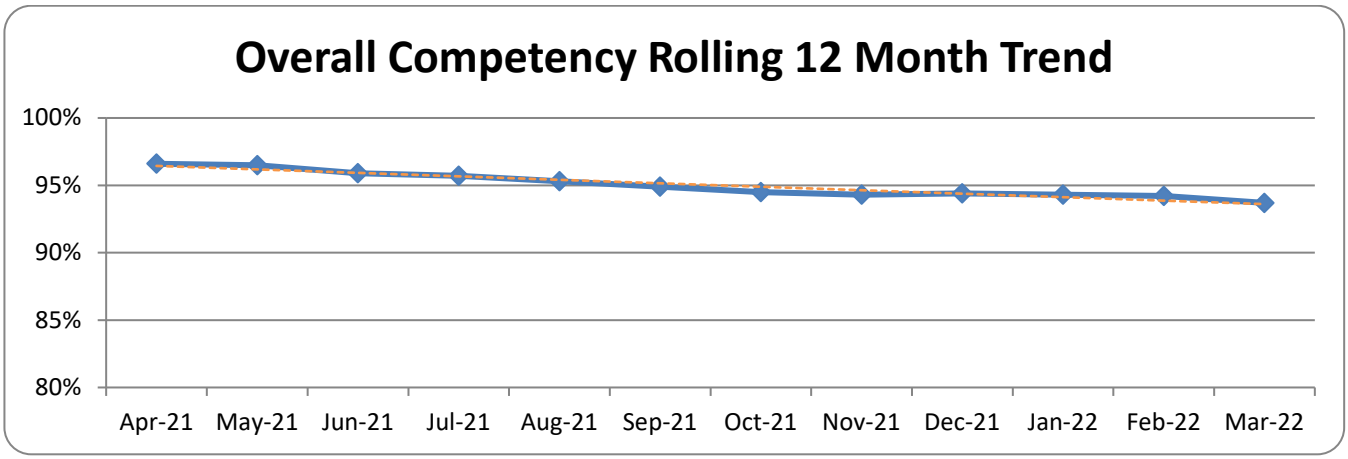
4. Warnings Issued & Multi-Disciplinary Team Meetings

103 warning letters were issued in period. These warning would be because of incident reports including those of a racial, religious, gender and or violent aggressive nature. Warnings are issued in line with the Violence Prevention & Reduction policy (formerly Violence & Aggression Policy)

5. Other Issues & Updates

Training compliance (Target is 95%)

RBH



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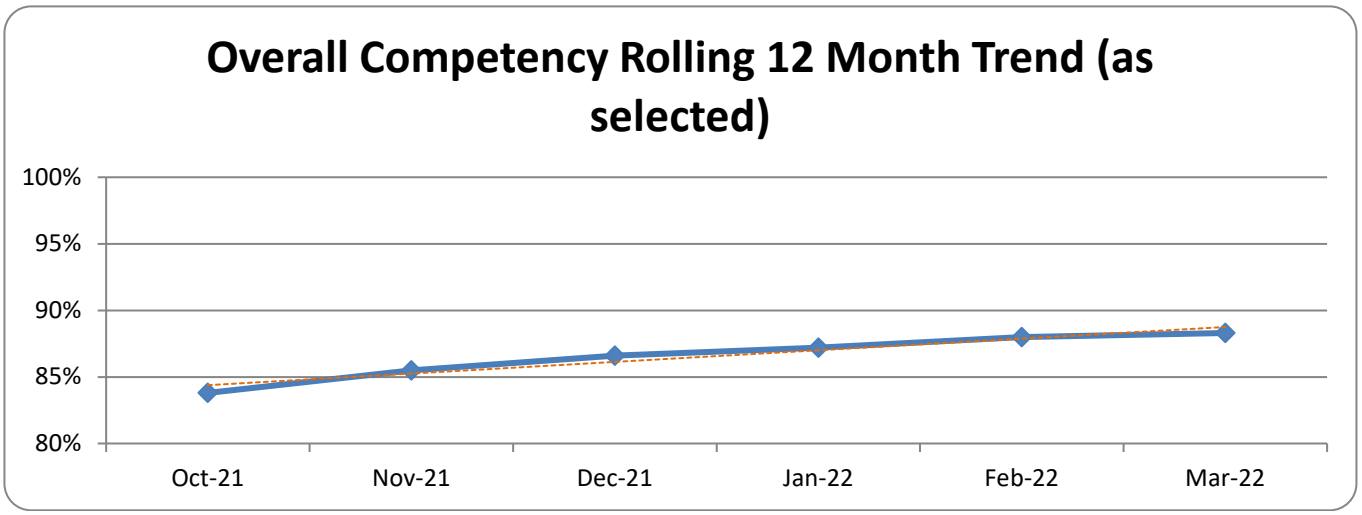
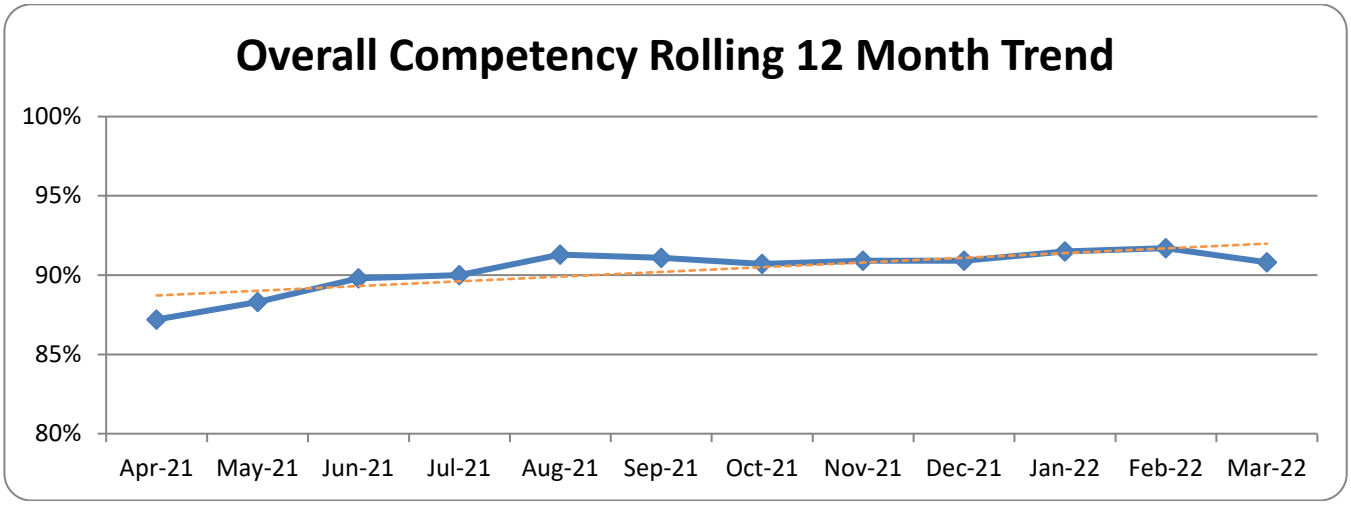


Conflict resolution (Face to face)

RBH



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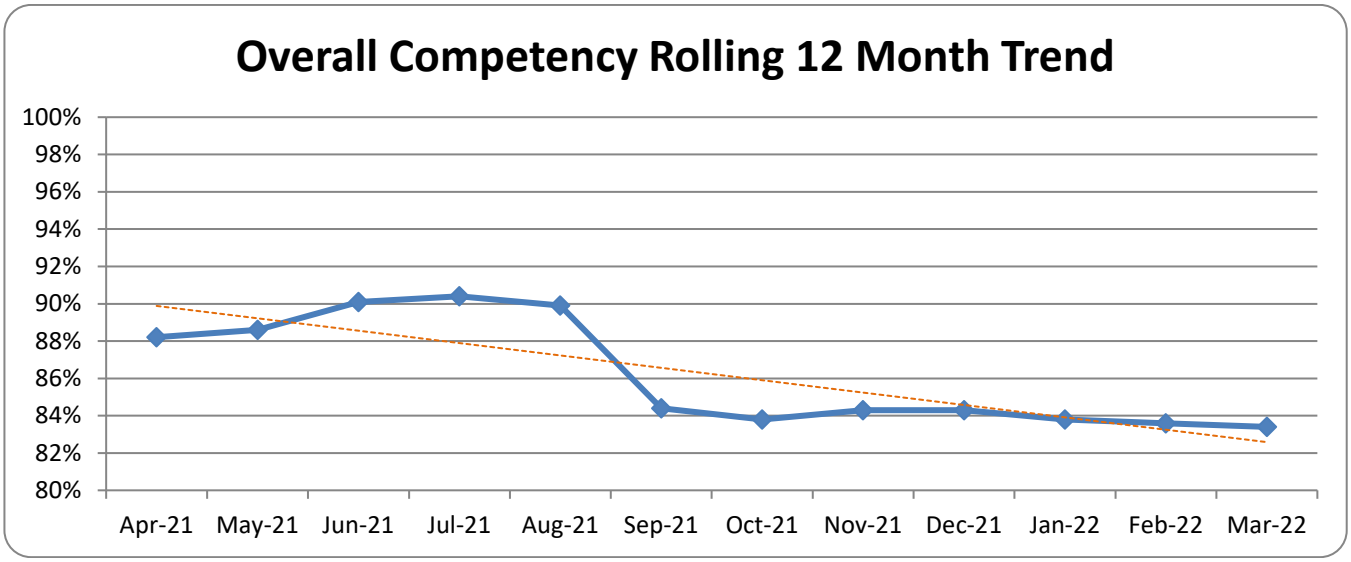


Where compliance is low or seen to be in decline this is raised at the Security Management Group meeting for discussion to identify actions required with relevant care group to make improvements.

Security, Violence & Fraud Training Delivery – Implemented on Poole site from October 2021 to standardise training and reporting across UHD (E-Learning -see charts)

In terms of education and training, significant steps in terms of developing training programmes to help support staff in managing patients (and relatives) with behaviours that can be challenging.

Feedback from staff on Conflict de-escalation training courses, staff survey and in various meetings over the years, around dealing with behaviours that challenge led to more work on developing supportive training modules for staff in specific areas of the Trust who experience more difficulties than others. Actions that have been agreed after a review of staff survey feedback are listed below;

1. Training representation involved in security & safety meetings & linking to various groups over the years to support staff with managing enhanced care for our different patient groups, some of whom can display violence towards staff.
2. Breakaway & Safe holding Training (3-hour practical programme across UHD), for staff working with patients from OPM, ED, AMU in particular (working with DHUFT).
3. Based on feedback from staff working in ED & AMU -Mental Health steering group agreed Mental Health Awareness training delivered for staff working with patients with mental health needs coming into an acute hospital, and often displaying behaviours that can be challenging (working with Psych Liaison).
4. Bespoke conflict de-escalation training for ED staff in response to requests from ED trainers.
5. Bespoke sessions for Ward 5 (RBH) to look at ways to reduce V&A from patients living with Dementia, in response to feedback from their staff regarding increase in incidents.
6. Linking staff training to staff support, this has looked at training programmes available nationally and locally to offer extra support for staff – Education Lead LM introduced TRIM to RBH/UHD
7. Linking TRIM support to staff affected by incidences of V&A. TRIM practitioners available across UHD and follow up post incidents.
8. Training reviews based on staff feedback through staff survey, feedback on Conflict Resolution (CRT L1) training, in meetings and in discussions with practice educators and matrons around needs of their staff.
9. Bespoke training for external security staff coming to work in an acute hospital to look at how we work and support our patients – sessions on mental health, Dementia, supporting Trust values.
10. Highlighting recommendations for more security trained staff – Prevention Management of Violence and Aggression (PMVA) training and for more Mental health trained staff.

Preventative Management of Violence & Aggression (PMVA) Training

This training is provided to support the security response team with enhanced de-escalation skills and application of restraint as a last resort.

Poole	Count	Compliant	Unfit	Non-Compliant	%
Porters	47	42	5	0	100%
Security	12	9	2	1	92%
RBCH					
Porters	37	31	5		97%
Total	**96**	**82**	**12**	**1**	**98%**

Violence Prevention & Reduction Standards

Violence and aggression is a concern in most health care settings. Repeated exposure to violent and aggressive behaviour can have a highly negative effect on staff morale and performance. It can leave staff feeling vulnerable, and undervalued. It can also be very costly to the organisation as it may also result in high levels of sickness and failure to retain staff.

In January 2021 NHS Improvement published the Violence Prevention and Reduction (VPR) Standards to provide a risk-based framework to support a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

The definition of violence that is being used in this context is: ‘the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.” This definition includes verbal assaults and aggressive behaviour. The NHS does not accept violence or the threat of it as an inevitable part of daily routine and aims to develop a culture of effective prevention and reduction and management of violence. The Assault on Emergency Workers (Offences) Act 2018 has increased the maximum custodial punishment for violence against NHS staff from six months to a year.

The standards state that all NHS Commissioners and all providers of NHS-funded services operating under the NHS Standard Contract should ‘have regard’ to the standards and are required to review their status against it and provide board assurance that they have met the standards twice a year.

At University Hospitals Dorset, compliance with the VPR Standards is currently being managed and monitored by the Operations and Facilities team who have RAG (Red, Amber Green) rated the Trust's compliance with each element of the standards under the four headings: Plan, Do, Check and Act. This has identified that currently the Trust is 73.8% compliant with the standard.

		Compliant					
Section	**Elements**	**Y**	**N**	R	A	G	Check Total
PLAN	**14**	**12**	**2**	0	2	12	14
DO	**11**	**6**	**5**	1	4	6	11
CHECK	**12**	**10**	**2**	1	1	10	12
ACT	**5**	**3**	**2**	5	3	12	20
	42	**31**	**11**	**7**	**10**	**40**	**57**

A task and finish group has been established to verify, challenge, support and update initial findings as proposed by the Trust Accredited Security Managers.

Audit

To verify Trust VPRS findings BDO (the Trust auditors) have been asked to review how compliance may be monitored and how we compare to peers. Initial feedback is UHD are making good some progress ahead of other Trusts.

Staff survey results (see also appendix 3 survey currently available)

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)

13a. In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	2020		2021		Comparator	
	n	%	n	%	n	%
Never	2,787	86%	2,929	87%	185,285	86%
1-2	286	9%	264	8%	18,827	9%
3-5	82	3%	100	3%	6,427	3%
6-10	40	1%	27	1%	2,021	1%
More than 10	51	2%	53	2%	2,538	1%
Missing	25		20		1,191	
Positive Score	86%		87%		86%	
Negative Score	14%		13%		14%	
Base	3,246		3,373		215,098	

13b. In the last 12 months how many times have you personally experienced physical violence at work from managers?	2020		2021		Comparator	
	n	%	n	%	n	%
Never	3,222	100%	3,336	99%	212,373	99%
1-2	8	0%	18	1%	930	0%
3-5	2	0%	2	0%	246	0%
6-10	0	0%	0	0%	99	0%
More than 10	0	0%	0	0%	114	0%
Missing	39		37		2,527	
Positive Score	100%		99%		99%	
Negative Score	0%		1%		1%	
Base	3,232		3,356		213,762	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (CONTINUED)						
13c. In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	2020		2021		Comparator	
	n	%	n	%	n	%
Never	3,172	99%	3,272	98%	208,421	98%
1-2	31	1%	53	2%	2,722	1%
3-5	4	0%	4	0%	539	0%
6-10	3	0%	0	0%	162	0%
More than 10	1	0%	1	0%	172	0%
Missing	60		63		4,273	
Positive Score	99%		98%		98%	
Negative Score	1%		2%		2%	
Base	3,211		3,330		212,016	

13d. The last time you experienced physical violence at work, did you or a colleague report it?	2020		2021		Comparator	
	n	%	n	%	n	%
* *Yes, I reported it*	*185*	*47%*	*192*	*51%*	*12,470*	*49%*
* *Yes, a colleague reported it*	*62*	*16%*	*54*	*14%*	*3,540*	*14%*
* *Yes, both myself and a colleague reported it*	*10*	*3%*	*11*	*3%*	*766*	*3%*
* *No*	*133*	*34%*	*122*	*32%*	*8,641*	*34%*
Don't know	31	7%	33	7%	2,137	7%
Not applicable	51	11%	50	11%	3,055	10%
Missing	2,799		2,931		185,680	
Positive Score	66%		68%		66%	
Negative Score	34%		32%		34%	
Base	390		379		25,417	

The above staff survey findings for 2021 have also been included in the Violence Prevention & Reduction Standards and where practical to do so will be addressed in the relevant sections of Plan, Do, Act and Check. All incidents are shared with the Care Groups and Departments for individual remedial plans. The staff survey has identified several areas that have high frequencies of incidents. SMG will monitor hots spots and support Care Group/Departmental actions plans. The Trust severity levels have shown previously very low incident at the most severe level. Where necessary the warning letter process is instigated and reviewed via SMG. This for example has resulted in an introduction of Out of Hours security presence at the Poole site to match the Bournemouth arrangements.

Strategy

To be agreed, that the People Directorate who have potentially the most influence across the range of issues and culture raised to ensure that staff concerns are addressed in the appropriate manner and that these actions are communicated widely.

Staff Survey that the Trust's national report includes results on security related questions. These are Q13a, Q13b, and Q13 c and Q14 a, Q14 b, and Q14c, which feature in the We are Safe and Healthy section of our national report (attached) from pages 45 to 53. Overall, for this People Promise, the report also shows this People Promise result by experience on page 19.

In terms of responding to acting on the voices given to this Staff Survey:

- All national reports have been made available on the Staff Survey intranet page so that all staff have access to the results, including those which relate to staff security and safety.

- There is a Staff Survey 'action planning' tool available which enables teams to look at their areas of concern shown in the heat map, enabling actions to respond to staff views in that area to be recorded and monitored.

- Heat Maps have again been commissioned and secured. These include question level reporting at departmental level for all departments where 11 or more staff have taken part in the Staff Survey. There is also directorate level reporting across the questions. This means that we can understand and act on staff experience at local level.

Although the survey results in the national reports are set out by People Promise, including the promise that 'We are safe and healthy' the heat map reporting follows the question sections of the survey questionnaire.

The Trust Staff Survey 2021 Management Report is also attached to this report, released before the national reports and so based on our initial and non-benchmarked results, which contains staff security information on page 15.

Staff Support group

Multidisciplinary group to be led by a mix of clinical and non-clinical colleagues, including representatives from Health & Safety, Estates, Nursing, Comms, Risk and Staff side teams.
This group was set up to short term set how to improve the links and findings such as staff survey, leading some task and finish groups on how to interpret the VPRS initiatives. To improve site movement logistics, also how we communicate improvements, so staff know what has changed. Three key areas to date: Incident Recording for staff, VPR Standards task group, staff/visitor site movement. This will report back to Health and Safety group.

6. ASMS Work Update

Body Worn Cameras

Following a request from the UHD COO, we have engaged with Provider (Reveal) Trust IG and IT to implement 30-day (free) trial November (IT support dependant) 2021.

Initial feedback from users is positive with a case to be submitted post trial for funding and implementation. There is evidence of these being used at other Trusts already and we will be templating existing SOPs (in full) to implement at UHD. The intention is to limit the areas these are used with staff that are trained and development of clear protocols for use.

Mortuary and Emergency Department Security Reviews

Mortuary – improvement implemented across 3 sites

Work undertaken to review the security provision for the mortuaries across UHD as required by the Human Tissue Authorities (HTA) Standards. Recommendations have been made to the Cell Sciences Manager to fully comply with standards, cost circa £35k to include:

- Additional access control to several doors
- Increased CCTV internal to mortuary areas
- Reduction in staff allocated with access rights to the Mortuary
- Introduction of Escorted access for non-Mortuary staff

These works have now been accepted and implemented.

Emergency Department/Urgent Treatment Centre CCTV Review - 2 main sites

At the request of Emergency Department (ED) matron, a review was undertaken to identify gaps in CCTV coverage of potential ‘hot spots’ across ED. A recommendation paper has been places with ED matron to consider and if acceptable gain support, cost circa £23 K

Both above contained requirement for additional CCTV this would require additional capacity to the current operating system which contributed to the higher than anticipated costs.

This work has been accepted and implemented.

Additional External Sites Support

Security Reviews have been conducted with recommendations for ‘Beales’ the Outpatient Assessment Clinic and Yeoman’s House.

The Clinic works are complete however there are still some issues to resolve with regards intruder alarm monitoring response at Yeomans House. Discussion for a suitable solution is ongoing.

Pharmacy CCTV review for the implementation of additional CCTV to the robot facilities and dispensing areas.

Emergency Department Alignment of Security

A single provider is now in place for out of hours dedicated security attendance and a parity of service provision for both main ED sites to support and protect staff.

UHD Documentation Review

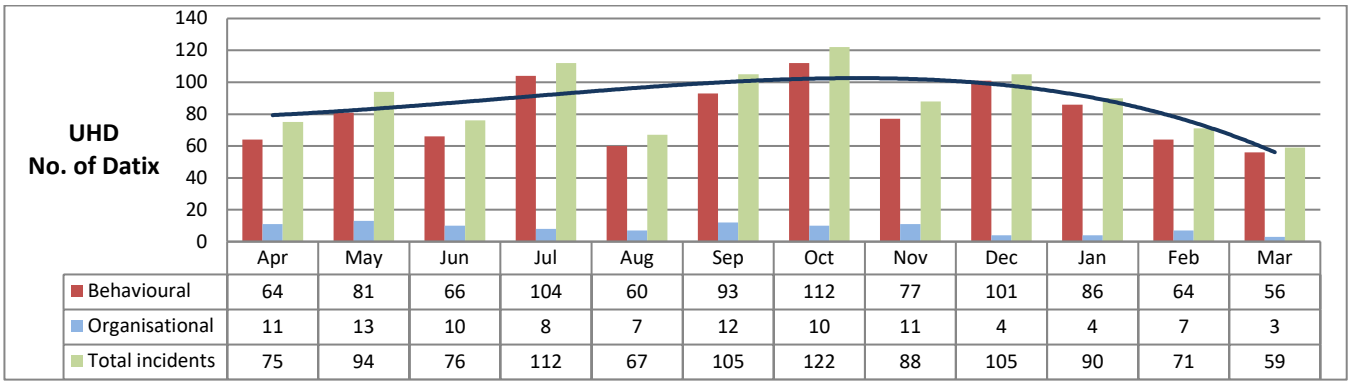
Several documents have been reviewed, updated to reflect UHD alignment and submitted to Policy & Procedure Group.

- Security Management Policy
- Violence Prevention & Reduction Strategy
- Violence Prevention & Reduction Policy
- Lone Worker Policy
- Missing Person Procedure

Appendix 1 - Datix reported incidents - UHD

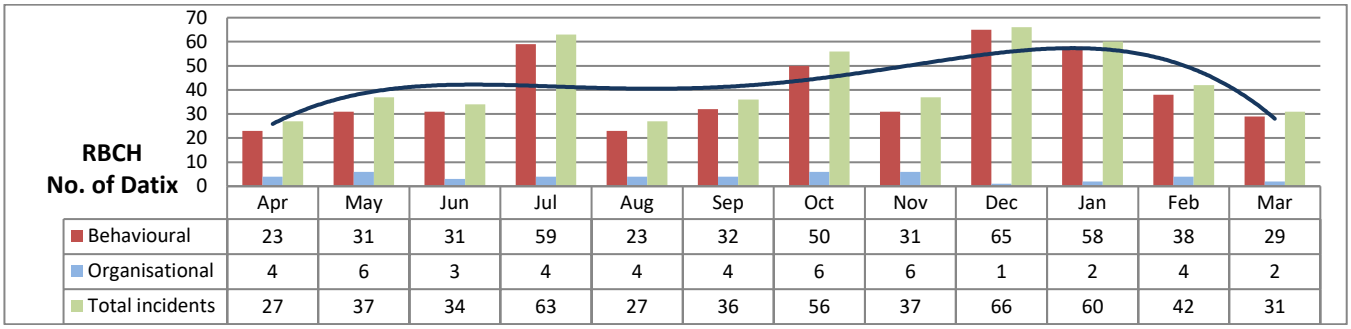
The graphs below illustrate the number of security related incidents reported by incident group.

UHD



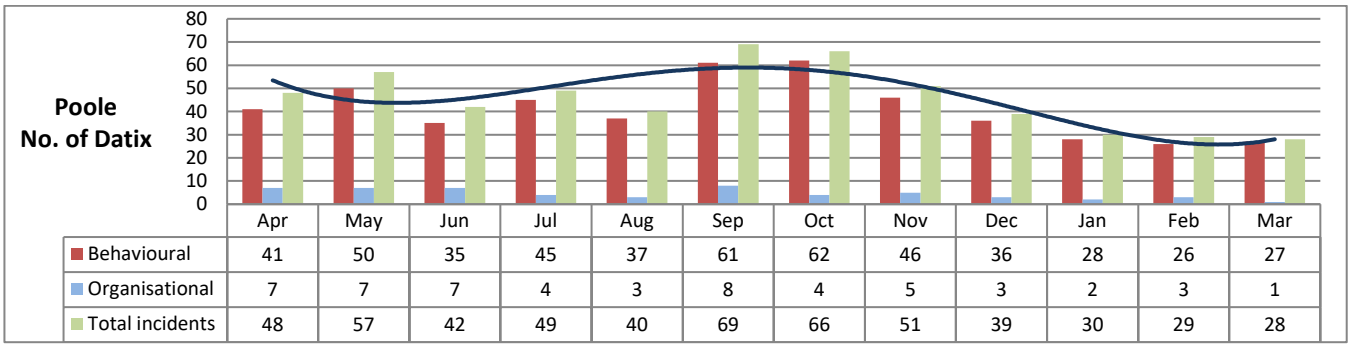
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Behavioural	64	81	66	104	60	93	112	77	101	86	64	56
Organisational	11	13	10	8	7	12	10	11	4	4	7	3
Total incidents	75	94	76	112	67	105	122	88	105	90	71	59

RBCH



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Behavioural	23	31	31	59	23	32	50	31	65	58	38	29
Organisational	4	6	3	4	4	4	6	6	1	2	4	2
Total incidents	27	37	34	63	27	36	56	37	66	60	42	31

PH



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Behavioural	41	50	35	45	37	61	62	46	36	28	26	27
Organisational	7	7	7	4	3	8	4	5	3	2	3	1
Total incidents	48	57	42	49	40	69	66	51	39	30	29	28

It is unclear as to why there has been a decrease in the number of reported incidents but could be attributable to the Trauma Risk Investigation Meeting and Post Restraint Investigations Meeting processes and the feedback this has given to staff involved.

Appendix 2 - Top Reported Incidents

The tables below show the top reported incidents by type per quarter

UHD Behaviour Related Incidents	Q1	Q2	Q3	Q4	12 month
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure	8	15	23	14	**60**
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	7	14	21	13	**55**
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	4	4	3	2	**13**
Inappropriate/Aggressive Behaviour towards a Patient by Staff	4	2	5	4	**15**
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	15	42	17	10	**84**
Inappropriate/Aggressive Behaviour towards Staff by a Patient	118	120	169	113	**520**
Inappropriate/Aggressive Behaviour towards Staff by Staff	15	16	10	6	**47**
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	1	0	0	0	**1**
Inappropriate/Aggressive Behaviour towards Visitor by a Visitor	1	0	0	1	**2**
Inappropriate/Aggressive Behaviour towards Visitor by Staff	0	1	1	0	**2**
Missing Patient (absconded/abducted patient)	13	28	12	15	**68**
Patient Restraint Processes	19	14	23	22	**78**
Persons Performing Unauthorised Acts	3	0	1	0	**4**
Use/Possession of Prohibited/Stolen Goods	3	1	5	6	**15**

Behavioural Incidents

UHD Behaviour Related Incidents	Q1	Q2	Q3	Q4	12 months
Inappropriate/Aggressive Behaviour towards Staff by a Patient	118	120	169	113	**520**
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	15	42	17	10	**84**
Patient Restraint Processes	19	14	23	22	**78**
Missing Patient (absconded/abducted patient)	13	28	12	15	**68**
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure	8	15	23	14	**60**
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	7	14	21	13	**55**
Inappropriate/Aggressive Behaviour towards Staff by Staff	15	16	10	6	**47**
Inappropriate/Aggressive Behaviour towards a Patient by Staff	4	2	5	4	**15**
Use/Possession of Prohibited/Stolen Goods	3	1	5	6	**15**
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	4	4	3	2	**13**
Persons Performing Unauthorised Acts	3	0	1	0	**4**
Inappropriate/Aggressive Behaviour towards Visitor by a Visitor	1	0	0	1	**2**
Inappropriate/Aggressive Behaviour towards Visitor by Staff	0	1	1	0	**2**
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	1	0	0	0	**1**
Total	**211**	**257**	**290**	**206**	**964**

Organisational Incidents

UHD Organisational	Q1	Q2	Q3	Q4	12 month
Break in/Forced Entry (proven, alleged or suspected)	0	0	2	0	**2**
Missing/Lost Property	23	21	20	11	**75**
Other	1	2	1	0	**4**
Property Theft (proven, alleged or suspected)	1	2	0	0	**3**
Theft (proven, alleged or suspected)	4	0	0	0	**4**
Trespassing/Intrusion	1	1	1	2	**5**
Unauthorised access/disclosure	0	0	0	0	**0**
Unconsented or Unauthorised use	0	0	0	0	**0**
Unconsented or Unauthorised use of Property	0	0	0	0	**0**
Vandalism (proven, alleged or suspected)	4	1	3	1	**9**
Total	**34**	**27**	**27**	**14**	**102**

Appendix 3 – Staff survey

University Hospitals Dorset NHS Foundati

ST21 Management Report - Full report -

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 7.10

Subject:	Committee Annual Reports

Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance & Sarah Locke, Deputy Company Secretary
Presented by:	Committee Chairs

Purpose of paper:	Reports have been prepared and approved by the following Committees of the Board: • the Audit Committee; • Charitable Funds Committee; • Finance and Performance Committee • Private Patients Strategy Committee; • Quality Committee; • Sustainability Committee; • Transformation Committee; and • Workforce Strategy Committee to set out how each of such Committees has satisfied its terms of reference during the period for the financial year ended March 2022 and to seek to provide the Board with evidence relevant to each Committees' responsibilities.
Background:	Monitor's (NHS Improvement's) Code of Governance provides that the Board of Directors should undertake a formal and rigorous evaluation, not only of its own performance, but also that of its sub-committees on an annual basis.
Key points for Board members:	Summary conclusions from the reports were: • That the Audit Committee and Workforce Strategy Committee complied with their respective terms of reference during 2021/22; • That the Charitable Funds Committee, Finance & Performance Committee, Private Patients Strategy Committee, Quality Committee, Sustainability Committee and Transformation Committee predominantly complied with their terms of reference during the period. General observation: Some of the Committees' Terms of Reference provide for the agenda/papers/minutes to be circulated to members of the Board of Directors, with this

	not having occurred during the period. In addition, some (but not all) of the Committees Terms of Reference provide that there should be a section in the Trust's annual report relating to the work of the Committee, which was not included in the 2020/2021 Annual Report.
Options and decisions required:	None.
Recommendations:	That the Committees' Terms of Reference be reviewed and refreshed (whether as part of the annual review or on an off-cycle basis).
Next steps:	

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	**To be a well governed and well managed organisation** that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well led domain

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AUDIT COMMITTEE ANNUAL REPORT APRIL 2021 – MARCH 2022

1 PURPOSE OF THE REPORT

1.1 The Audit Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during 2021/22 and seeks to provide the Board with evidence relevant to its responsibilities for the Annual Governance Statement.

1.2 The Audit Committee terms of reference, which cover the main aspects of the NHS Audit Committee Handbook (HFMA), set out the constitution, membership and attendance, frequency of meetings, quorum, notice of meetings, accountability, authority, responsibilities, relationships with other committees, reporting mechanisms, process, monitoring and review.

2 OVERVIEW

2.1 The existence of an independent audit committee is the central means by which the Trust Board ensures that effective control arrangements are in place. In addition, the Audit Committee provides an independent check upon the executive arm of the Board of Directors together with the Quality Committee, Finance and Performance Committee, Workforce Strategy Committee, Transformation Committee and Sustainability Committee.

2.2 The Committee independently reviews, monitors and reports to the Board of Directors on the attainment of effective control systems and financial reporting processes. In particular, the Committee's work focuses on the framework for; risk management, integrated governance, external and internal audit, clinical audit, counter fraud and other related assurances that underpin the delivery of the Trust's objectives.

2.3 The Committee receives and considers reports from both internal and external auditors, counter fraud specialists and scrutinises the Trust's annual accounts, financial statements and the annual report.

2.4 A governance cycle detailing which papers are to be expected at each Audit Committee meeting is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was reviewed in March 2022. It is attached as **Appendix 1**.

3 MEMBERSHIP

3.1 The Committee membership in respect of the financial year 2021/22 comprised:

- Mr Philip Green, Non-Executive Director and Committee Chair
- Mr Stephen Mount, Non-Executive Director
- Mr John Lelliott, Non- Executive Director
- Mr Pankaj Dave, Non-Executive Director

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 The annual review of the Committee's terms of reference was completed in October 2021. This compromised of minor changes to wording around the Committee minutes being available to the Board of Directors, the External Auditors length of contract and the Freedom to Speak Up process. The terms of reference are subject to annual review with the next review scheduled to take place in October 2022.

4.2 The Trust Chair is not a member of the Committee but may attend meetings at the invitation of the Audit Committee Chair. For the period from April 2021 to March 2022, the Trust Chair attended one Committee meeting.

4.3 One Governor from the Trust's Council of Governors may attend the Committee as an observer. For the period from April 2021 to March 2022, a Governor attended five Committee meetings.

4.4 It is usual for the External and Internal auditors and the Counter Fraud Specialist to attend all formal meetings of the Committee. There was a representative from External Auditors, Internal Auditors and the Counter Fraud Specialist at all meetings from April 2021 to March 2022.

4.5 The Chair of the Committee allows the External Auditors, Internal Auditors and Counter Fraud Specialists to raise any concerns without the presence of the Executive Team. There have been no occasions when this has been required.

4.6 The quorum of the Committee is the Chair or a nominated deputy and one other Non-Executive Director. All meetings in 2021/22 were quorate.

5 MEETINGS

5.1 There were four formal Audit Committee meetings held from April 2021 to March 2022:

- 20 May 2021
- 22 July 2021
- 21 October 2021
- 10 January 2022
- 17 March 2022

5.2 There were two formal joint Audit and Finance and Performance Committee meetings held from April 2021 to March 2022:

- 26 April 2021
- 09 June 2021

5.3 Meeting attendance is detailed in **Appendix 2**.

6 AUDIT AND COUNTER FRAUD PROVISION

Internal Audit

6.1 The Trust's Internal Auditors to 31 March 2022 were and continue to be BDO.

6.2 An assessment of performance was undertaken by members of the finance department and presented to the Committee at the 21 October 2021 meeting. The Committee concluded that the internal audit provision by BDO LLP had been effective.

6.3 The Committee received the internal audit plan at the 18 March 2021 meeting for the Trust in the period April 2021-March 2022. The 2022/23 internal audit plan was received at the 17 March 2022 meeting.

External Audit

6.4 The Trust's External Auditors to 31 March 2022 were and continue to be KPMG.

6.5 An assessment of performance was undertaken by members of the finance department and presented to the Committee at the 21 October 2021 meeting. The Committee concluded that the external audit provision by KPMG LLP had been effective.

6.6 The External Audit highlights report and the annual review of the effectiveness of the External Auditors was presented at the Council of Governors Part 1 meeting on 28 October 2021.

6.7 The annual external audit plan was presented at the Council of Governors Part 1 meeting on 27 January 2022.

Counter Fraud

6.8 Counter Fraud Services for 2020/21 were provided by RSM UK. Nationally, counter fraud services have operational responsibility for ensuring all instances of suspected fraud and corruption within the NHS are properly investigated and RSM provides this service across Dorset.

6.9 An assessment of performance was undertaken by members of the finance department and presented to the Committee at the 21 October 2021 meeting. The Committee concluded that the local counter fraud services provision by RSM UK had been effective.

6.10 The Counter Fraud Specialist is not required to attend the Joint Audit and Finance and Performance Committee.

6.11 The Committee agreed the draft Counter Fraud Work Plan for 2022/23 in March 2022.

7 DUTIES AND FINDINGS

7.1 The Committee's terms of reference were updated and approved in October 2021 as part of the annual review. The terms of reference require the Committee to review the establishment and maintenance of effective systems of:

Integrated Governance

7.2 Throughout 2021/22 the Trust had in place governance arrangements complying with various statutory, regulatory and best practice requirements; for example, NHS Constitution, NHS Act 2006 and the Health and Social Care Act 2012, the Trust's Constitution and the Provider Licence.

7.3 The Audit Committee members are also members of the Board of Directors.

7.4 The Committee received for scrutiny the Senior Information Risk Owner (SIRO) report for information governance across the Trust at the May 2021 and January 2022 Committee meetings.

7.5 The Annual Information Governance report was presented to the Committee at the July 2021 Committee meeting for noting.

7.6 The Committee reviewed the working document of the Board's assessment of compliance to the NHS Improvement's Terms of Licence out of Committee in March 2022. The NHS Improvement's Code of Governance was deferred from the March 2022 meeting to the May 2022 meeting.

Risk Management

7.7 The Committee received a report at every meeting on new risks rated 12 and above that had been added to the Trust's Risk Register since the previous meeting. The Committee also received a verbal update on the strategic ICS risks at each meeting.

7.8 The Committee received the Board Assurance Framework report for January 2021- March 2022 at the May 2021 meeting. The draft Board Assurance Framework for 2021/22 was also presented at the May 2021 meeting.

Internal Control

7.9 The Committee reviewed the losses incurred and special payments made by the Trust at each meeting. There were no losses and special payments reportable to the Committee from April 2021 to March 2022.

7.10 During 2021/22 the Committee paid particular attention to the following areas:

i) Cyber Security.

ii) Effectiveness of Board Governance post-merger.

iii) Governance and Process for managing the Capital Programme.

iv) Freedom to Speak Up Policy – revisions for Whistleblowing.

v) Review of Post Transaction Integration Plans (PTIPs).

Internal Audit

7.11 The Internal Audit work plan for 2022/23 was agreed at the March 2022 meeting.

At each meeting the Committee received an internal audit progress report detailing a summary and a review of the 2021/22 work, internal audits completed, sector updates and key performance indicators. A schedule of all the internal audits for the Trust undertaken in 2020/21 is attached as **Appendix 3.**

7.12 The Committee has overseen and supported the work of Internal Audit through:

- Agreeing the Audit Plan including the prioritisation of work.
- Considering the results of internal audit reviews.
- Suggesting areas which Internal Audit might review.

7.13 The Committee is satisfied that the delivery of the Internal Audit plan for 2021/22 has given it assurance that controls are effective and action plans are developed for improvement. Internal audit was able to confirm that the level of cooperation received from the Trust was appropriate and that the Trust had a good record of addressing recommendations arising from internal audit reviews.

Production of the Annual Report and Accounts

7.14 The Committee received a timeline for the annual report and accounts at the 20 January 2022 meeting.

8 CONCLUSION

8.1 The Committee has complied with its terms of reference during 2021/22, during which time it has:

i) reviewed reports prepared by Internal and External Auditors together with the ensuing management actions, where appropriate.

ii) reviewed reports prepared by the Counter Fraud Service together with the ensuring management actions, where appropriate.

iii) reviewed the risk register and received regular updates.

iv) reviewed Board Assurance Framework Exception Reports and the Annual Board Assurance Framework.

Philip Green
Chair of the Audit Committee, May 2022

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AUDIT COMMITTEE

GOVERNANCE CYCLE

REGULAR REPORTS

Audit Committee Minutes	Chair
Audit Committee Action List	Chair
Commercial Compliance Report	CFO
Review of Losses and Special Payments by exception £15K>	CFO
Risk Register: New Risks rated 12 and above and any changes in the risk ratings since the previous reporting period	CNO
External Audit	
External Audit Progress Report	KPMG
Internal Audit	
Internal Audit Progress Report	BDO
Counter Fraud	
Counter Fraud Progress Report	LCFS

QUARTERLY, BI-ANNUAL AND ANNUAL REPORTS

External Audit		
KPMG Audit Plan	October	KPMG
Report on the Financial Statements	May/June	KPMG
Internal Audit		
Internal Audit Annual Report	May	BDO
Internal Audit Work plan • Draft • Final	 January March	BDO
Counter Fraud Service		
Counter Fraud Annual Report	May	LCFS
Counter Fraud Draft Workplan	January	LCFS
Counter Fraud Final Workplan	March	LCFS
Chair		
Review of Terms of Reference	October	Chair
Audit Committee Annual Report	May	Chair
Company Secretary		
Audit Committee Governance Cycle	March	CoSec
Review of Scheme of Delegation (3 yearly)	October 2023	CoSec
Audit of Non-Clinical Policies	January	CoSec
Register of Interests and Gifts and Hospitality	July	CoSec
Chief Executive		
Monitor's Terms of Licence –Draft Compliance Report	March	CEO
Monitor's Code of Governance – Draft Compliance Report	March	CEO
Draft Annual Governance Statement (Annual Report)	March/May	CEO (CNO)

Quality Governance Framework	May	CEO (CNO)
Final Draft Annual Report & Accounts (inc Quality)	May*	CEO (CSTO/CFO/ CNO)
Annual Letter of Representation (re Financial Statement)	May*	CEO (CFO)
Draft Assurance for Board Governance Statement (APR)	May	CEO (CNO)
Chief Finance Officer		
Review of External Auditors' Performance	October	CFO
Review of Internal Auditor's Performance	October	CFO
Review of Counter Fraud Service Performance	October	CFO
Annual Review of Standing Financial Instructions	October	CFO
Annual Review: Going Concern	March	CFO
Final Draft Annual Financial Statement (Final Accounts)	May*	CFO
Annual Review of Losses and Special Payments	May	CFO
Chief Nursing Officer		
Annual Risk Register Review (To inform next year Audit Plan) – *confirmation by Internal Audit that it is taken into account as part of process of developing the annual plan*	March	CNO
Draft Annual Governance Statement and process for the production of the Annual Governance Statement (coming year)	May	CNO
Quality Impact Assessment Process	May	CNO
Board Assurance Framework: Risks to the Trust's Strategic Objectives	May, Oct	CNO
Draft Board Assurance Framework (coming year)	May	CNO
Chief Operating Officer		
Emergency Preparedness, Resilience and Response	May	COO
Chief Information Officer		
Cyber Security Report	Jan, Jul	CIO
SIRO Information Governance Report (Quarterly)	Jan, Mar, May, Oct	CIO
Chief People Officer		
Chief Medical Officer		
Clinical Audit Work Plan	May 2021	CMO
Clinical Audit Work Plan: progress report and any risks to the plan	January 2021	CMO
Chief Strategy & Transformation Officer		
Timeline for Annual Report and Accounts	January	CSTO
ICS Risks (Quarterly)	Jan, Mar, May, Oct	CSTO

***Joint meeting with Finance and Performance Committee in May to consider Annual Report and Accounts**

March 2022

APPENDIX 2

AUDIT COMMITTEE MEETING ATTENDANCE RECORD

2021/22

NAME OF COMMITTEE:	Audit Committee						
REPORT TO:	Board of Directors						
	MEETING DATES						
Membership (as per Terms of Reference). Please give names and/or full job title below:	26 April 2021*	20 May 2021	09 June 2021*	22 July 2021	21 October 2021	10 January 2022	17 March 2022
Philip Green (Chair) Non-Executive Director	✓	✓	✓	✓	✓	✓	✓
Pankaj Davé Non-Executive Director	✓	✓	✓	✓	✓	✓	✓
Stephen Mount Non-Executive Director	✓	✓	✓	✓	✓	×	×
John Lelliott Non-Executive Director	✓	×	✓	✓	✓	✓	✓
In Attendance:							
Debbie Fleming Chief Executive	×	✓	✓	×	×	×	×
David Moss Trust Chairman	×	×	✓	×	×	×	×
Pete Papworth Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓
Richard Renaut Chief Strategy and Transformation Officer	✓	×	×	✓	✓	×	×
Peter Gill Chief Informatics and IT Officer	×	✓	×	✓	✓	✓	×
Alyson O'Donnell Chief Medical Officer	×	×	×	×	×	✓	×
Paula Shobbrook Chief Nursing Officer	×	✓	×	×	×	✓	×
Helen Martin Freedom to Speak Up Guardian	×	×	×	×	×	✓	×
David Triplow Public Governor	✓	✓	✓	✓	×	✓	✓
Jonathan Brown KPMG, External Audit	✓	✓	✓	✓	✓	✓	✓
Rob Andrews KPMG, External Audit	×	×	×	×	×	✓	✓
Adam Spires BDO, Internal Audit	×	✓	✓	✓	✓	✓	✓
Mark Stabb BDO, Internal Audit	✓	✓	✓	✓	✓	✓	×
Heather Greenhowe RSM, Local Counter Fraud Specialist	×	✓	×	✓	✓	✓	✓
Quorate	✓	✓	✓	✓	✓	✓	✓

***** denotes joint Audit and Finance and Performance Committee.

Appendix 3

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

INTERNAL AUDIT RESOURCE CONTROL SCHEDULE

1 April 2021 to 31 March 2022

Report Issued	Design	Operational Effectiveness
Board Governance Effectiveness	N/A – Advisory	N/A – Advisory
Cultural Maturity	N/A – Advisory	N/A – Advisory
Waiting List Management	Moderate	Limited
Data Centres Environment	Moderate	Moderate
Cash Handling	Moderate	Moderate
Learning from SIs (Serious Incidents) / Deaths	Substantial	Substantial
Key Financial Systems	Substantial	Substantial
Cyber Security	Moderate	Moderate
DSP Toolkit	Substantial	Moderate

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE ANNUAL REPORT 2021/22

1 PURPOSE OF THE REPORT

1.1 The Charitable Funds Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference – which relate to the operation of the University Hospitals Dorset NHS Foundation Trust Charitable Funds (Charity Registration Number 1057366) (the "Charity") - between 1 April 2021 and 31 March 2022. The Committee seeks to provide the Board with evidence that it has met its responsibilities as set out in its terms of reference during the relevant period.

2 OVERVIEW & RESPONSIBILITIES

2.1 The Committee exists as a committee of the Trust (in its capacity as Corporate Trustee of the Charity), with the Board of Directors acting as the Board of the Trustee.

2.2 The Committee is responsible for:

- Monitoring and authorising the application of all charitable funds in accordance with the Charities Acts, external guidance and applicable legislation and to ensure that decisions on the use or investment of such funds are compliant with the explicit conditions or purpose of each donation or bequest;
- Making decisions involving the investment of charitable funds with regards to existing and subsequent legislation, policy and guidance from the Charity Commission;
- Ensuring compliance with the Trust's Standing Financial Instructions and Scheme of Delegation as applicable to charities;
- Monitoring the performance of the investment portfolio, to include the review of spending plans and balances held within individual charitable funds;
- Recommending approval to the Board of Directors of the Annual Report and Accounts of the Charity for submission to the Charity Commission;
- Receiving and reviewing the quarterly charitable funds income and expenditure accounts together with any other supporting information;
- Ensuring that expenditure is controlled and utilised on suitable projects;
- Establishing policies and procedures to ensure the effective day to day management of the charitable funds and to ensure that these procedures are followed;
- Reviewing detailed business cases relating to major investment decisions and to recommend investment or otherwise;
- Ensuring legacies are realised in a timely and complete manner;
- Safeguarding donated money;
- Review annually the overall fundraising strategy and fund raising projects and recommend schemes to the Board of Directors for approval;
- Enact the overall strategy, as set by the Board of Directors, on the use of the Charitable Fund.

2.3 The Committee receives a number of annual reports appropriate to its purpose.

2.4 A governance cycle detailing which reports are to be expected at each Charitable Funds Committee was produced and approved in November 2021 and will be formally reviewed annually and updated as necessary throughout the year. The governance cycle is attached as **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Committee comprises three Non-Executive Directors, the Chief Finance Officer, the Chief People Officer and the Chief Strategy & Transformation Officer

Membership of the Committee in 2021/22 comprised of:

- John Lelliott, Non-Executive Director and Committee Chair
- Philip Green, Non-Executive Director
- Caroline Tapster, Non-Executive Director
- Christine Hallett, Non-Executive Director *(until 31 December 2021)*
- Pete Papworth, Chief Finance Officer
- Karen Allman, Chief People Officer
- Richard Renaut, Chief Strategy & Transformation Officer

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 Until 31 December 2021, the Committee was comprised of four Non-Executive Directors until 31 December 2021. From 1 January 2022, the Committee's composition was aligned to its terms of reference, comprising three Non-Executive Directors, in addition to the Chief Finance Officer, Chief People Officer and Chief Strategy & Transformation Officer.

4.2 Four meetings took place in the period from 1 April 2021 – 31 March 2022 and all were quorate.

4.3 A formal review of the terms of reference was undertaken in November 2021. A review of the Committee's compliance with its own terms of reference was undertaken in April 2022 by scrutinising the agendas and minutes of the four Committee meetings which took place between 1 April 2021 and 31 March 2022. The findings of these reviews are summarised in section 5.

5 DUTIES AND FINDINGS

5.1 The review indicates that reports were received, scrutinised and discussed as set out in the Committee's terms of reference. The Committee discussed the following regular reports at each meeting:

- Quarterly Investment Report;
- Quarterly Fundraising Report;

- Fundraising Events[1];
- Quarterly Financial Report
- NHS Charities Together (NHSCT) Fund Allocation

5.2 At the 10 May 2021 Meeting, the Committee received the following reports:

- Merger Report
- Robert White Legacy Fund Update
- Walkerbot Robotic Tilt Table Business Case – *the Committee approved the business case in principle, subject to sufficient funds being raised*.
- Robert White Legacy Fund Manager Business Case – *the Committee delegated authority to the Chief Finance Officer and Chief People Officer to agree the length of renewal*.
- Staff Recognition Coffee Vouchers – *the Committee ratified this application, following approval by the Executive Directors*.

5.3 At the 9 August 2021 meeting, the Committee received the following reports:

- Charity Recharges - *the Committee approved the approach*.
- Financial Forecast & Compliance with Reserves Policy - *the Committee noted the report and approved the reserves policy*.
- Draft Annual Report & Accounts (Poole Hospital Charity)
- Draft Annual Report & Accounts (Royal Bournemouth Hospital Charity)
- Neuroendocrine Tumour Specialist Dietician Business Case - *the Committee approved the business case.*
- SPRING Fundraising Assistant Business Case - *the Committee approved the business case.*
- Cancer Care Social Worker Haematology/Oncology Business Case - *the Committee approved the business case.*
- Faxitron Business Case - *the Committee approved the business case.*
- Multimedia Officer Business Case - *the Committee approved the business case.*
- Christchurch Outpatient Physiotherapy Hub Business Case - *the Committee approved the business case.*
- Youth Development Officer Business Case - *the Committee approved the business case.*
- Eye Clinic Liaison Officer Funding - *the Committee approved the business case.*
- Refurbishment of Eye Unit Seminar Room - *the Committee approved the refurbishment.*
- Ultrasound Machine for Pleural Procedures Business Case - *the Committee approved the business case.*
- Christmas Staff Benefits - *the Committee approved the funding in principle, requesting a further update at the next meeting.*

5.4 At the 8 November 2021 meeting, the Committee received the following reports:

- Fund Review & Rationalisation - *the Committee approved the proposal.*

[1] From August 2021

- Charity Lottery Proposal - *the Committee approved the proposal.*
- Risk Register - *the Committee approved the Charity Risk Register subject to the "investments" risk being increased to moderate.*
- Annual Report & Accounts (Poole Hospital Charity) - *the Committee endorsed the annual report and accounts.*
- Annual Report & Accounts (Royal Bournemouth Hospital Charity) - *the Committee endorsed the annual report and accounts.*
- Charitable Funds Committee Terms of Reference - *the Committee endorsed the terms of reference.*
- Charitable Funds Committee Governance Cycle, *the Committee approved the governance cycle.*
- Christmas Staff Benefits, *the Committee approved the proposal.*
- Robert White Paediatric Oncology Service – *the Committee endorsed the business case.*
- Six Degrees of Freedom Linac couches - *the Committee endorsed the business case.*
- Robert White Legacy Fund Update & Maggies Centre Concept - *the Committee agreed to the development of a business case for the Maggie's Centre.*
- EYESI Surgical Cataract Simulator – *the Committee approved the go-ahead of the fundraising project.*
- Health Inequalities Prevention at Dorset Health Village – *the Committee approved the business case in-principle.*
- Image Capture for Women's Health – *the Committee approved the business case.*

5.5 At the 14 February 2022 meeting, the Committee received the following reports:

- Risk Register – *the Committee approved the charity risk register subject to the risk level of "investments" being increased to high.*
- Fundraising Strategy – *the Committee approved the fundraising strategy.*
- Fundraising Policies – *the Committee approved the fundraising policies*.
- Fund Rationalisation Update – *the Committee approved the continued proposal for fund rationalisation.*
- Manometry System for Assessment of Oesophageal Motility – *the Committee approved the business case.*
- Vapotherm Precision Flow Unit & Oxygen Assist Module – *the Committee approved the business case.*
- Angiojet Mechanical Thrombectomy - *the Committee approved the business case.*
- Siemens Acuson Integrated Vascular Ultrasound – *the Committee approved the business case.*
- Continuation of Wellbeing Services – *the Committee endorsed Option 3, as outlined in the business case.*

5.6 Under the current governance cycle, the Committee's Annual Report should have been presented in May 2021; however, this did not occur during the period; a governance cycle for the Committee had not been established until November 2021. Subject to this, the Committee received and discussed all annual reports set out in its governance cycle.

5.7 Under section 4.2 of its Terms of Reference, unless otherwise agreed, notice of each meeting, together with an agenda of items to be discussed and supporting papers shall be sent to Committee members and to other attendees no later than 6 working days before the date of the meeting.

For the meetings respectively held on:

- Monday 10 May 2021, papers were published 4 working days before the date of the meeting;
- Monday 9 August 2021, papers were published 5 working days before the date of the meeting;
- Monday 8 November 2021, papers were published 5 working days before the meeting (with subsequent late papers received); and
- Monday 14 February 2022, papers were published 5 working days before the meeting (with subsequent late papers received).

5.8 Under section 6.6 of its Terms of Reference, the Committee is authorised to agree expenditure of charitable funds of up to £250,000 per individual item of expenditure. In August 2021, the Committee approved a Christchurch Outpatient Physiotherapy Hub Business Case with a contribution of £400,000 towards the project utilising a pledge from Christchurch Hospital League of Friends.

5.9 Section 9.1 of the Committee's Terms of Reference provides that the agenda and papers will be circulated to members of the Board of Directors and those required for regular attendance, normally seven days before the meeting. This has not occurred during the period.

6 MEETINGS

6.1 Four formal meetings were held during the year:

- Monday, 10 May 2021
- Monday, 9 August 2021
- Monday, 8 November 2021
- Monday, 14 February 2022

6.2 Meeting attendance is detailed in **Appendix 2.**

7 CONCLUSION

7.1 The Committee has predominantly complied with its terms of reference in 2021/22, subject to the matters detailed in sections 4.1, 5.6 to 5.9 of this report.

John Lelliott OBE
Chair, Charitable Funds Committee
May 2022

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE

GOVERNANCE CYCLE 2022

QUARTERLY REPORTS (February, May, August, November)

Charitable Funds Committee Minutes	Chair
Action List	Chair
Key items for communication	Chair
Investment Report	Quilter Cheviot
Risk Register	HoC[2]
Fundraising Report	HoC
Financial Report	ADoF
Fundraising Events	HoC
Business Cases / Charitable Funds Applications	HoC

ANNUAL REPORTS

	Lead	Annual Reports
Draft Annual Accounts & Report	CFO	August
Annual Accounts & Report	CFO	November
Fundraising Strategy	HoC	February
Fundraising Policies	HoC	February
Charity Recharges	ADoF	August
Financial Forecast & Compliance with Reserves Policy	ADoF	August
Charitable Funds Committee: Governance Cycle	CoSec	November
Charitable Funds Committee: Annual Report	Chair	May

BIENNIAL REPORTS

	Lead	Biennial Reports
Charitable Funds Committee: Terms of Reference	CoSec	November 2023

ADoF = Associate Director of Finance
CFO = Chief Finance Officer

[2] From November 2021

CoSec = Company Secretary
HoC = Head of Charity

Appendix 2

CHARTIABLE FUNDS COMMITTEE ATTENDANCE REGISTER 2021/22

NAME OF COMMITTEE:	**CHARITABLE FUNDS COMMITTEE**			
REPORTS TO :	**BOARD OF DIRECTORS**			
Membership (as per Terms of Reference).	**MEETING DATES**			
	10 May 2021	**9 August 2021**	**8 November 2021**	**14 February 2022**
JOHN LELLIOTT Non-Executive Director / Chair	✓	✓	✓	✓
PHILIP GREEN Non-Executive Director	✓	✓	✓	✓
CHRISTINE HALLETT Non-Executive Director	✓	✓	✓	NE
CAROLINE TAPSTER Non-Executive Director	✓	✓	✓	✓
KAREN ALLMAN Chief People Officer	✓	✓	✓	✓
PETE PAPWORTH Chief Finance Officer	✓	✓	✓	✓
RICHARD RENAUT Chief Strategy & Transformation Officer	✓	x	x	x
In attendance:				
Head of Charity	✓	✓	✓	✓
Associate Director of Finance	✓	✓	✓	x
Governor Observer	✓	✓	✓	✓
Was the meeting quorate?	Y	Y	Y	Y

*NE – Not Eligible

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE ANNUAL REPORT

APRIL 2021 – MARCH 2022

1. PURPOSE OF THE REPORT

1.1. This annual report has been prepared by the Company Secretariat on behalf of the Finance and Performance Committee (the "Committee") for the Board of Directors. It sets out how the Committee satisfied its terms of reference during the period April 2021 to March 2022 and seeks to provide the Board with evidence relevant to its responsibilities for reviewing material plans, proposals, financial planning, budgeting processes, business cases and cost improvement programmes, scrutinising strategic risks relating to finance and operational performance, maintaining an overview of the progress towards the delivery of agreed capital investments and agreeing the Treasury Management Policy.

2. OVERVIEW

2.1. The effective operation of the Committee is the central means by which the Board ensures that the Trust has adequate appropriate financial planning controls in place. The Committee monitors financial performance against the budget on a monthly basis and examines requests for capital expenditure in excess of £300,000 with a view to approving those less than £1,000,000 (excluding VAT) or recommending those in excess for board approval. It provides expertise and advice on the long term financial strategic plans, level of capital investment and financial risk.

2.2. The Committee independently scrutinises and monitors the Board Assurance Framework with regard to the strategic risks relating to finance and operational performance.

2.3. In accordance with its terms of reference, the Committee receives a number of annual reports appropriate to its purpose which include:

- Costing Transformation Programme
- Annual Report and Annual Accounts
- National Costs Submission Assurance
- Budget Setting Process and Timetable
- Operational Budget
- Going Concern
- Key Areas of Judgement and Estimation within the Annual Accounts

2.4. A governance cycle detailing which papers are to be expected at each Finance and Performance Committee is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was reviewed and approved in March 2022. The preceding governance cycle that was in effect during the period from April 2021 March 2022 is attached as **Appendix 1**.

2.5. The following items were not scheduled on the agenda in accordance with the Governance Cycle:

- April 2021
  - Costing Transformation programme
  - Reporting Accountant: Financial reporting procedures action plan (this was noted to be a legacy item following the merger and therefore should have been removed from the Governance Cycle)
- May 2021
  - Deep dive on performance by theme or service
  - Update from Transformation Committee
  - Update from Dorset ICS (this was presented at the July 2021 meeting)
- June 2021

    - Update from Sustainability Committee
- July 2021
    - Deep dive on performance by theme or service
    - Reporting Accountant: Financial reporting procedures action plan
- August 2021
    - Update from Transformation Committee
    - Update from Dorset ICS
- September 2021
    - Update from Sustainability Committee
    - National costs submission assurance
- October 2021
    - Budget Setting Process and Timetable (verbal update on H2 given and a paper was submitted to the November 2021 Committee)
    - Reporting Accountant: Financial reporting procedures action plan
- November 2021
    - Update from Transformation Committee
    - Deep dive on performance by theme or service
- January 2022
    - Deep dive on performance by theme or service
    - Reporting Accountant: Financial reporting procedures action plan
- February 2022
    - Update from Transformation Committee (updated provided at the March 2022 Committee)
- March 2022
    - Draft Annual Revenue Budget
    - Draft Annual Capital Programme

3. MEMBERSHIP

3.1. The Finance and Performance Committee membership comprised of:

- Stephen Mount, Non-Executive Director and Committee Chairman
- Pankaj Davé, Non-Executive Director
- John Lelliott, Non-Executive Director
- Pete Papworth, Chief Finance Officer
- Richard Renaut, Chief Strategy and Transformation Officer
- Mark Mould, Chief Operating Officer

4. MEETINGS

4.1. There were 11 formal meetings of the Finance and Performance Committee held from April 2021 and March 2022. There was no meeting held in December 2021:

- 26 April 2021
- 24 May 2021
- 28 June 2021
- 26 July 2021
- 23 August 2021
- 27 September 2021
- 25 October 2021
- 22 November 2021
- 24 January 2022
- 21 February 2022
- 28 March 2022

4.2. There were two formal joint Audit and Finance and Performance Committee meetings held from April 2021 to March 2022:
- 26 April 2021
- 9 June 2021

4.3. The meeting attendance is detailed in **Appendix 2**.

5. COMPLIANCE WITH TERMS OF REFERENCE

5.1. In accordance with its terms of reference, during the year, the Committee was composed of four Non-Executive Directors, the Chief Finance Officer, the Chief Strategy and Transformation Officer and the Chief Operating Officer. The Chief Executive was removed as a member of the Committee in June 2021, at her request, with the terms of reference being amended to permit the Chief Executive to attend meetings on an ad hoc basis or as required.

5.2. The Committee is chaired by a Non-Executive Director of the Trust, who is not the Chairman of the Trust or the Chairman of the Audit Committee. In the absence of the Committee Chairman, another Non-Executive Director who is a member of the Committee chaired the meetings.

5.3. A Governor attended all of the Committee meetings throughout April 2021 – March 2022 as an observer.

5.4. All meetings for 2021/22 were quorate with the exception of August 2021. It was agreed in the meeting that any items requiring decision would be referred directly to the next meeting of the Board of Directors.

5.5. The Committee's terms of reference require the Committee to receive detailed financial and operational reports to ensure that the Board of Directors is properly sighted on key financial and operational matters that may impact on key performance metrics, scrutinising variances to plan and considering improvement plans where appropriate. The Financial Performance Report, the Productivity and Efficiency Report and the Operational Performance Report were scrutinised at the Committee on a monthly basis.

5.6. The terms of reference are reviewed annually, and the last formal review took place in September 2021, when no material changes were made. A review of the Committee's compliance with its own terms of reference has been carried out in June 2022 by scrutinising the agendas and minutes of the eleven Committee meetings that took place between April 2021 and March 2022.

6. DUTIES AND FINDINGS

6.1. This review indicated that reports were generally received, scrutinised and discussed in accordance with the Committee's terms of reference.

6.2. **Board Assurance Framework (BAF)**
The Committee received and scrutinised the Board Assurance Framework report of strategic risks relating to finance, investment, performance and strategy at all its meetings.

6.3. **Financial Performance, Budgets and Capital Investment**
From April 2021 – March 2022 the Committee received the following reports relating to financial performance, budgets and capital investment:
- Financial Performance Report (monthly)
- Productivity and Efficiency Report (monthly)
- Operational Performance Report and Phase 3 Recovery
- 2021/22 Budget Update
- Consultancy Commitments (quarterly)

- Contract Decision Timetable (monthly)
- Model Hospital Update
- Patient Level Information and Costing System – Audit Report
- Parkstone House (Sovereign Housing)
- Standing Financial Instructions – UK Procurement Regulations Changes
- ICS Financial Update (quarterly)
- H2 Planning
- New Hospitals Programme Design Fees Update
- Antenatal to St Mary's site move
- Service Line Reporting
- Update on Christchurch Masterplan
- Orthodontics Update
- Medium Term Capital Programme
- Enabling Accountability Framework
- Sovereign Housing
- Theatre Improvement and Productivity Programme
- Road and Infrastructure Instruction
- Main Entrance and Patient and Visitor Instruction
- Staff Car Parking Charges
- Masterplan for Poole, Bournemouth and Christchurch

6.4. **Contracts and Business Cases**

From April 2021 – March 2022 the Committee received and discussed contracts and business cases pertaining to:

Contract or Business Case	Valuation of Contract/ Business Case	Outcome at the Committee
Revised Strategic Outline Case for Dorset New Hospital Programme	Updated strategic outline case. The overall strategy and total capital amount remained the same.	Agreed to recommend to the Board. Delegated authority given to Richard Renaut for non-material changes.
Harmonised UHD Hospitals FT Rota System	£1,479,900	Endorsed and submitted to the Board
Think Big	£3,298,000	Endorsed out of Committee and submitted to the Board
Bed Capacity Business Case	£5,800,000	Endorsed and submitted to the Board
Staff Car Parking Charges	Increase to car parking rates to staff members	Approved
Christchurch Phase 2 Business Case	£16,000,000	Endorsed and submitted to the Board
Staff Car Parking – Stadium Car Park Poole	£415,055	Supported and agreed for Board sign off
Main Entrance Ground Works	£11,000,000	Endorsed and submitted to the Board
Supply of Pathology Services for One Dorset, Lot 3 Coagulation	£2,220,000 (10 year contract)	Endorsed and submitted to the Board
Digital Dorset Shared Service Strategic Outline Case	£10,077,000	Endorsed and submitted to the Board
Insulin Pumps and Consumables (adults and paediatrics)	Cost increase of £50,226 per annum over four years. Total contract value £5,674940	Endorsed and submitted to the Board
UHD Microsoft Enterprise Agreements	£2,776,938.36	Endorsed and submitted to the Board
Radiology Reporting	£2,419,048	Endorsed and submitted to the Board

Commercial Insurance	£495,000	Approved
Managed Printer Services	£556,440	Approved
Lokomat Robotic Gait Trainer	£305,830	Approved
Endoscopy Consumables	£834,180	Approved
Endoscopes	£508,778	Approved
Anaesthetic Machines	£1,840,000	Endorsed and submitted to the Board
Ad Hoc Security Services	£536,000	Approved delegated authority to Pete Papworth
Codex Services	£400,000	Approved
Pathology Hub	£12,760,336	Endorsed and submitted to the Board
Infusion Pumps	£3,300,000	Endorsed and submitted to the Board
Philips Replacement Radiology – Room 10	£433,322	Approved
Supply of Design Services for the Building Refurbishment Under the New Hospital Programme	£6,200,000	Endorsed out of Committee and submitted to the Board
Poole Theatres Design	£1,200,000	Endorsed out of Committee and submitted to the Board
Radiology Equipment for Room 10	£907,584	Endorsed out of Committee and submitted to the Board
Development and Delivery of a Care Hotel	£823,284	Endorsed out of Committee and submitted to the Board
CT Scanner Maintenance x2	£818,644 £805,099	Approved Approved
Contrast Media and Barium	£1,774,550	Endorsed and submitted to the Board
PCI Consumables	£9,058,088	Endorsed and submitted to the Board
Philips Maintenance	£2,536,676	Endorsed and submitted to the Board
Pathology Loan Agreement	£16,217,031	Endorsed out of Committee and submitted to the Board
Dorset Orthotics and Prosthetics Managed Service	£2,734,800	Endorsed and submitted to the Board
Payroll Management Services	£2,649,500	Endorsed and submitted to the Board
Pharmacy Outpatient Services – Lloyds PH	£6,516,425	Endorsed and submitted to the Board
Blood Track System	£406,566	Approved
Maintenance for Scopes and Equipment	£951,340	Approved
Specialist Building Services and Assessments	£369,772	Endorsed out of Committee and submitted to the Board
ED Security Services	£800,838	Approved
Olympus Medical Equipment	£624,308	Approved
CT Scanner	£795,458	Approved
Radiology Breast Ultrasounds	£557,604	Approved
Surgical Robot (TIF)	£10,173,389	Endorsed out of Committee and submitted to the Board

6.5. **NHS Improvement**

Submissions to NHSE/I were scrutinised by the Committee prior to their submission dates:

- May 2021
    - Draft statutory accounts
    - Strategic Outline Business Case: New Hospital Programme
- August 2021
    - Referral to treatment – 104 week-wait recovery plan.
    - New Hospitals Programme

- September 2021
    - Medium Term Capital Programme
- November 2021
    - 2020/21 National Cost Collection
- February 2022
    - Christchurch Business Case
- March 2022
    - Interim Operational Budget 2022/23

The Committee received reports on Consultancy Costs from April 2021 – March 2022 and scrutinised agency costs, both medical and nursing. The Committee received updates as part of the Monthly Financial Performance Reports.

6.6. **Minutes**

In accordance with the terms of reference, minutes of each meeting of the Committee were formally recorded and submitted to the next meeting for approval. However, section 10.3 of the terms of reference specify that the minutes will be reported to the Board of Directors which has not happened throughout the reporting period.

The Committee receives and reviews action items at each monthly meeting (in accordance with section 10.4 of its terms of reference).

6.7. **Communication and Monitoring**

Under section 13.2 of the Committee's terms of reference, the Trust's Annual Report should include membership attendance, frequency of meetings and whether meetings were quorate. The Trust's Annual Report should also contain a section on the work of the Committee (section 12.2 of the terms of reference).

However, the Trust's Annual Report 2020/21 did not include such information. The Trust's Annual Report 2020/21 contains a section regarding the work of the Finance and Performance Committee, and throughout the annual report, some of its work is referenced, such as under the headings 'The risk and control framework', 'Review of economy, efficiency and effectiveness of the use of resources' and 'Operating segments'.

The information that was not included in the 2020/21 Trust Annual Report has been included for the Trust's Annual Report 2021/22.

6.8. **Reports from Other Committees**

The Committee received verbal updates from the following Committees in March 2022:

- Sustainability Committee
- Transformation Committee

The terms of reference specify that the Committee will receive reports from the following Groups:

- Financial Planning Group
- Capital Management Group
- Income and Coding Group
- Patient Level Costing Group

The reports from these Groups have not been received for the reporting period. However escalations should be brought to the Committee through the Finance Performance Report on a monthly basis. The Finance Performance Report is presented by the Deputy Chief Finance Officer who also attends all of the above Groups.

7. CONCLUSION

7.1. While the Committee has predominantly adhered to its terms of reference, there are elements of the terms of reference that have not been complied with during the reporting period:

- The agenda should be agreed, with the Committee Chairman in discussion with the Chief Finance Officer. The process is currently for the agenda setting to be agreed with the Chief Finance Officer.
- The minutes are not shared with the Board of Directors on a regular basis. This will be reviewed going forward to align with the approach for other Committees.
- The Trust's Annual Report should include information on membership attendance, frequency of meetings and quoracy. It should also contain a section regarding the work of the Finance and Performance Committee. This was not included in the Trust's Annual Report for 2020/21. This information has been included for 2021/22.
- Reports should be received from the following Committees and Groups:
    - Transformation Committee
    - Sustainability Committee
    - Financial Planning Group
    - Capital Management Group
    - Income and Coding Group
    - Patient Level Costing Group

  A verbal update from the Transformation Committee and the Sustainability Committee was received in March 2022 but there has been no direct report or update from the Groups that are listed. The Deputy Chief Finance Officer attends the Groups and can provide an escalation to the Committee from those Groups were required. This should also be included in the monthly Finance Performance Report.
- Section 2.5 above outlines the agenda items that were not presented to the Committee in accordance with the Governance Cycle. It should be noted that at the review for the Governance Cycle in March 2022, the 'Reporting Accountant: Financial reporting procedures action plan' was noted to be a legacy item following the merger and therefore should have been removed. At the same review of the Governance Cycle the deep dives were felt to no longer be required due to the detail that is presented in the Financial Performance Report, the Product and Efficiency Report and the Operational Report. Unless stated in section 2.5 above, the Committee complied with the Governance Cycle as approved in November 2020.
- The Committee is authorised to approve the Treasury Management Policy and policies and procedures that are in place for ensuring economy, efficiency and effectiveness in the use or resources. The Committee received no policies from April 2021 to March 2022. A verbal update on the Treasury Management Policy was given in March 2022 where it was stated that the policy would be reviewed and brought back to a subsequent Committee meeting.
- It was noted as part of the review that the terms of reference provide that "The Committee is authorised to approve or reject tenders, contracts and business cases for capital and revenue schemes for which the aggregated value is in excess of £300,000 but less than £1,000,000". It is recommended that this be updated and aligned to the Trust's Standing Financial Instructions to make clear that the amounts are exclusive of VAT.

Stephen Mount
Chair of Finance and Performance Committee
June 2022

APPENDIX 1

FINANCE AND PERFORMANCE COMMITTEE GOVERNANCE CYCLE

REGULAR REPORTS

Finance and Performance Committee Minutes	Chairman
Financial Performance Report	CFO
Productivity & Efficiency Update	CFO
Contract Decision Timetable	CFO
Operational Performance Report	COO

EXCEPTION REPORTS

Financial Planning Group	CFO
Capital Management Group	CFO
Income and Coding Group	CFO
Patient Level Income & Costing Group	CFO
Board Assurance Framework: Exception Reporting of Strategic Risks relating to Finance and Performance	CFO/COO
Audit Reports (as appropriate)	CFO
Investment and Business Cases	CFO
Debtors Reports (as appropriate)	CFO
Financial Systems Development Updates	CFO
Charitable Funds Committee Reports	CFO

QUARTERLY REPORTS

Review Board Assurance Framework changes relating to Finance and Performance (Q1 - July; Q2 - Nov; Q3 – Jan; Q4 May)	CFO
Consultancy Commitments (July, Oct, Jan, April)	CFO
Deep Dive on Performance by theme or service (Q1 – July; Q2 – Nov; Q3 – Jan; Q4 – May)	COO/GDO's
Update from Transformation Committee (TC) (Aug; Nov; Feb; May)	CSO/Chair of TC
Update from Sustainability Committee (SC) (Sept; Dec; March; June)	CSO/Chair of SC
Update from the Dorset Integrated Care System (ICS) (Aug; Nov; Feb; May)	Dorset CCG DoF
Reporting Accountant: Financial Reporting Procedures Action Plan (Jan; April; July; Oct)	CFO

½ YEARLY / ANNUAL REPORTS

	Lead	½ Yearly	Annual Reports
REVIEW REPORTS			
National Costs Submission Assurance	CFO	-	September
Costing Transformation Programme (Board Declaration)	CFO	----	April
Budget Setting Process and Timetable	CFO	----	October
Draft Operational Plans	CFO	----	Jan/Feb
Draft Annual Accounts	CFO	-----	April
Annual Report and Annual Accounts*	CFO	----	May
Draft Annual Revenue Budget	CFO	----	March
Draft Annual Capital Programme and half year update	CFO	Sept	March
Going Concern	CFO	-----	March
Key Areas of Judgement and Estimation within the Annual Accounts	CFO		March
Finance & Performance Committee Governance Cycle	Chairman	-----	March
Finance & Performance Committee Terms of Reference	Chairman	----	September
Finance & Performance Committee Annual Report	Chairman	-----	June

* denotes Special Audit Committee and Finance and Performance Committee meeting

CLS October 2020

APPENDIX 2

FINANCE AND PERFORMANCE COMMITTEE ATTENDANCE REGISTER 2021/22

Name of Committee:	Finance and Performance Committee												
Report to:	Board of Directors												
Membership (as per Terms of Reference). Please give names and/or full job title below:	**MEETING DATES**												
	26 April 2021	**26 April 2021***	**24 May 2021**	**09 June 2021***	**28 June 2021**	**26 July 2021**	**23 August 2021**	**27 September 2021**	**25 October 2021**	**22 November 2021**	**24 January 2022**	**21 February 2022**	**28 March 2022**
Stephen Mount (Chair) Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	×	✓
Pankaj Davé Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Lelliott Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mark Mould Chief Operating Officer	✓	✓	✓	✓	✓	✓	×	✓	×	✓	✓	×	×
Pete Papworth Chief Finance Officer	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Richard Renaut Chief Strategy and Transformation Officer	✓	✓	✓	×	✓	×	×	✓	×	✓	✓	✓	✓
In Attendance:													
Jacqueline Coles Deputy Chief Operating Officer	NE	NE	NE	NE	NE	NE	✓	NE	NE	NE	NE	NE	NE
Debbie Fleming Chief Executive	×	×	×	✓	✓	×	✓	×	×	×	×	✓	×
Andrew Goodwin Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Marjorie Houghton Public Governor	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Judith May Associate Director	×	×	×	×	×	×	×	×	×	×	×	✓	×
David Moss Trust Chairman	✓	×	✓	✓	✓	✓	✓	×	×	×	×	✓	✓
Donna Parker Deputy Chief Operating Officer	NE	NE	NE	NE	NE	NE	NE	NE	✓	NE	NE	NE	NE
Nikki Rowland Chief Finance Officer, Dorset CCG	×	×	×	×	×	✓	×	×	×	✓	×	×	✓
Helen Rushforth Head of Productivity and Efficiency	✓	×	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quorate	✓	✓	✓	✓	✓	✓	×*	✓	✓	✓	✓	✓	✓

***** Agreed that items requiring decision would be passed to the Board of Directors meeting.

NE = Not eligible

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

QUALITY COMMITTEE ANNUAL REPORT 2021/22

1 PURPOSE OF THE REPORT

1.1 The Quality Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference between 1 April 2021 and 31 March 2022. The Committee seeks to provide the Board with evidence that it met its responsibilities as set out in its term of reference during the relevant period.

2 OVERVIEW & RESPONSIBILITIES

2.1 The Committee serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely and cost-effective manner across the following areas: quality, patient experience, patient safety, clinical outcomes, risk management, health and safety, safeguarding (Children and Vulnerable Adults), Infection Prevention and Control, Medicines Management, Learning from Deaths and End of Life Care. The Committee acts as a means of internal assurance for compliance against the Care Quality Commission regulating and inspection compliance framework.

2.2 The Committee receives a number of quarterly, bi-annual and annual reports appropriate to its purpose.

2.3 A governance cycle detailing which papers are to be expected at each Quality Committee is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was formally reviewed and approved in March 2021. This updated governance cycle is attached as **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Quality Committee comprises four Non-Executive Directors, one of whom is a member of the Audit Committee, the Chief Nursing Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief People Officer. The Chief Executive was a member of the Committee until 26 May 2021, preceding an amendment to the Terms of Reference. The Committee membership in 2021/22 comprised:

- Caroline Tapster, Non-Executive Director and Committee Chair
- Philip Green, Non-Executive Director
- Christine Hallett, Non-Executive Director *(until 31 December 2021)*
- Cliff Shearman, Non-Executive Director
- Debbie Fleming, Chief Executive *(until 26 May 2021)*
- Alyson O'Donnell, Chief Medical Officer

- Paula Shobbrook, Chief Nursing Officer
- Mark Mould, Chief Operating Officer
- Karen Allman, Chief People Officer

4 MEETINGS

4.1 Eleven formal meetings were held during the year:

- Monday, 26 April 2021
- Monday, 25 May 2021
- Monday, 28 June 2021
- Monday, 26 July 2021
- Monday, 23 August 2021
- Monday, 27 September 2021
- Monday, 25 October 2021
- Monday, 22 November 2021
- Monday, 20 December 2021
- Monday, 21 February 2022
- Monday, 28 March 2022

4.2 Meeting attendance is detailed in **Appendix 2.**

5 COMPLIANCE WITH TERMS OF REFERENCE

5.1 In accordance with its terms, the Committee is composed was four Non-Executive Directors, the Chief Nursing Officer, Chief Medical Officer, Chief Operating Officer and Chief People Officer. Philip Green is the Chair of the Trust's Audit Committee; ensuring the Committee meets the requirement to have a member of the Audit Committee. The Chief Executive was a member of the Committee until 26 May 2021.

5.2 Eleven meetings took place in the period from 1 April 2021 – 31 March 2022 and all were quorate.

5.3 A formal review of the terms of reference was undertaken in March 2022 and the terms have been updated as necessary throughout the year. A review of the Committee's compliance with its own terms of reference has been undertaken in May 2022 by scrutinising the agendas and minutes of the eleven Committee meetings which took place between 1 April 2021 and 31 March 2022. Additionally, the Committee commissioned an annual review of its effectiveness in March 2022, the results of which would be presented to the Committee outside of this reporting period.

6 DUTIES AND FINDINGS

6.1 The Committee received the following regular reports over the period:

- Serious Incidents Report
- Integrated Performance Report (Quality)

- Risk Register: risks rated 12-25
- Covid Update
- Care Group Quality Reports
- CQC Insight Report (bi-monthly)

6.2 The Committee received the following quarterly reports, either as a standalone report or through the relevant sub-group reporting, as set out in its terms of reference:

- Infection Prevention & Control
- Safeguarding
- Mortality
- Medicines Safety
- Complaints & Patient Experience

6.3 The Committee, according to its terms of reference should also have received the following quarterly reports:

- Getting it Right First Time
- Maternity Safety Champions

The Maternity Safety Champions report was received at each meeting as part of the regular Maternity Report, and not as a standalone item.
The Committee did not receive a quarterly report on Getting it Right First Time in the reporting period. This was, however, incorporated into the Governance Cycle approved in March 2022 (Appendix 1) and would be reported going forwards.

6.4 The Committee received the following annual reports, as set out in its terms of reference:

- Annual Infection Prevention & Control Report
- Annual Complaints & Patient Experience Report
- Annual Safeguarding Report

6.5 The Committee should also, according to its terms of reference, have received the following annual reports:

- Annual Quality Account
- Annual Patient Survey Report
- Annual End of Life Report and Care of the Dying Audit
- Annual CQC Self-Assessment Report
- Annual Radiation Report

The Annual Quality Account was not required during this period due to the Trust having been formed less than 12-months.
The Annual End of Life Report and Care of the Dying Audit was received by the Clinical Governance Group.
An Annual CQC Self-Assessment Report was not received, however the Committee did receive bi-monthly CQC Insight Reports, in addition to a CQC well-led action plan in April 2021.
There was no Annual Radiation Report received during the period due to the Radiation Protection Group only recently having been established by the scheduled time of reporting. This was noted by the Committee at the October 2021 meeting.

6.6 In line with its terms of reference, the Committee received a half-yearly and an annual report on claims and litigation.

6.7 In line with its terms of reference, the Committee reviewed the Trust Risk Register (risks rated 12-25) at each meeting and reviewed changes relating to quality to the Board Assurance Framework during the period.

6.8 The Committee received, by exception, reports from its sub-groups:

- Medicines Governance Group
- Strategic Nursing, Midwifery & Professions Group
- Clinical Governance Group
- Health & Safety Group
- Mortality Surveillance Group
- Infection Prevention & Control Group
- Radiation Protection Group
- Safeguarding Group
- Care Group Quality & Risk Groups

6.9 The Committee's terms of reference specify that the agenda and supporting papers for each meeting should be circulated to members and required attendees, at the latest, five working days prior to the meeting. This requirement was met for all meetings except April and May 2021, where the papers were circulated six working days prior to the meeting.

6.10 In line with the Committee's terms of reference, a copy of the meeting papers was sent to the Chief Executive and was made available to other members of the Board of Directors on request.

7 CONCLUSION

7.1 The Committee has predominantly complied with its terms of reference in 2021/22, subject to the matters detailed in section 6 of this report.

Caroline Tapster CBE
Chair, Quality Committee
May 2022

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

QUALITY COMMITTEE GOVERNANCE CYCLE [1]

REGULAR REPORTS	LEAD
Quality Committee Minutes	Chair
Action List	Chair
Items to escalate to Board of Directors	Chair
Learning Event Report Notification (LERN) Report	CMO
Integrated Performance Report: Quality Report	CNO
Covid Update	DCNO
Risk Register: Risks rated 12-25 (new and current)	ADQGR
Care Group Quality Reports	CG DoN/DoM
CQC Insight Report (bi-monthly)	CNO/ADQGR

QUARTERLY REPORTS	QUARTER	LEAD
Review Board Assurance Framework changes relating to quality	Q1-Jul; Q2-Nov; Q3-Jan; Q4-May	CNO/ADQGR
Complaints and Patient Experience Report	Q1-Sep; Q2-Nov; Q3-Mar; Q4-Jun	CNO
Mortality Report	Q1-Aug; Q2-Nov; Q3-Feb; Q4-May	CMO
Quality Impact Assessment Process Report	Apr; Aug; Oct; Dec	CNO
Quality Impact of Getting it Right First Time (GIRFT)	Mar, Jun, Sep, Dec	CMO

½ YEARLY / ANNUAL REPORTS	½ YEARLY	ANNUAL REPORTS	LEAD
Quality Account Draft Report (including Quality Priorities)	-	May	CNO ADQGR
Quality Priorities Review	-	November	CNO ADQGR
National Patient Surveys	-	When published	CNO
Annual Safeguarding Report (Children, Young Adults & Adults)	-	October	CNO

[1] Governance Cycle approved March 2022

and to include Annual Learning Disabilities access statement			
Annual Infection Prevention and Control Report and Statement of Commitment	-	October	CNO
Annual Radiation Safety Report	-	October	CMO/ IR(ME)R Lead
Claims and Litigation Detailed Report	January	July	CMO
Annual Complaints and Patient Experience Report	-	July	CNO
Annual PLACE Report	-	August	CNO
Mixed Sex Accommodation Declaration	-	July	CNO
Annual Committee Effectiveness Review	-	April	ADQGR/ Company Secretary
Quality Committee Governance Cycle	-	March	Company Secretary
Quality Committee Terms of Reference	-	January	Company Secretary
Quality Committee Annual Report	-	May	Company Secretary

EXCEPTION REPORTS	**LEAD**
CQC Reports/Submissions	CNO/ADQGR
Medicines Governance Group	CMO
Strategic Nursing, Midwifery & Professions (SNMP) Group	CNO
Clinical Governance Group	CNO
Health and Safety Group	CPO
Mortality Surveillance Group	CMO
Infection Prevention & Control Group	CNO
Radiation Protection Group	CMO/IR(ME)R Lead
Safeguarding Group	CNO
Quality Committee Commissioned Reports	Executive Lead
Statutory Inspections (by exception)	Executive Lead
Adhoc Reports (by exception)	Executive Lead

Appendix 2

QUALITY COMMITTEE ATTENDANCE REGISTER 2021/22

NAME OF COMMITTEE:	**QUALITY COMMITTEE**										
REPORTS TO:	**BOARD OF DIRECTORS**										
Membership (as per Terms of Reference):	**MEETING DATES**										
	26 April 2021	25 May 2021	28 June 2021	26 July 2021	23 August 2021	27 September 2021	25 October 2021	22 November 2021	20 December 2021	21 February 2022	28 March 2022
CAROLINE TAPSTER Non-Executive Director & Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
PHILIP GREEN Non-Executive Director	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
CLIFF SHEARMAN Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
CHRISTINE HALLETT Non-Executive Director	✓	x	✓	✓	✓	✓	x	✓	✓	NE	NE
DEBBIE FLEMING Chief Executive	✓	x	NE	NE	NE	NE	NE	NE	NE	NE	NE
PAULA SHOBBROOK Chief Nursing Officer and Deputy Chief Executive	✓	✓	✓	✓	x	✓	x	✓	✓	✓	✓
ALYSON O'DONNELL Chief Medical Officer	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓
KAREN ALLMAN Chief People Officer	✓	✓	x	x	✓	✓	✓	✓	✓	✓	x
MARK MOULD Chief Operating Officer	✓	✓	✓	✓	x	x	x	✓	✓	x	x
Was the meeting quorate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*NE - *Not Eligible*

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

PRIVATE PATIENTS STRATEGY COMMITTEE ANNUAL REPORT JULY 2021 – MARCH 2022

1 PURPOSE OF THE REPORT

1.1 The Private Patients Strategy Committee (the "Committee") has prepared this annual report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during the period July 2021 (when the Committee was established) to March 2022 and seeks to provide the Board with evidence relevant to its responsibilities.

2 OVERVIEW

2.1 The Committee's terms of reference refer to its responsibilities as being undertaken through its governance cycle and including:

- To set an agreed strategy for private patients at the Trust;
- To monitor the strategy implementation;
- To ensure good governance is in place for private practice that benefits the Trust and its wider mission and vision, as well as meeting the needs of patients and clinicians;
- To ensure compliance with legal and regulatory requirements.

The terms of reference also refer to its responsibilities being as set out in its governance cycle.

In relation to the Committee's responsibility for ensuring good governance is in place (referenced above), the terms of reference set out the Committee's relationship with other committees/groups. This includes that "the governance of Private Health UHD is within the Surgical Care Group and Dorset Heart Clinic within the Medical Care Group. There are operational management groups for both of these, who report via the Care Group management governance".

2.2 A limitation of this report is that the Committee does not yet have an approved form of governance cycle, although this is being tracked as an action through the Committee.

2.3 At the inaugural meeting of the Committee in June 2021:

- An options appraisal report was presented considering structural approaches to address certain aspects of the existing governance arrangements for private patients services. It was noted that identifying the structure for the private patient service needed to be prioritised before the development strategy in view of potential conflicts of interest; and
- Themes for consideration were discussed as part of the development of the strategy
- It was agreed that the Governance Cycle would be developed outside of the meeting in consultation with Committee members.

2.4 At its meeting on 11 November 2021, the Committee considered a draft Private Patient Service Level Agreement and a proposal for the approach to the private patient strategy development at the Trust, with updates on these also having been provided at its meeting on 22 March 2022.

The terms of reference for the PHUHD Limited Medical Advisory Committee were reviewed by the Committee in March 2022.

3 MEMBERSHIP

3.1 During the period of this report, the Committee membership comprised of:

- Cliff Shearman, Non-Executive Director and Committee Chair
- Jehangir Din, Chair of the Medical Advisory Committee for Dorset Heart Clinic
- Debbie Fleming, Chief Executive Officer
- Mark Mould, Chief Operating Officer
- Stephen Mount, Non-Executive Director
- Pete Papworth, Chief Finance Officer
- Richard Renaut, Chief Strategy and Transformation Officer
- Martin Schuster-Bruce, Chair of the Medical Advisory Committee for Private Health UHD

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 The Committee has pursued its responsibilities towards the setting of a strategy for private patients at the Trust (section 1.2 of its terms of reference).

4.2 As noted above, the Committee's governance cycle have not yet been established; section 8.1 of the Committee's terms of reference provide for its responsibilities being as set out in such governance cycle.

4.3 The quorum of the Committee is the Chair or a nominated deputy and at least three members, to include one Non-Executive Director, one MAC Chair and One Chief Officer. Each meeting of the Committee during the reporting period was declared quorate, save for the meeting held on 29 July 2021 where the absence of quoracy was highlighted at the meeting and that an item requiring approval would be submitted to the Board of Directors.

4.4 Minutes of the meeting are formally recorded and reviewed by the Committee. The Committee papers and minutes are available to the Board of Directors if required (sections 10.2 and 10.3 of the terms of reference).

4.5 An action list is recorded at each meeting and progress monitored at the Committee, with this being a standing item on each agenda (section 10.4 of the terms of reference).

4.6 Under its terms of reference, the Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if the Committee considers this necessary. Browne Jacobson, solicitors, attended the meetings in March 2021 and November 2021.

5 MEETINGS

5.1 There were three formal Private Patients Strategy Committee meetings held from July 2021 to March 2022:

- 29 July 2021
- 11 November 2021
- 9 March 2022

5.2 Meeting attendance is detailed in **Appendix 2**. The level of clinical engagement was noted as part of the review. There was discussion at the Committee meeting held on 13 July 2022 in relation to the importance of clinical engagement as part of a private patients' strategy.

6 DUTIES AND FINDINGS

6.1 The Committee's terms of reference were written and approved in July 2021 when the Committee was established. The terms of reference require the Committee to set an agreed strategy for private patients at the Trust.

6.2 The Committee has pursued its responsibilities towards the setting of a strategy for private patients at the Trust (section 1.2 of its terms of reference).

7 CONCLUSION

7.1 From the review completed, the Committee has complied with its terms of reference between July 2021 and March 2022, noting that the governance cycle for the Committee is to be finalised.

7.2 It is recommended that the terms of reference for the Committee be reviewed and updated, particularly to further clarify the Committee's responsibilities for "ensuring good governance is in place for private practice…" in view of the governance responsibilities of the Care Groups for Private Health UHD and the Dorset Heart Clinic.

7.3 At its meeting on 13 July 2022, the Committee also noted the need for the proposed strategy to be presented to the Board for review and consideration of its appetite.

Cliff Shearman
Chair of the Private Patients Strategy Committee, July 2022

APPENDIX 1

PRIVATE PATIENTS STRATEGY COMMITTEE MEETING ATTENDANCE RECORD

2021/22

NAME OF COMMITTEE:	Private Patients Strategy Committee		
REPORT TO:	Board of Directors		
Membership (as per Terms of Reference). Please give names and/or full job title below:	**MEETING DATES**		
	29 July 2021	11 November 2021	9 March 2022
Cliff Shearman (Chair) Non-Executive Director	✓	✓	✓
Jehangir Din Chair of the Medical Advisory Committee for Dorset Heart Clinic	×	×	×
Debbie Fleming Chief Executive	×	✓	×
Mark Mould Chief Operating Officer	✓	✓	×
Stephen Mount Non-Executive Director	✓	×	×
Pete Papworth Chief Finance Officer	✓	✓	✓
Richard Renaut Chief Strategy and Transformation Officer	✓	✓	✓
Martin Schuster-Bruce Chair of the Medical Advisory Committee for Private Health UHD	×	✓	✓
In Attendance:			
Abigail Daughters Group Director of Operations, Surgical Care Group	✓	✓	✓
Christian Dingwall Browne Jacobson LLP	✓	×	×
Rebecca Hainsworth Browne Jacobson LLP	✓	✓	×
Georgia Kingsnorth Browne Jacobson LLP	×	✓	×
Mark Major Deputy Group Director of Operations, Surgical Care Group	×	✓	✓
Alex Lister Group Director of Operations, Medical Care Group	×	✓	×
Sarah Macklin Group Director of Operations, Operations	×	✓	×
Quorate	×	✓	✓

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

SUSTAINABILITY COMMITTEE ANNUAL REPORT 2021/22

1 PURPOSE OF THE REPORT

1.1 The Sustainability Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference between 1 April 2021 and 31 March 2022. The Committee seeks to provide the Board with evidence that it met its responsibilities as set out in its term of reference during the relevant period.

2 OVERVIEW & RESPONSIBILITIES

2.1 The Committee is responsible for:

- Ensuring a clear and ambitious strategy is set for sustainability along with annual plans with SMART objectives.
- Reviewing the Trust's annual business plan and other strategies to ensure sustainability and mitigations to climate change is assured and embedded.
- Maintaining an overview of the progress towards the delivery of agreed strategies, and escalating issues as appropriate to the Board. This includes scrutinising the Board Assurance Framework with regard to the strategic risks relating to Sustainability.
- Reviewing the Trust's draft annual report and recommending to the Board of Directors, for submission to NHS Improvement and other regulators as appropriate on issues of sustainability, including carbon reduction and corporate social responsibility.
- Receiving for scrutiny the quarterly report from the Sustainability Steering Group.
- Approving its Governance Cycle.

2.2 The Committee receives a number of reports appropriate to its purpose.

2.3 A governance cycle detailing which papers are to be expected at each Committee meeting is to be reviewed annually and updated as necessary throughout the year. The Committee's governance cycle was developed and approved in December 2021. This governance cycle is attached as **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Committee comprises three Non-Executive Directors, the Chief Executive, the Chief Strategy & Transformation Officer and the Chief Finance Officer. The Committee membership in 2021/22 comprised:

- John Lelliott, Non-Executive Director and Committee Chair
- Philip Green, Non-Executive Director
- Stephen Mount, Non-Executive Director
- Debbie Fleming, Chief Executive
- Pete Papworth, Chief Finance Officer
- Richard Renaut, Chief Strategy & Transformation Officer

4 MEETINGS

4.1 Four formal meetings were held during the year:

- Tuesday, 11 May 2021
- Monday, 13 September 2021
- Monday, 13 December 2021
- Wednesday, 9 March 2022

4.2 Meeting attendance is detailed in **Appendix 2.**

5 COMPLIANCE WITH TERMS OF REFERENCE

5.1 In accordance with its terms of reference, the Committee was composed of three Non-Executive Directors, the Chief Executive, Chief Strategy & Transformation Officer and Chief Finance Officer.

5.2 Four meetings took place in the period from 1 April 2021 – 31 March 2022 and all were quorate.

5.3 A formal review of the terms of reference was undertaken in December 2021 and the terms have been updated as necessary throughout the year. A review of the Committee's compliance with its own terms of reference has been undertaken in May 2022 by scrutinising the agendas and minutes of the four Committee meetings which took place between 1 April 2021 and 31 March 2022.

6 DUTIES AND FINDINGS

6.1 In accordance with its terms of reference, the Committee received and recommended for approval the Trust's draft strategy in May 2021. Progress against this strategy was then reviewed at each meeting, complemented by a deep dive into a specific work area.

Furthermore, the Committee received at each meeting an update on staff and public engagement, as well as feedback from partners – specifically Bournemouth University and Bournemouth, Christchurch & Poole Council.

6.2 As per its terms of reference, the Committee received a regular report on risk. The delivery of the sustainability strategy also featured in the Trust's Board Assurance Framework.

6.3 The Committee received a quarterly update from the Sustainability Steering Group, either as a standalone item or as part of the update on progress against the sustainability strategy.

6.4 In accordance with its terms of reference, the Committee approved its governance cycle in December 2021.

6.5 During the period, the Committee did not review the Trust's annual business plan or annual report as per its terms of reference. This would be incorporated going forward.

7 CONCLUSION

7.1 The Committee has predominantly complied with its terms of reference in 2021/22, subject to the matter detailed in section 6.5 of this report.

John Lelliott OBE
Chair, Sustainability Committee
June 2022

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

SUSTAINABILITY COMMITTEE

GOVERNANCE CYCLE 2022[1]

QUARTERLY REPORTS (March, June, September, December)

Sustainability Committee Minutes	Chair
Action List	Chair
Key items for communication	Chair
Trust Strategy Update	ADE
Staff & Public Engagement Update	HoC
Partnership Feedback	BU/BCP/ICS
Risk Register	CSTO
Deep Dive	Action Area Lead

ANNUAL REPORTS

Sustainability Committee: Annual Report	June	Chair
Sustainability Committee: Governance Cycle	December	CoSec
Sustainability Committee: Terms of Reference	December	CoSec
UHD Green Plan: Annual Report	June	ADE
UHD Green Plan: Annual Plan Update	June	ADE

EXCEPTION/SBAR FROM GROUP CHAIRS

Sustainability Steering Group	SCM

ADE – Associate Director of Estates
CoSec – Company Secretary
CSTO – Chief Strategy & Transformation Officer
SCM – Trust Sustainability & Carbon Manager
HoC – Head of Communications

[1] From December 2021

Appendix 2

SUSTAINABILITY COMMITTEE ATTENDANCE REGISTER 2021/22

NAME OF COMMITTEE:	**SUSTAINABILITY COMMITTEE**			
REPORTS TO:	**BOARD OF DIRECTORS**			
Membership (as per Terms of Reference):	**MEETING DATES**			
	11 May 2021	13 September 2021	13 December 2021	9 March 2022
John Lelliott (Chair) Non-Executive Director	✓	✓	✓	✓
Philip Green Non-Executive Director	✓	x	✓	✓
Stephen Mount Non-Executive Director	✓	✓	x	x
Debbie Fleming Chief Executive	✓	✓	✓	x
Pete Papworth Chief Finance Officer	✓	✓	✓	✓
Richard Renaut Chief Strategy & Transformation Officer	✓	✓	✓	✓
Was the meeting quorate?	Y	Y	Y	Y

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

TRANSFORMATION COMMITTEE ANNUAL REPORT 2021/22

1 PURPOSE OF THE REPORT

1.1 The Transformation Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference between 1 April 2021 and 31 March 2022. The Committee seeks to provide the Board with evidence that it met its responsibilities as set out in its term of reference during the relevant period.

2 OVERVIEW & RESPONSIBILITIES

2.1 The Committee is responsible for:

i) Establishing the strategy and methodologies for setting, monitoring implementation and assurance of benefits realisation for the transformation agenda for the Trust, on behalf of the Board of Directors.

ii) The Committee's scope covers benefits realisation of identified transformation objectives, including those defined in the merger business case including:
- The Patient Benefits Case (PBC) for merger
- Post-merger transaction implementation plans (PTIPs)
- Delivery of financial and non-financial benefits of merger integration and reconfiguration
- The Digital Transformation strategy, as part of Digital Dorset and UHD's own digital strategy
- The Quality Improvement strategy (QI)
- The Clinical Services Review (CSR) implementation
- Estates transformation with particular focus on delivery of the elective and emergency hospitals reconfiguration (delivered via P22 framework)
- Wider service changes and system level transformation in services.

iii) Monitoring implementation progress of all components of post-merger Benefits Realisation and escalating issues and variances from the strategy to relevant Board Committees and the Board of Directors where there is risk to delivery.

iv) Ensuring coordination and coherence of the entire transformation agenda, including both major programmes of changes, as well as creating a culture of empowerment and continuous quality improvement.

2.2 The Committee receives a number of reports appropriate to its purpose.

2.3 A governance cycle detailing which papers are to be expected at each Committee meeting is to be reviewed annually and updated as necessary throughout the year. The Committee's governance cycle was developed and approved in December 2021. This governance cycle is attached as **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Committee comprises three Non-Executive Directors, the Chief Executive, the Chief Strategy & Transformation Officer and the Chief Finance Officer. The Committee membership in 2021/22 comprised:

- Pankaj Davé, Non-Executive Director and Committee Chair
- Cliff Shearman, Non-Executive Director
- Caroline Tapster, Non-Executive Director
- Karen Allman, Chief People Officer
- Debbie Fleming, Chief Executive
- Peter Gill, Chief Informatics Officer
- Mark Mould, Chief Operating Officer
- Richard Renaut, Chief Strategy & Transformation Officer

4 MEETINGS

4.1 Four formal meetings were held during the year:

- Thursday, 17 June 2022
- Thursday, 16 September 2022
- Thursday, 16 December 2022
- Friday, 11 March 2022

4.2 Meeting attendance is detailed in **Appendix 2.**

5 COMPLIANCE WITH TERMS OF REFERENCE

5.1 In accordance with its terms of reference, the Committee was composed of three Non-Executive Directors, the Chief Executive, Chief Strategy & Transformation Officer, Chief Operating Officer, Chief People Officer and Chief Informatics Officer.

5.2 Four meetings took place in the period from 1 April 2021 – 31 March 2022 and all were quorate.

5.3 A formal review of the terms of reference was undertaken in December 2021 and the terms have been updated as necessary throughout the year. A review of the Committee's compliance with its own terms of reference has been undertaken in June 2022 by scrutinising the agendas and minutes of the four Committee meetings which took place between 1 April 2021 and 31 March 2022.

6 DUTIES AND FINDINGS

6.1 The Committee fulfilled its responsibilities, in line with its terms of reference, through the receipt of a number of regular reports:

- Portfolio update
- Benefits realisation update
- New Hospitals Programme (NHP) update

Furthermore, the Committee received a regular deep dive into a specific Care Group or directorate.

6.2 The Committee reviewed relevant risks to the transformation agenda at each meeting, in accordance with its terms of reference.

6.3 The Committee monitored the delivery of the transformation agenda through the receipt of the reports detailed in 6.1 and 6.2, in addition to receiving an updates by exception on reconfiguration in June 2021, an update on the innovation programme in September 2021 and receiving the results of an integration assessment in December 2021.

6.4 In line with its terms of reference, the Committee reviewed the following strategies in June 2021, which would then be reviewed on an annual basis:

- Quality Improvement Strategy
- Innovation Strategy
- Bournemouth University Partnership Strategy

6.5 The Committee received, by exception, reports from the Transformation & Improvement Group.

6.6 The Committee's terms of reference specify that the agenda and supporting papers for each meeting should be circulated to members of the Committee seven working days prior to the meeting. During the period, this was completed five working days in advance.

Additionally, meeting agendas were not circulated to all members of the Board of Directors in advance of the meeting, as specified in the terms of reference. It is recommended that this requirement be reviewed going forward

7 CONCLUSION

7.1 The Committee has predominantly complied with its terms of reference in 2021/22, subject to the matters detailed in section 6.6.

Pankaj Davé
Chair, Transformation Committee
June 2022

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TRANSFORMATION COMMITTEE

GOVERNANCE CYCLE 2022[1]

QUARTERLY REPORTS (March, June, September, December)

Transformation Committee Minutes	Chair
Action List	Chair
Key items for communication	Chair
Strategy & Transformation Overview	CSTO
Portfolio Update	DoI&I
Benefits Realisation Update	HoP&E
New Hospitals Programme Update	DoT
Risk Register	DOI&I
Deep Dive	Area Lead

ANNUAL REPORTS

Transformation Committee: Annual Report	June	Chair
Transformation Committee: Governance Cycle	December	CoSec
Transformation Committee: Terms of Reference	December	CoSec
Forward Plan	March	DoI&I
Quality Improvement Strategy	September	DoI&I and Clinical Lead
Innovation Strategy	June	HoRINC and Clinical Lead
Bournemouth University Partnership Strategy	June	PM and Clinical Lead

EXCEPTION/SBAR FROM GROUP CHAIR

Transformation & Improvement Group	DoI&I

CoSec – Company Secretary
CSTO – Chief Strategy & Transformation Officer
DOI&I – Director of Improvement & Integration
DoT – Director of Transformation
HoP&E – Head of Productivity & Efficiency
HoRINC - Head of Research, Innovation, NICE and Clinical Audit
PM – Programme Manager

[1] From December 2021

Appendix 2

TRANSFORMATION COMMITTEE ATTENDANCE REGISTER 2021/22

NAME OF COMMITTEE:	**TRANSFORMATION COMMITTEE**			
REPORTS TO:	**BOARD OF DIRECTORS**			
Membership (as per Terms of Reference):	**MEETING DATES**			
	17 June 2021	16 September 2021	16 December 2021	11 March 2022
Pankaj Davé (Chair) Non-Executive Director	✓	✓	✓	✓
Cliff Shearman Non-Executive Director	✓	✓	✓	✓
Caroline Tapster Non-Executive Director	x	x	✓	✓
Karen Allman Chief People Officer	✓	✓	x	x
Debbie Fleming Chief Executive	✓	✓	x	x
Peter Gill Chief Informatics Officer	x	✓	✓	x
Mark Mould Chief Operating Officer	x	✓	✓	x
Richard Renaut Chief Strategy & Transformation Officer	✓	✓	✓	✓
Was the meeting quorate?	Y	Y	Y	Y

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

WORKFORCE STRATEGY COMMITTEE ANNUAL REPORT 2021/22

1 PURPOSE OF THE REPORT

1.1 The Workforce Strategy Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference between 1 April 2021 and 31 March 2022. The Committee seeks to provide the Board with evidence that it met its responsibilities as set out in its term of reference during the relevant period.

2 OVERVIEW & RESPONSIBILITIES

2.1 The Committee is responsible for the monitoring of matters relating to workforce planning, development, human resources policy and the People Strategy; ensuring workforce strategies are appropriate. The Committee monitors the management needed to deliver a workforce with the capacity and capability to provide high quality, safe patient care in line with strategic objectives, the Trust's values and the relevant elements of the Board Assurance Framework.

2.2 The Committee receives a number of quarterly, bi-annual and annual reports appropriate to its purpose.

2.3 A governance cycle detailing which papers are to be expected at each Committee meeting is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was formally reviewed and approved in October 2021. This updated governance cycle is attached as **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Committee comprises four Non-Executive Directors, the Chief People Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief Nursing Officer. The Committee membership in 2021/22 comprised:

- Cliff Shearman, Non-Executive Director and Committee Chair
- Caroline Tapster, Non-Executive Director
- Christine Hallett, Non-Executive Director *(retired 31 December 2021)*
- Stephen Mount, Non-Executive Director
- Karen Allman, Chief People Officer
- Alyson O'Donnell, Chief Medical Officer
- Paula Shobbrook, Chief Nursing Officer
- Mark Mould, Chief Operating Officer

4 MEETINGS

4.1 Five formal meetings were held during the year:

- Wednesday, 21 April 2021
- Wednesday, 16 June 2021
- Wednesday, 18 August 2021
- Monday, 11 October 2021
- Wednesday, 16 February 2022

A meeting had been scheduled for Wednesday, 15 December 2021. However, this meeting was cancelled due to operational pressures. The reports due to be presented were circulated to the Committee.

4.2 Meeting attendance is detailed in **Appendix 2.**

5 COMPLIANCE WITH TERMS OF REFERENCE

5.1 In accordance with its terms of reference, the Committee was composed of four Non-Executive Directors, the Chief People Officer, Chief Medical Officer, Chief Operating Officer and Chief Nursing Officer.

5.2 Five meetings took place in the period from 1 April 2021 – 31 March 2022 and all were quorate, noting that the meeting held 16 February 2022 began without a quorum but became quorate during the course of the meeting, allowing all necessary business to be transacted.

5.3 A formal review of the terms of reference was undertaken in October 2021 and the terms have been updated as necessary throughout the year. A review of the Committee's compliance with its own terms of reference has been undertaken in May 2022 by scrutinising the agendas and minutes of the five Committee meetings which took place between 1 April 2021 and 31 March 2022.

6 DUTIES AND FINDINGS

6.1 The Committee's terms of reference require it to have oversight of the following areas:

6.1.1 Workforce Development, Planning & Performance:

To fulfil this responsibility the Committee received regular reports from the Chief People Officer, Chief Nursing Officer and Chief Medical Officer, in addition to a regular update from each of the Trust's Care Groups.

Quarterly reports from the Freedom to Speak Up (FTSU) Guardian, and Guardians of Safe Working Hours were presented to the Committee.

The Committee received a review of safe staffing in February 2022.

Furthermore, a report on workforce planning was due to be presented to the December 2021 meeting which was cancelled due to operational pressures. This report was circulated to the Committee at the time and would be presented again to the April 2022 meeting (outside the scope of this reporting period).

6.1.2 **Risk Management**

The Committee received a regular report on risks relating to workforce and organisational development.

6.1.3 **Staff Engagement**

The Committee received a report on the staff survey in October 2021. An update on staff engagement also formed part of the Chief People Officer's regular report.

6.1.4 **Education, Training, Apprenticeship & Development**

The Committee received a quarterly report on education and training. Additionally, in February 2022, as part of an exception report from the Workforce & Organisational Development Group, the Committee discussed a Level 7 senior leaders apprenticeship offered in partnership with Bournemouth University.

6.1.5 **Equality, Diversity & Inclusion**

The Committee received quarterly ED&I reports, monitoring the implementation of the ED&I strategy. Additionally, an annual report on Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) was received in October 2021.

6.1.6 **Pay & Reward**

The Committee were due receive a report on gender pay at the cancelled December 2021 meeting. This report was circulated at the time and would be tabled for the April 2022 meeting to be formally discussed (outside the scope of this reporting period).

6.1.7 **Health & Wellbeing**

The Committee discussed and received regular updates on Health & Wellbeing as part of the Chief People Officer's report.

6.2 The Committee's terms of reference do not specify how far in advance meeting papers must be circulated to members of the Committee. This would be brought in line with the terms of reference of the Trust's other Committees at the next formal review of the terms of reference.

7 CONCLUSION

7.1 The Committee has complied with its terms of reference in 2021/22, as detailed in section 6 of this report.

Cliff Shearman
Chair, Workforce Strategy Committee
June 2022

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

WORKFORCE STRATEGY COMMITTEE

GOVERNANCE CYCLE OCTOBER 2021

REGULAR REPORTS

People Plan: report on progress to include Recruitment & Retention; Workforce Planning & Forecasting; People Engagement; Diversity, inclusion and race equality; Education and Training; Health and Wellbeing; People Policies, Processes and Systems; and Leadership and Management	CPO
Chief Medical Officer's Report	CMO
Chief Nursing Officer's Report	CNO
Care Group Updates	Care Group Dir. Ops
Staff Network: Staff Experience	Network Chairs
Board Assurance Framework – Quarterly review of strategic risks relating to Workforce and Organisational Development	CPO

QUARTERLY REPORTS

Freedom to Speak Up	February; April; August; December;	FTSUG
Guardian of Safe Hours Report	Q4 – June; Q1 – August; Q2 – December; Q3 – Feb	CMO
Monitoring and Implementation of the Equality, Diversity and Inclusion Strategy, including reports on staff networks	April/June/August December	Director of OD
Education and Training: including apprenticeships and essential core skills	February; June; October; December	Head of Education

BI-ANNUAL REPORTS

Safe Staffing Review	December/June	CNO
NHS Staff Survey Update	April/October	Director of OD

ANNUAL REPORTS

Workforce Strategy Committee Terms of Reference	October	Chair
Workforce Strategy Committee Governance Cycle	October	Chair
Workforce Strategy Committee Annual Report	June	Co Sec
Annual Freedom to Speak Up Report	April	FTSUG
Workforce Race Equality Standard (WRES)	October	Director of OD

Workforce Disability Equality Standard	October	Director of OD
Annual Equality and Diversity Workforce Monitoring Report	May	Director of OD
National NHS Staff Survey (Family and Friends Test)	When published	Director of OD
GMC Trainees Survey	When published	CMO
Revalidation: Annual Organisational Audit	June	CMO
Gender Pay Gap	February	CPO/ Director of OD

Appendix 2

WORKFORCE STRATEGY COMMITTEE ATTENDANCE REGISTER 2021/22

NAME OF COMMITTEE:	**WORKFORCE STRATEGY COMMITTEE**				
REPORTS TO:	**BOARD OF DIRECTORS**				
Membership (as per Terms of Reference):	**MEETING DATES**				
	21 April 2021	16 June 2021	18 August 2021	11 October 2021	16 February 2022
Cliff Shearman (Chair) Non-Executive Director	✓	✓	✓	✓	✓
Christine Hallett Non-Executive Director	✓	✓	✓	✓	NE
Stephen Mount Non-Executive Director	x	x	x	✓	x
Caroline Tapster Non-Executive Director	✓	✓	x	✓	✓
Karen Allman Chief People Officer	✓	✓	✓	✓	✓
Mark Mould Chief Operating Officer	x	x	✓	x	x
Alyson O'Donnell Chief Medical Officer	✓	✓	✓	x	✓
Paula Shobbrook Chief Nursing Officer	✓	✓	x	✓	x
Was the meeting quorate?	Y	Y	Y	Y	Y

*NE - *Not Eligible*

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 July 2022

Agenda item: 8.1

Subject:	Merger Benefits Realisation Update

Prepared by:	Helen Rushforth, Head of Productivity and Efficiency
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer

Purpose of paper:	For noting
Background:	As part of the process for the patient and merger case we identified a range of expected benefits from the changes and investment. Each Care Group is further developing a broader range of benefits and metrics which are being reported through the relevant Transformation Steering groups and the Benefits Realisation Assurance Group
Key points for Board members:	We are on target for meeting the majority of the identified patient benefits with only ED at risk due to the substantial COVID pressures in that area. The impact of the COVID pandemic has been felt more in the area of merger benefits with significant challenges relating to our workforce and the development of savings plans whilst we have been under significant operational pressures.
Options and decisions required:	None
Recommendations:	Benefits are being regularly monitored through the Care Group Transformation Steering Groups and Benefits Realisation Assurance Group and we are therefore recommending that this reporting update should come to Board on an annual basis.
Next steps:	An approach to focus on overall integration of services and a timetable up to reconfiguration will now be developed, to prepare the organisation for the planned changes ahead.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register		
Strategic Objective:		
BAF/Corporate Risk Register: (if applicable)		
CQC Reference:		
Committees/Meetings at which the paper has been submitted:		**Date**

Benefits Reporting Update

The table below sets out the current performance against the benefits identified as part of the PBC and MBC and their current status. Each Care Group is developing a broader range of benefits and metrics which are being reported through the relevant Transformation Steering groups and the Benefits Realisation Assurance Group.

As part of the plan to develop improvement priorities for each Directorate we are using a range of data sources (e.g. GIRFT, model hospital) to identify measureable areas of performance supporting patient quality and the wider transformation agenda. Increased communication from BRAG to celebrate opportunities has been developed (see Appendix).

Benefits are being regularly monitored through the Care Group Transformation Steering Groups and Benefits Realisation Assurance Group and we are therefore recommending that this reporting update should come to Board on an annual basis.

Initiative / Operational change	Implementation	Benefit to patients	Number of patients to benefit	Update
Emergency Hospital				
Integrated ED workforce	Pre-	Improved clinical decision-making as a result of systematic knowledge sharing between ED clinicians, particularly in those specialties that are only delivered at one of the merging Trusts	500 per year	Joint nurse training. Development of ED workforce model and template planned. Well developed flexing and intelligent conveying between Eds to reduce overall pressures on emergency care and improve resilience. RISK: Increase in majors demand and acuity impacting operational performance and may lead to the need to reconsider future model RISK: Difficulty of recruiting and training ANPs to support workforce model

Quality improvement through standardisation				
Standardisation of treatment protocols and patient pathways in overlapping specialties	Pre-	The adoption of standardised practices due to consolidation of overlapping services in a single location will lead to the adoption of best practice from each Trust	190,000 per year	Further development of single clinical pathways and engagement with Transformation programme of work has continued. Antenatal planning single service from later in 2022.
Haematology				
Patients at Poole Hospital able to access clinical trials operated from Bournemouth Hospital	Pre-	Early access to NHS licenced but unfunded drugs leading to better treatment outcomes	350 per year	Haematology research trials now started although some issues due to pharmacy capacity. Increased access to trials across sites (more recruited – currently observational trials)
Stroke				
Hyperacute stroke admissions consolidated at Royal Bournemouth Hospital	Pre-	Improved patient mortality and morbidity, reduced length of stay, greater independence and better quality of life following a stroke	1,300 per year	TIA weekend clinics moved to RBH site; increased activity through ESD (Early Supported Discharge) Dorset Clinical Reference Group supported move to single stroke unit. Timetable being confirmed. RISK: Long term sickness and vacancies causing operational challenges RISK: Delayed discharges with social services
TIA clinics consolidated at Poole Hospital	Pre-	Reduced risk of subsequent stroke	40 per year	

General Surgery				
Consolidation of colorectal cancer re-section activities, Complex Upper GI surgery and Pelvic Floor surgery	Pre-	Improved patient outcomes from concentrating small volume activity on consultants with most relevant sub-sector expertise	40 per year (min.)	Joint PTL and MDT now in place. Pelvic floor surgery consolidated. All complex upper GI moved to RBH. Currently reviewing future on-call rotas with external help secured to facilitate.
Maternity				
New maternity unit at Royal Bournemouth Hospital	Post-	Significantly improved birth experience for women, especially those with mental health issues, disabilities or raised BMI and accommodation for partners	4,400 per year	Birth centre at RBCH has now been consolidated at Poole site with the changes in access to care being implemented. Developments in the estate are being planned as part of the wider CSR transformation programme which will further support the improved birth experience. Agreement for the new model for antenatal clinics implemented
		Faster access to emergency services for women who develop complications before, during, or after giving birth at RBCH	100 per year	
		Faster access for women needing emergency care at PHT	25 per year	

Ref	Merger Benefit	Owner	Current Status	Comments	
MB1	Better workforce deployment and development	**Karen Allman**		Rotation of workforce across both sites in some Clinical Specialities. Role of Workforce Planning Group moving forward	Developing across site and with different clinical teams
MB2	Improved recruitment	**Karen Allman**		Recruitment/Retention being delivered in a joined up co-ordinated way across sites.	Significant international recruitment programme commenced. Job market significantly different due to COVID.

MB3	Reduction in temporary staffing (Agency and Bank)	**Karen Allman**		Linked to CIP (key metric spend); analysis limited by COVID impact	Significant work on-going to manage staffing; with ward template review process commencing. COVID has placed significant challenge on staffing and understanding changing baseline hence red risk. Agency costs reducing trend
MB4	Development of new roles	**Karen Allman**			On-going with appointments to RNDA and physician associate roles
MB5	Single strategic approach to estate development and utilisation	**Richard Renaut**		Capital Estates plan in place and Single Estates Team. Space Utilisation Group will play a role in decision making for future improvements on utilisation	In place and developing. Ability to work as a single team enabled fast response and development of new work programmes. Consistency of approach with rollout of ISO9001 quality compliance to ensure better and consistent assurance against standards.
MB6	Single unified IT strategy with improved reliability and productivity	**Peter Gill**		Single strategy in place. System Prioritisation approach developed to determine what systems will be integrated when. Financial benefits captured as part of MB8. Data Collection scorecard being developed for qualitative measures relating to reliability	Work on-going; see Digital part of papers Single PAS project completing.
MB7	Improved efficiency through combining non clinical support functions	**Pete Papworth**		Proposals are being drafted by Chief Officers and relevant teams; check and challenge process is being developed	Business needs are limiting opportunities to explore longer term changes; however, redesign is starting to identify changes and options
MB8	Efficiency in adopting new systems and processes for the Trust	**Pete Papworth**		Systems audit being completed; prioritisation and resource requirement scoping in progress	Delivery of merger savings delayed due to operational pressures. Need to re-consider modelling in light of new organisational reality. Merger savings have slipped into future years due to the pressures on staffing through the pandemic
MB9	Improved procurement and commercial contracting through greater purchasing power	**Pete Papworth**		Joint work-plan completed; resource requirements and timetables being developed	3 year contract management plan being developed to align the savings and usage; Development of ICS joint procurement approach commenced.

Merger Savings

Initial estimated merger savings were c. £8.539m and at the end of 21/22 we were reporting the delivery of c. £1.8m.

Whilst initial plans forecast these savings being delivered in 21/22 (in particular the workforce savings) COIVD has reduced operational capacity for delivery of change projects and fundamentally changed our cost base.

The savings are a mix of cash and cost avoidance so delays in our intended savings have impacted upon our delivery of CIP it is not the whole £6.6m that would reduce our CIP shortfall.

	Actual	Actual	Actual	Future Years	Total
	2019/20	2020/21	2021/22		
Non-Medical Clinical Workforce			461	4,496	4,957
Strategic Workforce: Policies and Processes				266	266
Strategic Workforce: Corporate Structure	350	522	476	544	1,832
Outpatients			0	243	243
IM&T				474	474
Procurement		42	25	634	698
Other			76		69
	350	**564**	**1,040**	**6,657**	**8,539**

1. Non-Medical Clinical Workforce – much of the savings in this assessment relate to a reduction in agency premium and as such would not be allocated against our cash-releasing CIP target; c. £1m is in our forecast for cost avoidance this year with the potential for this to increase further.
2. Strategic workforce relates to a change in approach to the delivery of overtime and as such does not deliver savings against our budgets
3. Corporate structure savings should be cash releasing as they relate to the consolidation of corporate teams. To date c. £145k has been included in our CIP forecast for this year
4. Outpatients relates to the consolidation and implementation of our digital outpatients approach and is mix of cash out and productivity. To date c. £150k of cash releasing is included within our forecast with a further £574k productivity opportunities in the pipeline.
5. IM&T savings related to the opportunities from consolidating IT systems; whilst there are relatively low values for this in this year's forecast IM&T are over-performing their CIP target due to opportunities in medical records.
6. Procurement c. £1m overall procurement savings are included within this year's forecast

Appendix 1

Transformation update

Time to 'BRAG'

Welcome to the latest update from our Benefits Realisation Assurance Group (BRAG), where we review achievements since merger.

UBook

You book through U book

Since April, colleagues have been increasingly using Ubook, a web-based system, to book offices, desks and meeting rooms, including at our new facility at Yeomans House. Feedback has been extremely positive - 'really nice working experience', 'I loved being able to book my parking space', 'knowing that I can guarantee that my desk will be there when I arrive is reassuring and saves me time trying to find where I can sit'. If you would benefit from using UBook to organise and facilitate office/room/desk bookings, please email **katie.pritchett@uhd.nhs.uk** or **juliet.jephson@uhd.nhs.uk**.

Helping to keep us safe

Both RBH and Poole now share one security provider, Allied Security, providing out of hours and weekends support under one combined contract ensuing consistent, effective support for patients and staff.

Site divert system helping with resilience

When one of our emergency departments is under pressure, we can now divert patients more quickly ensuring better care and a safer ED for everyone.

OH and wellbeing

As well as arranging vaccination clinics for all our staff, the OH team has now set up a rehabilitation programme for staff with long Covid in conjunction with the respiratory physio service. They have also extended the staff physiotherapy service to Poole Hospital staff and recruited more OH nurses to provide a more responsive service for our teams.

System-wide approach helping wellbeing

We are working collaboratively with the ICS wellbeing service to develop support for staff who are absent from work due to stress/mental health.

Digital support for life support

Our education department has reviewed and revised the basic life support training to reduce the amount of face-to-face training required by combining this with an e-learning module.

If there is something you want to 'BRAG' about in our next update, please get in touch. Send your suggestion to Helen Rushforth, head of productivity and efficiency at **helen.rushforth@uhd.nhs.uk**

Departure lounge trialling at Poole

Universal IT systems and processes mean UHD staff are able to support patient flow and discharge through the development of our new departure lounge (with staff moving between sites to ensure that resources are in the right place).