University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 30 November 2022

13:15 – 15:15

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 30 November 2022 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 30 November 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 28 September 2022	**Paper**	**Approval**	**Chair**
	4.2	Matters Arising - Action List	**Paper**	**Review**	**Chair**
13:30	**5**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
	5.1	Trust Chair's Update	**Verbal**	**Assurance**	**Chair**
	5.2	Chief Executive Officer's Report	**Paper**	**Assurance**	**CEO**
	5.3	ICB Trust Board Minutes – 1 September 2022	**Paper**	**Information**	**CEO**
13:45	**6**	**QUALITY AND PERFORMANCE**			
	6.1	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Assurance**	**EDs**
	6.2	Mortality Report (Q2)	**Paper**	**Information**	**ACMO**
	6.3	Annual Winter Plan	**Paper**	**Approval**	**COO**
	6.4	Risk Register Report	**Paper**	**Approval**	**CNO**
	6.5	CQC Inspection Update	**Paper**	**Information**	**CNO**

	6.6	Kirkup (East Kent) Review	**Paper**	**Information**	**CNO**
	6.7	Ockenden Report	**Paper**	**Information**	**CNO**
	6.8	Board Assurance Statement: Elective Care	**Paper**	**Ratification**	**COO**
14:25	**7**	**GOVERNANCE**			
	7.1	Board Assurance Framework (six-month review)	**Paper**	**Information**	**CNO**
	7.2	Standing Financial Instructions – Annual Review	**Paper**	**Approval**	**CFO**
	7.3	Amendment to the Trust's Constitution	**Paper**	**Approval**	**Chair**
	7.4	Board Schedules for 2023 and 2024	**Paper**	**Approval**	**Chair**
15:00	**8**	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 27 November 2022 to company.secretary-team@uhd.nhs.uk		**Receive**	**Chair**
	9	Any Other Business	**Verbal**		**Chair**
	10	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 25 January 2023 at 13:15.			
	11	**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	**12**	**Close**	**Verbal**		**Chair**

* to be received

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The recording will be deleted after the minutes of the meeting have been approved.

Items for Next Board Part 1 Agenda

Standing Reports

- Patient Story
- Trust Chair's Update
- Chief Executive Officer's Report
- Integrated Performance Report
- Risk Register Report
- Integrated Care Board Minutes (November 2022)
- Annual Board Effectiveness Report
- Terms of Reference:
    - Transformation Committee
    - Sustainability Committee

Quarterly Reports

- Quality Impact Assessment Overview Report

Reading Room Materials

Integrated Quality, Performance, Workforce, Finance and Informatics Report *(Agenda Item 6.1)*
Annual Winter Planning Slides – Appendix B *(Agenda Item 6.3)*
Risk Register Report *(Agenda Item 6.4)*
Kirkup Review *(Agenda Item 6.6)*
Board Assurance Framework *(Agenda Item 7.1)*

List of abbreviations:

ACMO – Acting Chief Medical Officer
CEO – Chief Executive Officer
CNO – Chief Nursing Officer
EDs – Executive Directors
ADCG – Associate Director of Corporate Governance
CFO – Chief Finance Officer
COO – Chief Operating Officer

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

AGENDA – PART 2 PRIVATE MEETING

15:30 on Wednesday 30 November 2022

Time	Item		Method	Purpose	Lead
15:30	**13**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	14	Declarations of Interest	**Verbal**		**Chair**
15:35	**15**	**MINUTES AND ACTIONS**			
	15.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 28 September 2022	**Paper***	**Approval**	**Chair**
	15.2	For Accuracy and to Agree: Part 2 Minutes of meeting held on 26 October 2022	**Paper***	**Approval**	**Chair**
	15.3	Matters Arising – Action List	**Paper***	**Review**	**Chair**
15:40	**16**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
	16.1	Trust Chair's Update	**Verbal**	**Assurance**	**Chair**
	16.2	Chief Executive Officer's Update	**Verbal**	**Assurance**	**CEO**
15:50	**17**	**QUALITY AND PERFORMANCE**			
	17.1	Serious Incident Report	**Paper**	**Information**	**ACMO**
	17.2	Cost Improvement Plan	**Paper**	**Information**	**CFO**
	17.3	Maternity Safe Staffing Report	**Paper**	**Information**	**CNO**
	17.4	Maternity Data Strategy	**Paper**	**Information**	**CIO**
	17.5	CQC Update	**Verbal**	**Discussion**	**CNO**
16:05	**18**	**GOVERNANCE**			
	18.1	Macmillan Caring Locally Enabling Works	**Paper**	**Approval**	**CSTO**
	18.2	Local Clinical Excellence Awards	**Verbal**	**Information**	**ACMO**
16:15	**19**	**STRATEGY & TRANSFORMATION**			
	19.1	Estates Update	**Paper**	**Information**	**CSTO**
16:50	**20**	Escalations from Board Committees: Charitable Funds Committee	**Verbal**	**Assurance**	**Committee Chairs**

		Finance and Performance Committee Quality Committee Private Patients Strategy Committee			
	21	Any Other Business	**Verbal**		**Chair**
	22	Reflections on the Board Meeting	**Verbal**		**Chair**
	23	**Date and Time of Next Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 25 January 2023 at 15:30.			
17:00	**24**	**Close**	**Verbal**		**Chair**

* late paper

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Items for Next Board Part 2 Agenda

Standing Reports

- Trust Chair's Update
- Chief Executive Update
- Integrated Performance Report Summary
- Cost Improvement Programme
- Serious Incident Report

Annual Reports

- Draft Annual Operational Plan

Reading Room Materials

Birthrate Plus Final Report *(Agenda Item 17.3)*

List of abbreviations:

Officer titles

ACMO – Acting Chief Medical Officer
CEO – Chief Executive Officer
CFO – Chief Finance Officer
CNO – Chief Nursing Officer
CSTO – Chief Strategy and Transformation Officer

Other abbreviations

ED – Emergency Department
HSMR – Hospital Standardised Mortality Ratio
ICB – Integrated Care Board
ICS – Integrated Care System
ITU – Intensive Therapy Unit
MSG – Mortality Surveillance Group
NHSE/I – NHS England/Improvement
#NOF – Fractured neck of femur
OPEL – Operational Pressures Escalation Levels
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UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Board of Directors Part 1 meeting held on Wednesday 28 September 2022 at 13:15 via Microsoft Teams.

Present:	Rob Whiteman	Trust Chair *(Chair)*
	Karen Allman	Chief People Officer
	Pankaj Davé	Non-Executive Director
	Peter Gill	Chief Informatics Officer
	Philip Green	Non-Executive Director
	Siobhan Harrington	Chief Executive
	John Lelliott	Non-Executive Director
	Mark Mould	Chief Operating Officer
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy & Transformation Officer
	Cliff Shearman	Non-Executive Director
	Paula Shobbrook	Chief Nursing Officer
	Caroline Tapster	Non-Executive Director
	John Vinney	Associate Non-Executive Director
	Ruth Williamson	Acting Chief Medical Officer
In attendance:	Yasmin Dossabhoy	Associate Director of Corporate Governance
	Ewan Gauvin	Corporate Governance Manager

BoD 223/22	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting. Apologies were received from: • Stephen Mount, Non-Executive Director The meeting was declared quorate.
BoD 224/22	**Declarations of Interest** No further interests were declared.
BoD 225/22	**Patient Story** Fiona Gillespie presented the patient story in relation to the taxi service at the Outpatients Assessment Clinic at Beales, Poole. Peter Gill congratulated the team on the patient focus and the support to staff. Siobhan Harrington echoed this, referencing her recent visit where she had been impressed with the innovation, teamwork, creative use of volunteers and positive outcomes for patients. The Trust was using it as an active Quality Improvement Process, with the teams transforming and changing their models. The Board NOTED the Patient Story.

BoD 226/22	**For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 27 July 2022** The minutes of the Board of Directors meeting held on 27 July 2022 were APPROVED as an accurate record.
BoD 227/22	**Matters Arising – Action List** **BoD 073/22 –** *Annual Board Effectiveness Report* **–** Rob Whiteman reported that work was ongoing. This action would be brought back to the November 2022 meeting of the Board of Directors. Action remained OPEN. **BoD 135/22 –** *Board Meeting Schedule* **–** The draft schedule had been included in the meeting materials. Action CLOSED.
BoD 228/22	**Trust Chair's Update** Rob Whiteman paid respect to Her Majesty the Queen following her passing. He reflected upon the difficult week it had been for the country, with the likelihood that interest rates may increase up to 6%. The impact of the cost of living crisis needed to be considered, not only for patients but also for staff. Commenting on the Treasury Spending Review, which had been deferred, he outlined the difficulty for public institutions, such as the Trust, of operating in a short-term position with the medium-term position to be resolved. While the Trust spent £100m greater than it did three years ago, prior to Covid, the spending pressures and demands upon its services exceeded the additional funding it received. He had been informed of the unannounced CQC inspections taking place that day and the following day in medicine and surgery, with the Board recognising the current demands on the executive team. Since the last meeting of the Board, Rob Whiteman had visited both A&E departments at Royal Bournemouth and Poole hospitals; met the Chair of the Integrated Care Board (ICB), and the chairs and chief executives of Dorset Healthcare and Dorset County Hospitals in addition to internal stakeholders. Referring to the draft Board and Committee schedule for 2023, he explained that the Board had received clear feedback from the executive team that while insight and challenge was welcome, there was considerable governance with large numbers and frequency of meetings. The draft 2023 schedule sought to redress this with Committee meetings not being in the same week as the Board meetings, providing opportunity for assurance reports to be written. Although the timetable for preparation of performance information would remain, a consequence would be such information being produced at the same time as the Committees met. However, it was intended that when the Committees met, they could be updated with that more up to date information verbally. He summarised that the next phase of the governance review would be the streamlining of, and reduction in, the number of committees, working with external governance advisers. The Trust's Annual Members' Meeting was being held on 18 October 2022 from 17:00 to 18:00 at Royal Bournemouth Hospital in the Education Centre. The Board NOTED the Trust Chair's Update.
BoD 229/22	**Chief Executive Officer's Report** Siobhan Harrington presented the Chief Executive Officer's Report, thanking all staff across the Trust for their work during the current challenging times.

	She highlighted the recent announcement by the new Secretary of State for Health and Social Care - the Trust was working with colleagues to understand the impact of the new regime. The focus on improvement was welcomed. The Trust continued to focus upon ambulance improvements and the support to discharge patients from hospitals, which the Trust was working upon, was also well received. The ICB had met twice since 1 July 2022. Going forward, minutes of the meetings would continue to be included in the Trust Board's meeting materials. Referencing the Covid data in her report, she reported that there had been a slight increase in the number of incidents. It was important that the Board supported the campaign in relation to Covid and flu vaccination. In relation to the seven-day services outlined in her Chief Executive Officer's Report, Siobhan Harrington explained that the aim was to have services, operating 24 hours a day, seven days a week across all the Trust's service lines. Regard for this was being had in plans as the reconfiguration of the Trust's services progressed, with Ruth Williamson leading on this in discussion with the Trust Management Group. She encouraged staff members to complete the NHS Staff Survey. During October, Trust staff were being asked to wear green on Wednesdays in recognition of Freedom to Speak Up month. Alyson O'Donnell had stepped down as Chief Medical Officer, with Siobhan Harrington extending thanks to her for all her contribution to the Trust. In addition to highlighting the current financial position (which would be covered later in the meeting), the antenatal and maternity services having come together and also the Staff Excellence awards, she referenced the steps that had been taken by the Trust to support staff with the current cost of living issues. The Board NOTED the Chief Executive Officer's Report and the ICB minutes.
BoD 230/22	**Integrated Quality, Performance, Workforce, Finance and Informatics Report (IPR)** Mark Mould presented key messages from the IPR in relation to performance. As a Dorset system, treatment and opportunities were being offered for patients where those opportunities could not be offered at either the Trust or Dorset County Hospital, citing examples within orthodontics and cancer. Innovation and creativity had been delivered in Super September within ear nose and throat (ENT) and gynaecology relating to the ordering of patient appointments, with significant clinically driven and operationally supported progress having been made. He outlined the additional insourcing that was being undertaken for two diagnostic areas and potential plans to retain the CT scanner at the Poole site, which was operating 12 hours a day, seven days a week thereby giving extra capacity for patients. Organisational flow continued to remain challenged, with high occupancy predominantly driven by patients with no criteria to reside and consequent impact on ambulance handovers. Discussions continued with local authority partners on unlocking flow in the social care market. Winter investment was being progressed to create alternatives to capacity, such as same day emergency care capacity. The Trust had adopted an innovative approach to create capacity through virtual wards.

	In August 2022, the Trust had seen the highest number of cancer referrals for four years, which was a trend unlikely to change. Pankaj Davé enquired how the Trust assured itself that patients with conditions who were waiting for extended periods were not experiencing further deterioration. Mark Mould outlined the Trust's active validation program across its active waiting lists. A validation letter was sent to understand whether patients continued to need their appointments. If this were considered by the patient as no longer needed, clinicians could validate that. If it were considered by the patient as still needed, then there were questions agreed with consultants to support a determination of whether intervention was required for that patient cohort. Ruth Williamson also commented upon the use of clinical validations to risk assess long waiters. Cliff Shearman commended Mark Mould on the extent of the data presented. However, he raised the increasing national and local concern relating to the clinical prioritisation grid, which had been set up for urgent surgery rather than long term elective. Commenting on the pressure to move two week cancer patients, he asked how the organisation would balance this against other patient groups, taking into account potential harm. Mark Mould referred to the engagement process that took place with clinicians. Referring to the IPR paper in the materials, Caroline Tapster enquired about how the data relating to health inequalities was being utilised and about the impact of it. Mark Mould responded that the usage was currently immature but with the data now available next steps would be to progress its application. Ruth Williamson added that she was part of a group considering health inequalities. The discovery phase was mature; the design phase was now an opportunity to help people from disadvantaged backgrounds to attend their hospital appointments. There was a notable discrepancy in appointment attendance between the most affluent and the least advantaged. Targeted interventions were being reviewed. In the context of the wider hospital population, efforts were underway to enhance siloed working - for example, the endocrine team were covering a ward historically looked after by gastroenterologists to free up gastro capacity to provide more endoscopy. There was evidence from the north east in relation to triaging patients to improve the conversion rate for lower gastrointestinal malignancy. Rob Whiteman asked whether there was an update on urgent treatment centres and aligning how the two emergency departments at Bournemouth and Poole hospitals operated before reconfiguration of services. Mark Mould confirmed that there was system funding to provide GP capacity in emergency departments. Nationally, there had been a shift with monies associated with primary care capacity being placed back in the primary care networks. This had left the Trust in a situation which potentially removed the primary care capacity it accessed. However, the ICB had been pragmatic with an interim solution until the end of March 2023, continuing the capacity. Ongoing conversations until January 2023 to describe and agree the final model for 2023/24 would continue, recognising that with a planned and emergency care hospital, the Trust had a significant treatment centre. Paula Shobbrook presented key messages from the IPR in relation to Quality. The key element of focus was upon falls, this having been discussed at Quality Committee the previous day. Several interventions were in place. A summit was being planned to review falls, looking at the pre-pandemic baseline. Patients that did not meet the criteria to reside had increased risk. In addition, there had been moving and handling team constraints with training. In addition to the highlights in the report, she added that there had been discussions the previous day in relation to maternity services. Additional

	maternity key performance indicators would be presented to the Board in the IPR in future. Rob Whiteman expressed concern about the data on falls and enquired how long the summit would take. Paula Shobbrook confirmed that it would be taking place within the month, with reporting to the following month's Quality Committee. The data was available and was being reviewed to ensure the appropriate staffing and model of managing bays and observations were in place. Karen Allman presented key messages from the IPR in relation to Workforce referencing turnover, recruitment both within the Trust and comparatively, sickness absence, mandatory training and wellbeing (including financial wellbeing and support). Brief reference was also made to potential national industrial action. Rob Whiteman enquired about the likely trend with turnover and vacancy rates, with Karen Allman responding that it was challenging with there being pressure in the system nationally and staff locally considering their options. Retention was a key area of focus, including having a balance of internal mobility. Peter Gill presented the Informatics highlights from the IPR. In relation to the measurement of network uptime, he cited the example that earlier that morning, one of the components that sends messages between systems went offline, resulting in four key systems not receiving updated patient data. The Trust had 130 critical systems impacted if the network goes down, hence the focus upon network uptime. The network team had recently deployed a new Wi-Fi network at Bournemouth and there had been a significant step change in demand for the service desk. Pete Papworth presented key messages from the IPR in relation to Finance. The Trust's financial performance was behind plan. He summarised the deficit at the end of August with drivers behind it and current position on CIP delivery. Over the next six months, continued focus was required on CIP delivery. It was expected that winter demand and capacity funding would be confirmed shortly. Further information was awaited in relation to the additional funding announced the prior week to support discharges and also the impact of the removal of the National Insurance uplift. During July and August 2022 agency expenditure had increased significantly, which was understood to be driven by the holiday season; it was important that this reduced in September 2022. The Trust was significantly behind plan on capital. Rob Whiteman referenced Philip Green having raised previously the protocols being introduced for agency spend and enquired about the progress on achieving those. Pete Papworth updated that the agency controls would be introduced from the beginning of October 2022, particularly focused on ensuring caps, such as national price caps for agency and reducing Tier 4 usage, were observed. Karen Allman also referenced work in progress in relation to medical rates, with Ruth Williamson adding that she had instigated a QI project relating to workforce reviews. Philip Green enquired whether the finance team had the opportunity to model the impact of inflationary pressures on the Trust's finances on a whole year basis. Pete Papworth updated on the commencement of the financial planning process for the upcoming year. The largest anticipated area of spend and inflationary pressure was energy, which was anticipated to increase from approximately £4.2m last year to £14.1m next year. He outlined the planning being undertaken for the Trust's energy and consideration being given to its contracts.

BoD 231/22	**Mortality Report** Ruth Williamson presented the Mortality Report noting that the Trust was performing as expected or better than expected in all aspects of mortality. Fractured neck of femur remained an area of focus, this also being a population health issue in terms of early prevention. This was a live issue across the ICB and Integrated Care System, with Dorset having some of the highest prevalence, representing its demographic. The Trust's medical examiners had been nominated for a Health Service Journal award for the way in which medical examination had been rolled out not only within the Trust but also for practices being brought on board in Dorset. Cliff Shearman commented on the exemplary approach taken by the Trust in relation to mortality, with it now having the double pronged approach of not only looking at mortality rates but also the causes of death with medical examiners. The Board NOTED the Mortality Report.
BoD 232/22	**Risk Register Report** Paula Shobbrook presented the Risk Register Report, highlighting the reduction in the risk related to maternity community services. She also drew to the Board's attention that within the detail of the full Risk Register Report, there were certain action plans noted as being out of date. She reminded the Board that the Risk Register was a point in time and that those had been actioned, although not aligned at the time of publication. The Board NOTED the Risk Register Report.
BoD 233/22	**Freedom to Speak Up Guardian Report** Helen Martin presented the Freedom to Speak Up Bi-Annual Report. She highlighted that based on the current trajectory for referrals, the Trust would continue to be above the average number of cases using this route. In 47% of cases, staff were using the Freedom to Speak Up team as a result of their line manager being the issue or being aware of an issue and not addressing it. A theme was also emerging of staff not feeling safe to speak with their line manager. Ongoing monitoring was needed in relation to anonymous referrals. Siobhan Harrington endorsed the Board signing the annual declaration and raised concern about the anonymous referrals. She encouraged Board members to complete the training, this also being supported by Cliff Shearman. A Freedom to Speak Up Board Development Session would be organised through the Company Secretary Team. The Board APPROVED the bi-annual Freedom to Speak Up Guardian Report.
BoD 234/22	**Guardian of Safe Hours Report** Ruth Williamson presented the Guardian of Safe Hours Report, adding that: • Doctors in postgraduate training were encouraged to report missed training opportunities or when service pressures were impacting upon their working lives. This reporting culture then informed workforce mitigations. She commented upon her concern related to the number of shifts that remain unfilled after a replacement doctor had been requested, with more resilient rotas needing to be built. • Work was ongoing in relation to a culture of supporting reporting as part of workforce reviews. The Board NOTED the Guardian of Safe Hours Report.

BoD 235/22	**Nursing Establishment Review** Paula Shobbrook summarised that safe staffing levels had been maintained across the last reporting period. While there was good oversight with matrons, with Care Group Directors of Nursing and through corporate teams, there had been a significant impact on staff where they were being moved across the hospital to provide safe staffing levels on wards. A particular focus was the healthcare support worker fill rate where data cleansing of ESR data had been undertaken. The information was being considered as part of the template review process. She reassured the Board that there was good assurance in relation to the process in place, noting the challenges with staffing. The risks on the risk register were actively being monitored through the Care Groups and the Workforce Strategy Committee. The Board NOTED the Nursing Establishment Review.
BoD 236/22	**Annual Safeguarding Report and Statement of Commitment** Paula Shobbrook introduced the Annual Safeguarding Report and Statement of Commitment, noting that this was a statutory report, which highlighted the processes in place. The report had been discussed at the Quality Committee. Following approval, the Statement of Commitment would be published on the Trust's website. While recognising it being a statutory report, John Lelliott commented on the benefit of trend analysis being included within the Annual Safeguarding Report to support triangulation. Paula Shobbrook responded that there had been an increase in the cause for concern in the mental health element. act and the mental health impact. There would be a significant piece of work following the Liberty Protection Standards coming through, to which the Trust would need to respond, which she had been discussing with Siobhan Harrington and Ruth Williamson. She also drew attention to the data in the report relating to learning disabilities. The Board APPROVED the Annual Safeguarding Report and Statement of Commitment.
BoD 237/22	**Annual Infection Prevention and Control Report – Board Assurance Statement** Paula Shobbrook presented the Annual Prevention and Control Report – Board Assurance Statement, noting that this was also a statutory report and which had been discussed at the Quality Committee. She highlighted ICNet being in place across the Trust. Positive antibiotic stewardship across the organisation had been continuing. Isolation facilities continued to be a concern but would be changed with the new build. Reference was made to the recommendations within the report that would be taken forward in the IPC group and monitored through the Quality Committee. The Board APPROVED the Annual Infection Prevention and Control Report – Board Assurance Statement.
BoD 238/22	**Emergency Preparedness Resilience and Response (EPRR) Assurance** Mark Mould presented the Emergency Preparedness Resilience and Response Assurance report, highlighting the audit that had taken place the

	previous week with positive feedback. The single control room had been established at Poole hospital. The notable change since August 2022 had been to the NHSE Core Standards. Although the extent of the changes was limited, a key theme was a deep dive in relation into evacuation and shelter, with which the Trust was partially compliant. Richard Renaut and Mark Mould would be working with nursing colleagues to test the evacuation and shelter requirement. There were some broader impactful issues with the guidance focusing upon continuity of care. The Trust would currently be declaring substantial compliance, although this had to go through an assurance process with the Dorset system to be agreed. This would be brought back to the Board. The Board APPROVED the Emergency Preparedness Resilience and Response (EPRR) Assurance.
BoD 239/22	**Equality, Diversity and Inclusion Annual Report, Workforce Race Equality Standards (WRES) Report and Action Plan; Workforce Disability Equality Standards (WDES) Report and Action Plan** Karen Allman presented the reports which had been discussed at the Workforce Strategy Committee. She drew attention to the areas of recommended focus and further work to be undertaken, while also highlighting the strong staff networks. Thanks were expressed to Debbie Robinson who had been a passionate lead for equality, diversity and inclusion and who was leaving the Trust to pursue a secondment opportunity. Siobhan Harrington commented that the theme around bullying and harassment was incredibly important and recommended a Board zero tolerance statement to bullying and harassment. The Board APPROVED the Equality, Diversity and Inclusion Annual Report, Workforce Race Equality Standards (WRES) Report and Action Plan; and the Workforce Disability Equality Standards (WDES) Report and Action Plan.
BoD 240/22	**Questions from the Council of Governors and Public** Sharon Collett, Public Governor, had submitted the following question to the Board in advance of the meeting: *Have you had chance to review Ms Coffey's policy paper: Our plan for patients and if so, what are your early thoughts on the content especially concerning the support for ambulance services and the £500m adult social care discharge fund?* Siobhan Harrington responded that it was early days, but the focus on ambulance handovers was important to the Trust. Considerable work had been undertaken by the Trust in urgent and emergency care to bring people off ambulances as soon as possible and to work with the local ambulance service. Close working with colleagues would need to continue to ensure the flow improved across the Trust. The strong focus on patients was welcomed. In terms of care, the national spotlight was helpful; the work that the Trust was focusing upon with local authority colleagues to seek to improve the discharge arrangements for patients had already been discussed. In relation to doctors and dentists, the main focus appeared to be on primary care doctors; although from the Trust's perspective, everybody was important. Keith Mitchell, Public Governor, had submitted two questions to the Board in advance of the meeting:

	RCN Nursing Workforce Standards – NWS 9 – Substantive nursing workforce below 80% is exceptional has not been achieved due to post merger, when do you think a clear vacancy position will be known? Paula Shobbrook responded that this was referenced in the Nursing Establishment Review report where the Trust had noted it did not have full compliance with the number of vacancies. She referred to the presentation earlier in the meeting when it was reported that a manual review had been completed with Karen Allman's team, the ESR team and matrons going through the level of detail and this now having been resolved. This was considered closely with the template reviews where the Finance Team and HR business partners worked alongside nursing colleagues. *Patient Flow – the average number of beds per days occupied by patients with a length of stay of over 7 and 21 dates has increased sharply. Does the Trust still operate the system of monitoring green and red days and if so is there any feedback on the number of red days?* Mark Mould explained that red and green related to "productive" and "unproductive" days in relation to a patient's stay in an organisation. The Trust's current focus across its wards was on the 10 high impact changes to make sure that there were timely ward rounds and board rounds, discharges happening over a weekend relative to the week (and where this was not happening), how Fridays were planned to encourage an increase in the number of discharges. The Trust was working on a roving team to work at weekends to increase the discharges. The current focus had not been on red and green. There were multiple initiatives nationally and locally and therefore the focus had to be on those which were considered to have the most significant impact. Ruth Williamson supported this adding that the Trust was focusing upon using its clinical staff and helping them to work with non-clinical support staff in the most effective way.
BoD 241/22	**Any Other Business** Peter Gill drew attention to a report for reference purposes in the Reading Room that would be brought to the Board in relation to the Electronic Patient Record approach. This was being worked through as a partnership arrangement across the whole of Dorset. A summit had been held with very positive attendance working through the options. Rob Whiteman thanked Board members and attendees for a thorough and positive meeting. No other business was discussed.
	The date and time of the next Board of Directors Part 1 Meeting was announced as Wednesday 30 November 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~~ Mar 2023	**November 2022:** Following the Committee Annual Reports presented to the Board in July 2022, the Board is in the process of reviewing its Committee structures (with external governance advisers engaged). It is proposed that following the Committee structures having been established that the Board Effectiveness Review be concluded at that time.	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	**July 2022:** Rob Whiteman noted that a draft schedule had been prepared and that there would be further discussion at the August 2022 Board Development Session around the Committee structure. **September 2022:** Draft schedule presented to the Board.	Complete

CHIEF EXECUTIVE'S REPORT
NOVEMBER 2022

Thank you to all our staff across UHD who continue to work incredibly hard through a demanding time. October was particularly challenging and we are now seeing some progress through November.

Whilst balancing the pressures we are all under, in October alone we saw 38,557 patients in our outpatients department and an additional 8,443 virtually. We carried out 1,319 day-case procedures, supported the birth of 352 babies, attended 14,018 patients in ED and started 211 new patients on their radiotherapy journey. We can positively reflect on the sheer volume of work the staff are continuing to manage on a day to day basis.

1 NATIONAL UPDATES

The political movements have continued since my last report and we have a new Prime Minister in Rishi Sunak. We also have a new Secretary of State for Health and Social Care, Steve Barclay. Steve Barclay has a focus on productivity, efficiency, capital spend and finance. It is likely he will visit Trusts where performance is an issue.

I attended a national CEO meeting in October organised by NHS England where there was acknowledgement of how challenging this winter will be and to continue our focus on patient safety and staff wellbeing. We're ensuring that this focus is maintained during our current planning for winter and ensuring we offer additional support for staff wherever possible.

There were a number of letters received from NHSE in October and November which focused on Winter Plans and Elective Recovery.

October was Black History Month and as part of this celebration, the Trust welcomed Yvonne Coghill, previously director of the Workforce Race Equality Standard Implementation in NHS England and deputy president of the RCN, virtually to UHD. She hosted a live Teams event focusing on compassionate leadership, authentic allyship, speaking up and changing attitudes. Listening to colleagues, we still have a lot of work to do to ensure that nobody faces discrimination or racist behaviour, abuse or even violence. An action plan is being prepared for the Trust Management Group to consider.

We have recently received communication regarding the UK COVID-19 Public Inquiry which included a request that Boards were made aware of the request on the Inquiry's behalf. As a first step in its Module 3 investigations, the Public Inquiry will be conducting a short survey of trusts and ICBs via a questionnaire to Chief Executives in the next week or so. NHS Trusts and ICBs will be asked to send the completed questionnaire to the Public Inquiry directly. The questionnaire will contain some broad open questions and a word limit for the total response.

2 QUALITY AND SAFETY

2.1 Covid

At the time of writing this report 28 inpatients have Covid across the Trust and 34 members of staff are absent due to Covid. This is an improvement from 20 October when 106 staff were symptomatic. We see a continuing reduction in covid cases.

2.2 Urgent & Emergency Care

A flow improvement programme is running to support recovery: comprising the Emergency Department, SDEC, and Operational Flow and Discharge programmes.

Attendances in October showed an 8.2% increase in ED attendances compared to September with just over 14,000 patients attending. This was more than seen in the October immediately before the COVID pandemic.

Ambulance attendances remain stable as a daily average @123 per day. The number waiting for longer than an hour rose by 120, both sites recorded just over 330 delays of more than an hour.

2.3 Elective Improvement Programmes

An elective portfolio of improvement programmes continues to support elective recovery despite the recent challenges. These programmes comprise: Theatres, Diagnostics, Cancer, Data and Validation optimisation and Outpatients programmes.

The overall waiting list size has reduced by 1942 patients since October. 104-week waiters have reduced to 63 from 76 in September. Colleagues continue to focus on every patient behind the numbers to reduce waits for our patients. The Integrated Performance Report gives further details on the waiting list activity.

2.4 Flow

Our hospitals have continued to be under pressure. An average of 258 patients were medically ready for discharge in October and this remains the biggest challenge for flow and has made the placement of patients challenging leading to ED handover delays/DTA breaches, elective cancellations and significant numbers of outliers. We continue to work with our ICS colleagues daily to manage the situation.

The average number of patients who are ready to leave/have no reason to reside (MRTL/NRTL) is at 258 this month. The overall proportion of MRTL patients remains at 29%. Internal processes accounted for 20% of patients no longer meeting Criteria to Reside (C2R). The overall delayed discharge position continues to challenge hospital flow. The overall proportion of MRTL patients in Trust Adult beds remains at 29%.

3 WINTER PLANNING

The Trust wide Winter Plan has now been agreed by the Trust Management Group and sets out the organisation's arrangements for the winter period. The plan sits as part of the wider Dorset system plan.

Winter is going to be challenging for health and social care organisations. Winter is not an emergency or considered an unusual event but recognised as a period of increased pressure due to demand Each year, all sites experience increased pressure in patient flow. The Trusts winter plan focusses on four main areas:

- Leading well
- Looking after our people & patients
- Creating the capacity to meet the demand
- Communication Plan

4 FINANCE

Operational pressures continue to drive the Trust's financial performance, increasing expenditure and limiting clinical and operational capacity to deliver efficiencies and transformation projects. This is exacerbated by rising inflation, with energy prices putting particular pressure on Trust budgets. Collectively, these pressures have resulted in a year to date deficit of £4.9 million.

However, it was pleasing to report a favourable variance against plan in October reducing the year to date adverse variance by £0.5 million. The Trust continues to forecast a full year break-even position, however, there remains considerable risk within this forecast linked to seasonal demand and capacity pressures and the potential financial impact of the planned nurses strike.

Our current focus is on identifying further savings opportunities to recover our year to date deficit in the remaining months of the year, whilst also starting the detailed planning for future years.

5 CARE QUALITY COMMISSION INSPECTIONS

In October our medical and surgical services were visited by the CQC at both our Poole and RBH sites. One consistent message we received from all the areas visited was the commitment of our dedicated staff. The CQC flagged concerns over staffing levels, staff not speaking up and our pathway for patients with a fractured neck of femur. We are still awaiting the full report from the visit, but we were pleased with the opportunity to talk to them about how we can make improvements our patients and our staff.

We received a CQC visit to our Maternity Unit at St. Mary's Hospital in early November. Again, the engagement and dedication of staff was noted. The CQC formally requested the Trust provide more information and assurance relating to Key Lines of Enquiry regarding staffing, estate, risk and governance in the maternity unit. This has been responded to and priority actions have been taken. The action plan with updated information is on track to be returned to the CQC by the deadline 5 December.

6 OTHER VISITS

I recently visited two Primary Care Networks, Poole Bay and Bournemouth PCN and Poole Central PCN. I also attended a Dorset-wide GP summit. It was clear from these meetings that the pressure currently being experienced in the acute hospitals is replicated across the whole system in Dorset.

6.1 Elective Care

On 9 November the leads for elective care from both the Regional NHSE team and Dorset ICB had an all-day visit to understand the scale of the transformation work taking place in preparing for the planned and emergency sites. It was an opportunity to share our elective challenges and plans and showcase some of the areas where the Trust is excelling. The group visited both Bournemouth and Poole hospital sites and toured ED and SDEC, the Derwent, the BEACH building and barn theatre developments and the Outpatient Assessment Centre at Beales, as well as hearing about the developments within Pathology.

The teams thoroughly enjoyed the visit and fed back that it was a privilege to see the progress – they also reflected back that no other trust in the South West is facing such transformation at scale at a time of extreme operational pressure and elective recovery.

6.2 Maternity Insight visit

UHD had the Maternity Insight visit at Poole Maternity Unit on 11 October, as part of the national programme of peer reviews to support immediate and essential actions identified in the Ockenden report. This was led by the Deputy Regional Chief Midwife, with Dorset Local Maternity and Neonatal System (LMNS) colleagues, and members of the Maternity Voices Partnership. High level verbal feedback was given at end of visit to our maternity Senior Leadership Team, our Chief Nursing Officer, Paula Shobbrook and me.

The Insight Team noted they had been made to feel very welcome and commended all staff who had been open and honest in sharing their experiences of working at UHD. The feedback highlighted dedicated staff, working hard and flexibly to maintain safety, going above and beyond to support women's choices. There was evidence that there are a number of areas of really good practice.

No immediate safety concerns were raised but the challenges and opportunities identified for improvement included: maintaining safe staffing levels, both from an obstetric and midwifery perspective, streamlining systems; including recruitment processes, meetings, and awareness of service user feedback. A report will follow, but our reflection is the recommendations also aligned with the work which is underway at UHD implementing 'Patient First' to develop our culture, increasing visibility of leaders and support innovation post Covid.

7 PATIENT FIRST

As we prepare to launch our Patient First programme, we are currently developing a detailed implementation plan. This plan will take account of our current position, and the strength and maturity of the key systems and processes within the organisation.

The first phase of the programme is an assessment of 'readiness' with support from Marianne Griffiths and colleagues. Over the coming weeks we have planned:

- a senior leadership workshop on 21 November, which was a successful session which greatly invigorated the senior team.
- individual discussions with members of the board
- 5 staff focus groups. It's gratifying to note that places have been in huge demand from interested staff across the organisation
- a 'desktop' performance data review

We have committed ourselves to a target that 95% of the Trust have heard of the term "Patient First" within a short timescale. Work is underway with our Communications team to help spread the message across the organisation.

A visit is being arranged to learn from other organisations who have adopted a similar continuous improvement approach

8 ESTATES

The Trust Executive Team have relocated to the Education Centre within Royal Bournemouth Hospital, as part of the team moves related to the new building plan. It is planned that the Executive Team will aim to be at Royal Bournemouth Hospital on Monday, Tuesday and Wednesday each week. Thursday and Friday the team will aim to be at Poole Hospital.

8.1 New Hospital Programme

The national Joint Investment Committee is meeting on 25 November to decide our Outline Business Case (OBC) for the New Hospitals Programme. A verbal update will be given at the Trust Board meeting. The funding is for the next phase of works to progress the creation of the planned and emergency hospital reconfiguration.

9 AWARDS

The following awards have been received by UHD in September and October.

Building Better Healthcare Awards

UHD and Intouch With Health won the Better Use of Technology (Acute Care) award on 2nd November for creating the outpatient Assessment Clinic (OAC) @ Dorset Health Village.

2022 Patient Experience Network National Awards

University Hospitals Dorset's (UHD) outpatient assessment clinic has picked up three accolades at the 2022 Patient Experience Network National Awards ceremony.

The Outpatient Assessment Clinic (OAC), based in Poole's Dolphin Shopping Centre, won in the following three categories: 'Partnership working to improve the experience', 'Integration and improving social care', and 'Integration and continuity of care'.

HSJ Awards

Our Outpatient Assessment Clinics have been highly commended under the Performance Recovery Award category in the National HSJ Awards which took place in November.

10 WORKFORCE

10.1 Industrial Action

The Royal College of Nursing (RCN) has announced that nursing staff at UHD have voted to take industrial action over pay levels and patient safety concerns. It is a legal requirement to give at least 14 days' notice of any intended industrial action date. Industrial action is expected to begin before the end of this year and until early May 2023. Meanwhile, The Royal College of Midwives (RCM), The Chartered Society of Physiotherapy (CSP) and Unison are currently balloting their members for industrial action. We are putting plans in place to ensure there is minimal disruption to patient care and that emergency services continue to operate as normal should any industrial action take place.

10.2 Launch of Internal Professional Standards

On 11 November we launched the UHD internal professional standards with 10 principles for effective emergency care. Staff have signed the pledge to uphold the standards. There is a QR code reader to flag when people see the standards being breached or if they have ideas to get us closer to 100%.

It's part of our emergency flow QI work and in place to help us keep each other accountable for our part in helping patients receive their care in a timely fashion.

10.3 Staff Survey

The staff survey response rate as of 23 November is 44% which is significantly above last year's response rate of 37%. The survey closes on 25 November and staff are out and about throughout the Trust encouraging staff to complete the survey prior to the closing date.

10.4 Vaccination Rates

32% of staff have received both their flu and Covid-19 vaccinations as of 23 November. This significantly lower than last year where 61% of our staff had the flu vaccine and 82% had the booster. There are several factors which appear to be affecting take up this year and it's has been noted that bank staff have very low take up rates of 14.5%. Work continues to encourage staff to be vaccinated and report if they have been vaccinated elsewhere.

10.5 Staff Wellbeing Offers

In response to the cost of living crisis and concerns about our staff a range of additional staff wellbeing offers have been set up for staff. It is hoped that these additional offers will help to ease some pressure, particularly around hot food and access to fruit and vegetables for families. The Soup and a Roll has been particularly well received by staff.

10.6 UHD Staff Excellence Awards

I have been pleased to present awards to eight staff members over the last two months. The following staff have been visited by me personally and presented with the coveted golden pin and a certificate to recognise their efforts to go above and beyond for our patients and other staff. We are preparing an intranet page where full details of the nominations are available.

Tony Bailey – Day Surgery Unit
Steph Aldridge – Macmillan Unit
Laura Thompson – Anaesthetics
Tim Brown – Materials Management
Elayne Goulding – IT
Pushpa Santosh – Stroke Rehabilitation

Jacqueline Twiss – OPD Patient Administrator
Sue Jupe – Housekeeper A4 Ward

11 DORSET INTEGRATED CARE BOARD (ICB)

I attended the ICB meeting which took place on 1 September. The minutes of the meeting are appended to my report.

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

THURSDAY 1 SEPTEMBER 2022

MINUTES

A meeting of the ICB Board was held at 10am on Thursday 1 September 2022 in the Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG

Present:

Jenni Douglas-Todd, ICB Chair (JDT)
Cecilia Bufton, ICB Non-Executive Member (CB)
Jonathon Carr- Brown, ICB Non-Executive Member (JCB)
Spencer Flower, Leader Dorset Council and ICB Local Authority Partner Member (West) (SF)
Nick Johnson, Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust (NJ) (nominated Deputy for the NHS Provider Trust Partner Member (University Hospitals Dorset)) (virtual)
Paul Johnson, ICB Chief Medical Officer (PJ)
Drew Mellor, Leader Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East) (DM)
Patricia Miller, ICB Chief Executive (PM)
Rob Morgan, ICB Chief Finance Officer (RM)
Vanessa Read, Interim Chief Nursing Officer (VR)
Dr Manish Tayal, Interim ICB Non-Executive Member (MT)
Kay Taylor, ICB Non-Executive Member (KT)
Dan Worsley, ICB Non-Executive Member (DW) (virtual)
Simone Yule, GP and ICB Primary Care Partner Member (virtual) (SY)

Invited Participants:

Neil Bacon, Chief Strategy and Transformation Officer (NB)
Sally Banister, Deputy Director Integration (SB) (part)
Louise Bate, Manager, Dorset Healthwatch (LB)
Sam Crowe, Director of Public Health (SC)
David Freeman, ICB Chief Commissioning Officer (DF)
Dawn Harvey, ICB Chief People Officer (DH) (part)
Leesa Harwood, Associate ICB Non-Executive Member (LH)
Dr Maggie Kirk, Medical Director, The HealthBus Trust (MK) (part)
Steph Lower, Corporate Office Manager (minute taker) (SL)
Stephen Slough, ICB Chief Digital Information Officer (SS)
Dean Spencer, Chief Operating Officer (DS)
Natalie Violet, Business Manager to the ICB Chief Executive (NV)
Dr Forbes Watson, Chair, Dorset GP Alliance (FW)

		Action
1.	**Apologies**	
	- John Beswick, ICB Non-Executive Member - Dawn Dawson, Acting Chief Executive – Dorset Healthcare and ICB NHS Provider Trust Partner Member - Siobhan Harrington, Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member - Matt Prosser, Chief Executive, Dorset Council - participant - Andrew Rosser, Chief Finance Officer, SWASFT – participant - Ben Sharland, GP and Primary Care Partner Member	
	The Chair advised that Dr F Watson had stepped down from his ICB Board non-executive member role having been appointed as Chair of the Dorset GP Alliance. It was planned this role would become one of the two ICB Board Primary Care Partner Members. In the interim, pending the completion of the required process, Dr Manish Tayal, Associate Non-Executive Member would undertake the role of Interim Non-Executive Member.	
2.	**Quorum**	
2.1	It was agreed that the meeting could proceed as there was a quorum of members present.	
3.	**Declarations of Interest, Gifts or Hospitality**	
3.1	There were no Declarations of Interest made at the meeting.	
3.2	Members were reminded of the need to ensure Declarations of Interest were up to date and to notify the Corporate Office of any new declarations.	
4.	**Minutes**	
4.1	The Part 1 minutes of the meeting held on 20 July 2022 were **approved** as a true record subject to the following amendment:-	
	- Paragraph 7.1.6 – to remove the word ‘no’ from the final sentence to read ‘….to ensure unmet needs were identified’.	SL

Louise Bate joined the meeting.

5. Matters Arising

5.1 8.5.3 – the Board directed that a post meeting note be provided regarding the provision of a more comprehensive response in relation to urgent appointments for the eating disorder service and how the statistics had declined over the last couple of quarters. DF

5.2 8.7.3 – work was progressing regarding the future timings of annual reports being brought to the ICB Board.

Nick Johnson joined the meeting virtually.

5.3 The Board **noted** the Report of the Chair on matters arising from the Part 1 minutes of the meeting held on 20 July 2022.

6. Patient Story

6.1 The Chief Commissioning Officer introduced Dr Maggie Kirk, Medical Director for the HealthBus Trust, a charity that provided accessible and appropriate healthcare to people experiencing homelessness in Bournemouth and the surrounding areas. The Board received a video which showed the vital work and included hearing first-hand experience from people who had accessed the service.

6.2 The integrated GP-led service was launched in December 2016 and had a close relationship with a multi-disciplinary team and other providers of homeless services. All had a common aim but there was a need to continue to become more joined up. The service also needed to be better integrated into the NHS to ensure it remained sustainable.

6.3 One of the key priorities of the ICB would be to reduce health inequalities and the HealthBus was a good example of the great work already being done. Dr Kirk would liaise with the Director of Public Health accordingly regarding the development of the Integrated Care Partnership Strategy. MK/SC

6.4 The average life expectancy in Dorset was 83 years but for the individuals needing the support of the HealthBus, the average was 43 for men and 47 years for women.

6.5 Marginalised communities often felt invisible and as a result did not seek help when needed and there was a need to safeguard people from becoming homeless in the first place.

Simone Yule joined the meeting virtually.

6.6 Taking a cohort of individuals from August 2020-21 the positive effects of the specialist focused care could be seen with an increase in the engagement with specialist homeless care and a reduction in the use of Accident and Emergency.

Dawn Harvey joined the meeting.

6.7 Core20PLUS5 was a national NHS England and Improvement approach to support the reduction of health inequalities for the most deprived 20% of the national population at both national and system level and identified five focused clinical areas that required accelerated improvement. Alongside people experiencing homelessness, this would include groups such as vulnerable migrants, Gypsy, Roma and Traveller communities and sex workers. With a common thread between all groups, the Chief Clinical Commissioning Officer would link with Dr Kirk to gain her valuable insight. PJ

6.8 GP practices were experiencing issues with the number of registered patients experiencing homelessness adversely affecting their ability to meet their health improved targets under the Quality and Outcomes Framework (QOF) which was the performance part of the GP contract. It was agreed this issue be raised nationally. DF

6.9 Unresolved dental issues remained a challenge. The charity Dentaid supported the HealthBus with a mobile dental service every few months to provide access to essential dental treatment. One barrier in attracting more NHS dentists was the current national dental contract which was not fit for purpose. National negotiations were underway regarding changes to the contract. Recognising the commissioning for dental services would come to the ICB from April 2023, the Board directed a further paper be brought to a future meeting setting out the challenges and proposed actions. DF

6.10 The HealthBus service actively networked and there was good recognition from elsewhere that it was a tried and tested mechanism of delivering accessible healthcare.

6.11 There was a need to consider what could be done in the short-term to enable consistency in the service. There were already a number of practical next steps underway including a review of the provision around people

experiencing homelessness with some planned Autumn workshops.

7. Chief Executive Officer's Report

7.1 The Chief Executive introduced her report.

7.2 The key issues were set out in detail in the report, but a summary of the highlights included:-

- The Operational Pressures Escalation Levels Framework (OPEL) method used by the NHS to measure hospital stress, demand and pressure was at a Level 4 for the Dorset system leaving organisations unable to deliver comprehensive care. The system was likely to remain at this level throughout the winter period.
- It was hoped implementation of a number of transformation programmes would support the prevention of unnecessary hospital admissions.
- There had been a reduction in emergency activity requiring hospital conveyancing which had assisted the South Western Ambulance Service NHS Foundation Trust (SWASFT) in delivering their quality standards. Work was ongoing to understand the reasons for the reduction.
- NHS England had published its winter resilience expectations. ICBs would be measured against a number of targets which would be incorporated into the Performance report for the next Finance and Performance Committee and ICB Board meetings.
- NHS England had published new statutory guidance on working with people and communities. The guidance aimed to support ICBs to meet their public involvement legal duties and the new 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources. A number of podcasts would be developed nationally to explain why the principle of co-design and community-driven services were important as opposed to consultation and would lead to a needs-based approach.
- The statutory guidance on Integrated Care Partnerships including the production of the Strategy had been published. Locally the work on the Dorset Integrated Care Strategy continued. Once a draft Strategy had been developed the strategic imperatives would be fed into the Health and Well-Being Board plans and development of the ICB 5-year joint plan with health partners. Running concurrently would be the development of the enabling plans, including the financial strategy which would need to align with the clinical and digital plans. It was

recognised external support may be required for this broader system piece of work.

- The system was experiencing ongoing issues regarding access to the right mental health provision for children, young people and adults. A system-wide workshop was held recently with good engagement from all but a robust plan was needed for this crucial piece of work.
- There was concern regarding the effect of the cost-of-living crisis on health services and the impact for the Dorset population, not only during the winter period but in the medium term/long-term. Discussions were ongoing with the two local authorities to enable a joined-up approach and consideration was being given as to how to use health/local authority estate to create accessible warm spaces for people.
- The additional cost of the NHS pay awards 2022-23 had led to NHS England and the Department of Health and Social Care to reprioritize centrally held budget and there was a need to ensure an appropriate message be shared with the Dorset public regarding what services would be available within the fixed cost envelope.

7.3 The Board **noted** the Chief Executive Officer's report.

8. Items for Decision

8.1 Annual Governance Statement

8.1.1 The Interim Chief Nursing Officer introduced the Annual Governance Statement report.

8.1.2 The Statement covered the final three months of Dorset Clinical Commissioning Group to 30 June 2022. Due to the timescale for submission the Statement had come to the Board prior to the Risk and Audit Committee. If approved, the Statement would be taken to the September Risk and Audit Committee for completeness.

8.1.3 The narrative was based on a nationally mandated template so there was no content regarding the closedown of Dorset Clinical Commissioning Group and handover to the ICB. It was noted this would be included in the Annual Report and Accounts.

8.1.4 There were a number of minor spelling/formatting errors within the Annual Governance Statement and the Interim Chief Executive Officer, DCHFT would highlight these to the Interim Chief Nursing Officer. NJ

8.1.5 The Board **approved** the Annual Governance Statement.

9. Items for Noting

9.1 Quality Report

9.1.1 The Interim Chief Nursing Officer introduced the Quality Report.

9.1.2 The report format remained work in progress and would be reformatted to align more to the ICB's risks. Consideration was being given to a future joint report with the Chief Medical Officer.

9.1.3 A key focus of the system Quality Surveillance Group remained the pressures in urgent and emergency care. including an ongoing review of any potential harm due to delays created by the ongoing pressures.

9.1.4 The first Dorset case of a MRSA bloodstream infection in 2022-23 had been recorded. The root cause analysis did not identify any learning themes or lapses in care with the case being deemed unavoidable.

9.1.5 Delays in Initial Health Assessments for children continued with performance not reaching the required standard. Ongoing discussions were being held with the providers to improve the position.

9.1.6 Action plans were in place to improve mandatory safeguarding training compliance across all providers. This had been a repeated issue for a number of years. The improvement of services for children and young people would be a key priority for the ICS, particularly those who were vulnerable. All NHS providers were asked to prioritise this improvement and to ensure actions put in place were sustainable. There was no associated risk appetite and the ongoing training issues needed to be addressed as a priority.

9.1.7 In relation to ICB staff, training compliance was good. It was recognised some individuals would require a higher level of training than currently undertaken and this would be addressed.

9.1.8 It was anticipated there would be an increase in CQC inspections which had re-commenced post pandemic. Support would be offered to practices in preparation for this. There were several CQC inspections being undertaken elsewhere across the system and any lessons learned/knowledge would be shared.

9.1.9 Concern remained regarding the care sector and the availability of care packages both in the individual's own home and residential/nursing homes.

9.1.10 The new Patient Safety Incident Response Framework (PSIRF) had been launched and implementation work was underway.

9.1.11 It was planned to have an integrated Performance report that joined up the cause and effect of the four pillars of performance to enable an understanding of the consequences when certain areas are not delivered. This will set out the issue, action being taken, the proposed timeline and the impact. Further work was needed to access all the data required to enable production of a single report that could be aggregated for the different audiences.

9.1.12 Progress had been made regarding the University Hospitals NHS Foundation Trust (UHD) discharge summaries backlog however, a new risk has emerged regarding the completion of very old discharge summaries. UHD would explore a risk-based approach to reduce this risk with a review in early September including an agreed completion timescale.

9.1.13 The Board **noted** the Quality Report.

9.2 Performance Report

9.2.1 The Deputy Director (Integration) introduced the Performance Report.

9.2.2 The most significant issue affecting a wide range of metrics was the system flow with the number of "no criteria to reside" patients remaining high.

9.2.3 The Patient Administration System merger issues at UHD meant the elective metrics derived from the overall waiting list could not be relied upon. This created a significant risk that the overall position for Dorset could be inaccurate. The Board noted there did appear to be a reduction in duplicate records.

9.2.4 A focus remained on reducing long waiters. Action plans were in place and most 104-week waits had been addressed. As a helpful collaborative indicator, there was a suggestion that future reports contain information regarding mutual aid offered across Dorset and outside of Dorset. SB

9.2.5 The diagnostics waiting list continued to reduce with 21% of patients waiting 6 weeks or more against a target of 1%. Dorset remained the best performing system in the South West.

9.2.6 Concern was raised regarding the continued reduction in the GP workforce versus increased demands including digital access. There was optimism regarding the long-term position with a record number of trainee GPs, but a need to enable the role to remain attractive to encourage individuals to stay once training was completed. However, there was a recognition that more needed to be done to attract GPs and retain them by making the role more attractive. The implementation of the Fuller review would counter some of this but not all.

9.2.7 More needed to be done as a system to address the broader workforce challenges and this would be taken forward by the Chief People Officer. To work effectively as a system there needed to be a joined-up approach with a single workforce across Dorset and joined up recruitment which would be more cost effective.

9.2.8 There needed to be clear public messaging regarding primary care waits for routine appointments to reset expectations.

9.2.9 In relation to the eating disorder service and Child and Adolescent Mental Health Services (CAMHS) service issues, there was a query whether it would be feasible to utilize the mental health schools' teams more effectively to support the wider mental health areas.

9.2.10 Many of the issues raised would need to be remitted to the relevant Committees and the Chief Executive Officer would consider how this could be taken forward.

9.2.11 The immediate priority was to ensure the system was able to manage the winter period safely and the ICB Executive Directors would be looking to agree a number of priority areas for focus until March 2023 whilst concurrently working on the more comprehensive long-term plans.

Sally Banister left the meeting.

9.2.12 The Board **noted** the Performance report.

9.3 Finance Report

9.3.1 The Chief Finance Officer introduced the Finance report.

9.3.2 By way of background, NHS Dorset had a financial allocation of £1.6Bn a year.

9.3.3 All ICBs nationally had been asked to submit a balanced financial plan for 2022-23. In doing this, Dorset ICB had identified financial risks of £88M including unidentified efficiencies of £42M. This would need to be managed in order to achieve a break-even position. The ICS had an ambitious efficiency programme for 2022-23 with the main workstream areas being agency costs, Covid-19 costs, elective care recovery/productivity and urgent and emergency care. It was noted NHS Dorset ICB was delivering proportionately more efficiencies than other ICBs in the South West region.

9.3.4 As at month 3 (June 2022) the ICS was reporting an £8.6M deficit against a break-even position, of which £5.9M related to NHS providers within the system.

9.3.5 The system capital funding plans submitted demonstrated a balanced plan except for the car park at DCHFT which did not currently have a funding source. Discussions with regional colleagues remained ongoing.

9.3.6 The Board noted that for the remainder of the current year, Bournemouth, Christchurch and Poole Council had taken a joint approach with the ICB in relation to funding adult and children social care with percentage contributions fixed at the beginning of the contract to more easily predict the year-end costs. The offer was made for a similar approach with Dorset Council.

9.3.7 The system financial position emphasized the need for better integrated working between partner organisations with an ‘open book’ process and sharing of information to enable the system to get into the right place.

9.3.8 The Board **noted** the Finance report.

9.4 Learning Disabilities Mortality Review (LeDeR) Annual Report 2021-22

9.4.1 The Interim Chief Nursing Officer introduced the LeDeR Annual Report 2021-22.

9.4.2 This was the third required Annual LeDeR report and the first following publication of the changes to the national policy.

9.4.3 In the past 12 months, there had been one grade 4 focused review. There had been no adverse impact on the outcome but there had been learning aspects from the review.

9.4.4 There were several recommendations and learning from the initial reviews in relation to aspiration pneumonia, end of life care planning and the use of Restore 2 (a physical deterioration and escalation tool designed to support care/nursing homes).

9.4.5 Reviews could only be undertaken if a notification was received, and work was ongoing to ensure the health and social care sector was familiar with the LeDeR process.

9.4.6 There was a query regarding the proportion of professionals within the Speech and Language Therapy team working in dysphagia (swallowing) and the associated capacity/access. The Interim Chief Nursing Officer agreed to provide further detail. VR

9.4.7 The Board **noted** the LeDeR Annual report 2021-22.

Sam Best joined the meeting virtually.

9.5 **Special Educational Needs and Disabilities (SEND) Update**

9.5.1 The Chief Commissioning Officer introduced the SEND Update.

9.5.2 The report highlighted the ongoing work with significant multi-factorial challenges to address. There were particular challenges within the Bournemouth, Christchurch and Poole Council area and the ongoing need to keep improvements moving within the Dorset Council area.

9.5.3 Discussions continued with the two local authorities to join up resources to help improve the service. There were a number of key areas of work including developing clearer system governance, developing effective partnerships and developing models of integrated commissioning.

9.5.4 There was a need to invest in early intervention to enable improvement on an individual's future well-being. Listening to families and carers regarding the patient's best interests and needs, which would help improve life expectancy, as would progressing the work on equality, diversity and inclusion (EDI) as a means to changing the perceptions of those with learning disabilities and the quality of their lives.

9.5.5	The Board approved the change in timing of the next SEND annual report to May 2023.	SL
9.5.6	The Board **noted** the SEND update.	
10.	**<u>Items for Consent</u>**	
10.1	There were no items for consent.	
11.	**Public Questions**	
11.1	There were no written questions from members of the public received prior to the meeting.	
12.	**Any Other Business**	
12.1	There was no further business.	
13.	**Date and Time of Next Meeting**	
13.1	The next meeting of the ICB Board would be held on Thursday 3 November 2022 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG	
14.	**Exclusion of the Public**	
	To resolve that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 30 November 2022

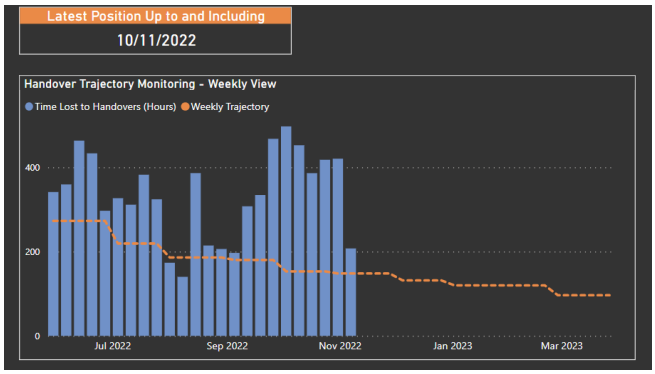
Agenda item: 6.1

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

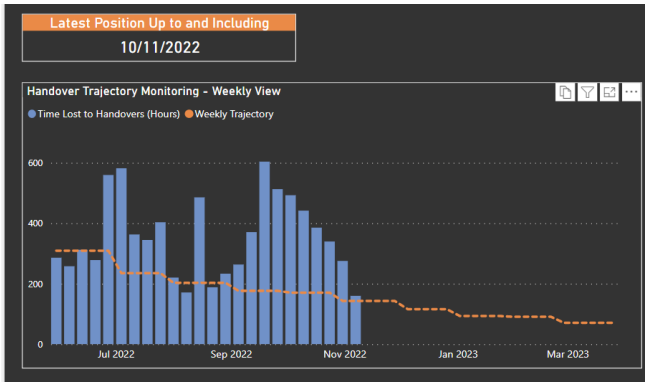
Prepared by:	Executive Directors, Alex Lister, Sophie Jordan, Judith May, David Mills, Fiona Hoskins, Matthew Hodson, Carla Jones, Irene Mardon, Jo Sims, Andrew Goodwin
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the Board of Directors on the performance of the Trust during October 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	Continuing pressure across the Urgent & emergency care pathway. Current Ambulance handover delays and the amount of time patients are spending in the emergency department. Continuing challenges with 'No Reason to Reside' (NRTR) linked to the increase in bed pressure and crowding in the emergency departments, contributing to overall high bed occupancy. The number of Covid admissions/contacts starting to reduce across the organisation. 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 are driving increased agency costs and staff wellbeing. Impact on hospital reputation and increased challenge to elective care recovery as a result of having to put 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** Type 1 attendances to our Emergency Departments increased to pre pandemic levels, an 8.2% increase in attendances when compared to September. Hospital occupancy continues to create challenges and there was a further deterioration in the number of patients in our EDs for more than 12 hours waiting for a bed, with almost 1300 patients spending longer than 12 hours in the departments. Ambulance handover delays also showed a deterioration in October although over the later weeks in October signs of improvement started to emerge on the back of improved flow to wards and the additional support at the front door with our external provider.

Poole



Bournemouth



The IPR provides the detailed performance against the new national Urgent & Emergency Care standards.

(colours based on change from last month)

		Oct-22		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	325	355	341
Time to Initial Assessment	15 mins	9	23	16
12 Hour ED Waits	0	643	649	1292
Internal Care Standards				
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	123	167	147
Mean Clinically Ready To Proceed to Leave Dept	60 mins	327	325	285

Weekly ED decompression action plan meetings continue led by the COO to progress and monitor front door actions and performance and support from ECIST is ongoing. These meetings saw the updated Internal Professional Standards concluded and a launch of the standards agreed and has taken place in November and the Timely discharge and admissions (Proof of Concept) – PDSA fortnight started.

Occupancy, Flow & Discharge

Both sites continued to maintain opening of escalation beds in October. Occupancy has risen to an average of 94.2% across UHD, however has often exceeded 100% on a single site, with OPEL 4 being declared across the system linked to business continuity.

There was an average of 258 patients MRFD occupying beds across both sites in October which is an increase of 20 compared to September figures. There are significant numbers of patients waiting for Local Authority interventions (Assessments & brokerage), Intermediate Care, Community hospital placements and Self-Funding support. During early November we have started to see an improvement in these numbers.

	A 2-week intensive initiative to reduce the number of patients waiting to be discharged home from Hospitals in Dorset started on 10 October and continues to complete the designated actions with system partners. Continuing discussion with Health & Social partners
Surge, Escalation and Ops Planning	At the time of writing, UHD has 45 confirmed Covid inpatients, a significant decrease in incidence (115 previous month) and mirrors the national picture and Epicell modelling. The operational teams have created a capacity and flow plan which aims to link with the Winter KLOEs and national board assurance framework. This is supported by the internal Hospital Flow Improvement Group Trust Wide action plan. A trial of a Timely Admission and Discharge process starts in November to improve the rate of early discharges to support the flow from ED. A systemwide bed capacity and demand plan has been launched with national funding to reduce the risk of high occupancy and insufficient winter beds. Funding has been agreed to support internal increase in SDEC capacity, additional escalation beds, commissioning of departure lounges on both sites and recruitment of Discharge Facilitators. External support ranges from additional care hours, care home beds and increased mental health beds for Quarter 4. Exercise Arctic Willow a table top system exercise for emergency preparedness will take place in November over three time periods to test the system resilience for winter,
Referral to Treatment (RTT)	

Planning requirement	**Sep 22**	**October 22**	
Referral to treatment 18-week performance	54.9%	55.5% ▲	National Target 92%
Eliminate > 104 week waits	76	63 ▼	Trajectory 20 by Oct 22
Reduce >78 week waits to zero	504	513 △	Trajectory 517 by Oct 22
Hold or reduce >52+ weeks	3,559	3,468 ▼	Trajectory 3,875 by Oct 22
Stabilise Waiting List size	72,860	70,918 ▼	**Reduction of-1,942 v September 2022**

- The RTT standard was not met in October 2022, with 55.5% of patients being treated within 18 weeks.
- Both >52 week waits and >104 week waits reduced in month. The number of patients waiting >104 weeks reduced by 17%. Two thirds of patients waiting >104 weeks were waiting for Orthodontic treatment and have declined offers to transfer their treatment to Dorset County Hospital under mutual aid arrangements within the system.
- Patients over >78 week remained within control levels of no change
- Outpatient DNA rate improved at 6.8% (down 0.6%). With the transition to new patient portal service planned (DrDoctor) in Autumn 2022.

	Key Elective outcomes delivered in reporting period: • The Trust has demonstrated an improvement across a range of data quality metrics, including a reduction in duplicate waiting list pathways. • Waiting list validation hubs have been held for ENT and colorectal surgery. Gastroenterology and OMF will hold hubs in December. • The 'Wait in line' project has been expanded to another 3 specialities. • A plan has been implemented to consolidate the theatre template to better align to staffing. Successful recruitment to key nursing posts also achieved. Key objective to reduce cancellations and support booking further out. • Superuser training has been completed ahead of the roll out of the DrDoctor patient portal in outpatients in November 2022.
Cancer Standards	The total number on the UHD PTL has decreased in October by circa 400 compared to September but remains ranked 18th when compared nationally. Two week wait referrals in September increased by 35% when compared to the same period in 2019. Referrals continue to challenge delivery of improvement in the performance standards.

Measure	Target	Q1 22/23 FINAL	Q2 22/23 FINAL	Jul 22 FINAL	Aug 22 FINAL	Sep 22 FINAL
Cancer Plan 62 Day Standard (Tumour)	85%	71.4%	68.5%	67.9%	65.9%	71.2%
62 Day Screening Standard (Tumour)	90%	82.4%	94.0%	91.1%	92.9%	98.2%
31 Day First Treatment (Tumour)	96%	97.4%	97.4%	97.5%	97.9%	96.7%
Subsequent Treatment - Surgery	94%	91.5%	92.2%	90.9%	91.7%	93.8%
Subsequent Treatment - Radiotherapy	94%	98.6%	99.3%	99.3%	99.3%	99.3%
Subsequent Treatment - Anti Cancer Drugs	98%	99.5%	98.8%	98.5%	100.0%	98.1%
Faster Diagnosis	75%	70.2%	63.7%	63.6%	62.9%	64.7%

- 28-day FDS performance increased in September to 64.7% (threshold 75%) with six tumour sites achieving the standard. First outpatient capacity to meet demand in colorectal and gynaecology are areas of particular challenge.
- 31-day standard – achieved.
- The 62-day performance in September improved to 71.2% (threshold 85%) and continues to be above the current national average of 62.2%.

Key outcomes delivered in reporting period (October):

- The ICB Elective Care Oversight Group have received and agreed a proposal to implement the changes to the 2ww referral pathway for FIT in the LGI suspected cancer pathway including FIT <10 safety netting.
- The new precision point template biopsy pathway for prostate is working well with extremely positive patient feedback. Benefits realisation work currently underway showing reduced rate of infection and repeat biopsies required.
- An E-forma for the Iron Deficiency Anaemia (IDA) pathway is undergoing soft-testing to standardise and streamline pathway across UHD.
- A review of Clinical Nurse Specialist (CNS) input to streamline colorectal clinical pathways across UHD is underway.

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Remote monitoring system functionality in the Somerset Cancer Register has gone live. This system will allow the roll out of patient initiated follow ups for cancer patients. The RMS pathway for Breast is being implemented and a roll out plan for the remaining specialities in place.
The pathology integration with RMS has been completed giving visibility of blood results to all clinical teams.

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<tr><td>DM01 (Diagnostics report)</td><td>
The DM01 standard has achieved 83.6% of all patients being seen within 6 weeks of referral, 16.4% of diagnostic patients seen >6weeks.

1% of patients should wait more than 6 weeks for a diagnostic test
<table>
<tr><th>August</th><th>Total Waiting List</th><th>< 6weeks</th><th>>6 weeks</th><th>Performance</th></tr>
<tr><td>UHD</td><td>11,431</td><td>9,559</td><td>1,872</td><td>16.4%</td></tr>
</table>

DM01 performance has improved in October. Increased demand for diagnostics due to an increase in 2ww pathways and increased elective activity, alongside workforce gaps, is impacting on the Trust’s overall recovery of diagnostics performance in echocardiology and endoscopy. Both Neurophysiology and radiology delivered the DM01 target in October.
UHD remains one of the top performing diagnostic trusts in the region.

Key outcomes delivered in reporting period:

Improved session and slot utilisation has been enabled in Echocardiology and Endoscopy and the DNA rate reduced.
Work on increasing Cardiac CT capacity and internal demand management has resulted in recovery of CT performance.

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<tr><td>Elective Recovery Actions</td><td>
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: 'back to basics' outpatient improvements focused on achieving immediate and sustainable efficiency improvements in Outpatients; Digital Outpatients transformation, and speciality led outpatient reviews of capacity and utilisation.
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.

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

<u>Health Inequalities</u>
Waiting list by Index of Multiple Deprivation (IMD): 8.3% of the Trust's waiting list are patients living within the bottom 20% by IMD (reduction of 0.2% compared to Sept). Analysing RTT activity, the average weeks waiting at the point of treatment among the 20% most deprived is 13.8 weeks compared to
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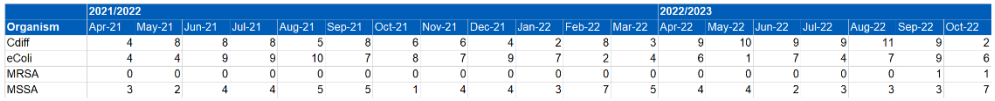
	12.9 weeks in the rest of the population treated. This variance has reduced from 1.2 weeks in Q1 to 0.9 weeks in Q2. <u>Waiting list by ethnicity</u> Where ethnicity is recorded, 10.8% of patients are within community minority ethnic populations (reduction of 0.4% since Sept). Patients from community minority ethnic groups had a marginally lower (0.1) average week wait compared to patients recorded as White British in Q2. A health inequalities improvement programme is supporting action in the following areas: • A deep dive review of DNAs to address variance according to deprivation and ethnicity. • A focus on people with learning disabilities and enhancing their access to care by tracking them against the 18 weeks RTT standard. • Proactively targeting specific groups for screening services, e.g. breast screening. • Assessing the Trust against the CORE20PLUS5 ambitions on health inequalities where relevant. • Publicising HI training opportunities working with the ICB on rolling of PHM and HI training offers.
Infection Prevention and Control:	**Quality, Safety, & Patient Experience Key Points** Hospital Associated cases trend  • Work continues on the follow up of COVID-19 outbreaks with post infection review for cases from Q3 2021 to Q1/Q2 2022. • Community cases of COVID-19 in Dorset continue to decline. • This reduction has allowed for the implementation of a reduced testing model for patients and staff focussed on those at high risk of a severe form of infection and those who are symptomatic. • The process for testing for COVID-19/ Influenza and RSV is now ready for deployment. • In line with this reduction, mask wearing in non-clinical areas has been removed from UHD guidance and as a Dorset system we will be reviewing mask wearing in clinical areas following the risk trigger tool. • Outbreaks of COVID-19 have been reported within Wards on both sites but at a reduced level. • Cases of Chloridoids Difficile have increased over the past 2 years. The frequency of patients relapsing, and the severity of cases has also increased. We are now near to our 22/33 trajectory. • 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. The UHD rate for hospital onset cases is currently below the England rate of 19.3 per 100,000 at 13.8. • 2 MRSA bacteraemia cases have been reported in this year. A post infection review is underway for the most recent case.
Clinical Practice Team	**Moving & Handling** **Core Induction** Level 2 Moving & Handling training is an essential component in the trust induction programme (day 2) for clinical staff.

	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	Jul-22	Aug-22	Sep-22	Oct-22
Cdiff	4	8	8	8	5	8	6	6	4	2	8	3	9	10	9	9	11	9	2
eColi	4	4	9	9	10	7	8	7	9	7	2	4	6	1	7	4	7	9	6
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
MSSA	3	2	4	4	5	5	1	4	4	3	7	5	4	4	2	3	3	3	7

	• These sessions have been protected (as much as possible) in order to support the safe onboarding of staff. • The M&H trainers have been supporting the Education & training team to deliver the level 2 training for the HCSW to cover staff sickness. **Essential Core Skills** • The ability to meet the face-to-face level two training requirements for clinical staff continues to be a challenge. The risk register entry remains at 10 (moderate) and under continuous review. • A recent report has shown that we have 2137 members of staff who are currently non-compliant with their M&H level 2 training. • A draft SBARN is being circulated for comment regarding the proposal to deliver a hybrid model of refresher level 2 training, of face to face and eLearning. **Falls prevention & management** A total of three severe fall harm events were reported in month. One patient sustained a subdural haematoma and two patients sustained #nofs. • The relevant scoping and investigations are being undertaken with support from the falls team. Falls summit was held on 13 October to review the 3 main themes: • Meeting enhanced care observations • Complex discharges for patients at high risk of falling • Harm experienced by patient's deemed MRFD Good multi-disciplinary engagement facilitated discussion around the importance of preventing deconditioning during admission, recognising the impact of harm sustained by patients deemed MRFD and those who no longer meet the C2R. Plans to repeat and expand the Falls Summit to a one-day conference are being explored for the beginning of next year. **Tissue Viability** The number of complex patients being referred to the service remains high. • The number of referrals to the service are now consistently above 200 per month • Since September there has been a reduced service. Staff have been advised to keep referring however the team will triage the most complex, those on admission and those requiring a review prior to discharge. • Noting an increase in complaints relating to skin integrity and pressure ulceration following discharge to other care providers • The team remain under sustained pressure and have had to take the difficult decision to cancel some planned training sessions • Plan to add the Tissue Viability Service capacity and demand to the risk register
Patient Experience:	**Friends & Family Test** FFT Positive responses for October have seen a slight decline at 89.8% compared with 90.0% in September. The response rate for FFT has continued to improve in October. **PALS and Complaints** In October the service saw an increase in numbers of contacts through the Patient Experience Team (PET) - there were 460 PALS concerns raised,

48 new formal complaints and 50 Early Resolution complaints (ERC) processed.

Care groups hold the responsibility to respond to the majority of complaints, coordinated through the PET. Regular meetings continue with the care groups to focus on closing of complaints, however delays in investigation and letter writing continue due to significant operational pressure.

Complaint response times

In October there were 212 outstanding open complaints including ERC, 60 of which have been open longer than 55 working days. Despite mitigations and support to care groups, this risk has been discussed in Governance meeting and agreed to be submitted to the risk register.

Key themes from PALS and complaints

- Communication – Absent or incorrect
- Respect, Caring & patient rights
- Organisation process – waiting times, accessing care

Red Flags

Red flag reporting showed a marked decrease in Q3 with 107 recorded in October; the result of nil Red Flags in Maternity. Patients requiring enhanced care and an inability to provide fundamental care accounted for 70% of the red flags across medical and surgical wards.

Mixed Sex Accommodation Breaches

There was 1 MSA incident in October 2022, with 6 patients involved. This is being investigated through the LERN process.

Workforce Performance:

Latest YTD Indicators - October

		22/23 YTD	21/22 YTD	Variance
Turnover (12 month rolling)		14.6%	11.8%	2.7%
Vacancy		6.1%	5.3%	0.8%
Sickness Rate (12 month rolling)		5.7%	4.9%	0.8%
Appraisals	Values Based	22.7%	27.7%	-5.0%
	Medical & Dental	57.7%	56.9%	0.9%
Statutory and Mandatory Training		85.3%	87.7%	-2.4%

Latest In Month Indicators - October

		Actual this month	Variance on last month
Turnover		14.6%	0.2%
Vacancy		3.9%	-0.4%
Sickness Rate		5.7%	0.2%
(of which Covid Related Sickness Absence)		0.1%	-0.2%
Appraisals	Values based	50.2%	13.2%
	Medical & Dental	66.4%	-8.1%
Statutory and Mandatory Training		85.3%	-0.4%

UHD turnover has increased by 0.2% in month, YTD it is 14.6%.

Vacancy rate is being reported at 3.9% in month, a decrease of 0.4% compared to September, YTD is 6.1%. The decrease this month is due to

	establishment data quality corrections, specifically in Corporate areas and Operations. **Overall Sickness absence** has increased by 0.2% in month to 5.7%. Covid related absence is recorded as 0.1%, a decrease of 0.2% compared to last month. YTD sickness is 5.7%. **Statutory and Mandatory training**: Overall UHD Trust compliance is standing at 85.3%, a decrease of 0.4% on September. Our aim is to reach 90% across all sites.
CPO Headlines:	• **Industrial action:** The Royal College of Nursing (RCN) has announced that nursing staff at UHD have voted to take industrial action over pay levels and patient safety concerns. It is a legal requirement to give at least 14 days' notice of any intended industrial action date. Industrial action is expected to begin before the end of this year and until early May 2023. Meanwhile, The Royal College of Midwives (RCM), The Chartered Society of Physiotherapy (CSP) and Unison are currently balloting their members for industrial action. We are putting plans in place to ensure there is minimal disruption to patient care and that emergency services continue to operate as normal should any industrial action take place. • **Fraud Awareness Week:** University Hospitals Dorset will be supporting International Fraud Awareness Week (13-19 November 2022), to aid in the fight against NHS fraud. Bulletins, awareness materials, videos and live training will be available for staff during the week. The Counter Fraud Team and UHD HR Operations will be meeting with staff and distributing information within Poole Hospital / Maternity site on 15 November, and RBH, Christchurch and Yeomans House sites on 24 November. • **LERN Conference**: On 3 November the Training and Education team held a conference within RBH Lecture Theatre to increase awareness of learning from our LERN process, to support staff to speak up and to promote our Restorative, Just and Learning Culture.
Occupational Health and Enhanced Wellbeing Service	• During October, all activity within Occupational Health remained high. 133 pre-placements forms were received and 136 Management referrals. 55% of the pre-placement referrals were cleared within 3 working days and 47% of staff referred by their manager were offered an appointment within 10 working days. The team are working to improve this percentage further. • **Autumn Vaccination Programme** - 8,000 appointments were available throughout October for staff, and clinics continue to be offered, however uptake is slow across the trust for both flu and Covid (booster) vaccinations. Clinical areas are now being asked to identify suitable times and places for Occupational Health to provide pop up clinics, to ensure easy access for staff.

Resourcing

General Recruitment	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
New Joiners to the Trust	125	123	129	60	101	80	97	119	92	93	81	111	131	114
Internal Candidates	121	143	121	90	142	119	95	121	94	102	112	114	125	117
Total number of starters	246	266	250	150	243	199	192	240	186	195	193	225	256	231
Number of Applications	2657	2838	2222	2029	2683	2316	3430	2123	2596	2005	1906	2891	2485	2876
Candidates Offered	257	247	299	229	248	271	257	246	264	275	254	188	263	212
Adverts Posted	295	257	299	345	319	312	368	370	355	316	331	284	267	357

Reporting on General Recruitment activity shows continued high levels of activity both in the number of adverts placed, applications received and numbers of starters. In month starters usually relates to activity 2 months prior.

Digital Marketing Recruitment, and Social Media report

- We attended the BU Annual Careers Fair, interacting with over 100 students studying IT, Finance, Communications, Biomedical Sciences, Psychology and many other courses of study, promoting the many opportunities available at UHD. Contact details of all visitors have been forwarded to department heads for follow up tours and visits.
- On Facebook we reached 22,000 people and 7,000 via Twitter with new accounts liking our Facebook page and following us on Instagram.

Our Digital Campaign for Newly Qualified Nurses reached over 35,000 people with only £111.75 spent.

Workforce Systems

- The total amount of changes processed by the team in October 2022 was 1835, a decrease of 369 compared to September.
- A programme to improve customer experience is being implemented, the first stage of which involves moving to one centralised telephone number using the Netcall functionality.
- The Medical Rostering project will start on 1 December with dedicated project support.

Temporary Workforce

- The Temporary Staffing team are still facing significant staffing challenges. A recent recruitment campaign is beginning to see new staff join the team.
- October saw an 8% increase in requested nursing hours in comparison to September. Despite the significant upturn, Bank fill remains stable with a 2% reduction in agency fill.
- A 73% fill rate for Medical locum shifts was maintained with over 5% of duties filled by medics from the Digital collaborative.

Organisational Development

- **Leadership Plan:** presented to Chief Officers in October. Focus on building a UHD Leadership and management pathway to support our leaders.
- New dates for Courageous Conversations available with a new forum theatre training provider.

	• **Team integration:** Remaining Directorate development days to be facilitated. Receiving a large number of requests to support integration plans. • **NHS Staff Survey 2022:** is currently open until Friday 25 November. • Comprehensive communication campaign to improve completion rates. • **EDI:** New lead successfully appointed and revised action plan for EDIG being developed • **Wellbeing:** - Winter Plan including reduced food offers being launched during November and coffee vouchers ready to be distributed. • **FTSU:** 45 referrals were received during October. Speaking Up; a 79% increase on the month before. Attitudes, worker wellbeing and process were predominant reasons for referral. 26% of referrals from our ethnic minority.
Trust Finance Position	Operational pressures continue to drive the Trusts financial performance, increasing expenditure and limiting clinical and operational capacity to deliver efficiencies and transformation projects. This is exacerbated by rising inflation, with energy prices putting particular pressure on Trust budgets. Collectively, these pressures have resulted in a year to date deficit of £4.9 million. However, it was pleasing to report a favourable variance against plan in October reducing the year to date adverse variance by £0.5 million to £5.4 million. The Trust continues to forecast a full year break-even position, however, there remains considerable risk within this forecast linked to seasonal demand and capacity pressures and the potential financial impact of the planned nurses strike. The year to date capital position represents an under spend of £18.0 million, largely driven by under spends against the Acute Reconfiguration (STP Wave 1) and New Hospital Programme together with under spends within IT and the One Dorset Pathology Hub. The full year forecast remains consistent with the budget save for the New Hospitals Programme early enabling works (£15.9 million) which the Trust continues to proceed with at risk. Funding of £8.2 million has been advised but not yet formalised leaving a residual risk of £7.7 million should all works progress to plan without any additional funding. The full Outline Business Case plus the five individual 'early enabling works' business cases will be considered at the Department of Health and Social Care and NHS England Joint Investment Committee on 25 November. The Trust ended October with a consolidated cash balance of £85.3 million, all of which remains fully committed against the mediumterm capital programme. The phasing of the capital plan alongside reduced payments to suppliers due the recent national cyber-attack has driven this increased cash holding. The Trust's payment performance remained strong up to 31 July 2022 with 95.4% of invoices paid within the agreed terms. This has subsequently reduced following the inability to pay invoices whilst financial systems were offline as a precaution during the national cyber-attack. Current performance stands at 91.1%, and is expected to improve over the coming months.
Options and decisions required:	No decisions required
Recommend-ation:	**Members are asked to note:** • Note the content of the report • 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 (TMG)

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**
Quality Committee (Quality)	29 November 2022
Finance & Performance Committee (Operational / Finance Performance)	28 November 2022
Trust Management Group	22 November 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 6.2

Subject:	Mortality Report

Prepared by:	Divya Tiwari
Presented by:	Ruth Williamson

Purpose of paper:	Current Mortality metrics are provided.
Background:	Monitoring mortality metrics is one of several quality and safety metrics for board assurance. Variations in weekday and weekend mortality are one of the key indicators for the 7-day services BAF.
Key points for Board members:	Mortality rates are improving compared with the previous report. Work is being done to address the coding issues arising from the PAS merger which created a spike in HSMR. Current alerts are highlighted with current action plans Learning from death QI project next steps outlined. Electronic mortality review process is being rolled out.
Options and decisions required:	For information.
Recommendations:	Continued support to mortality monitoring.
Next steps:	None.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	**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)	N/A
CQC Reference:	Safe and Well Led

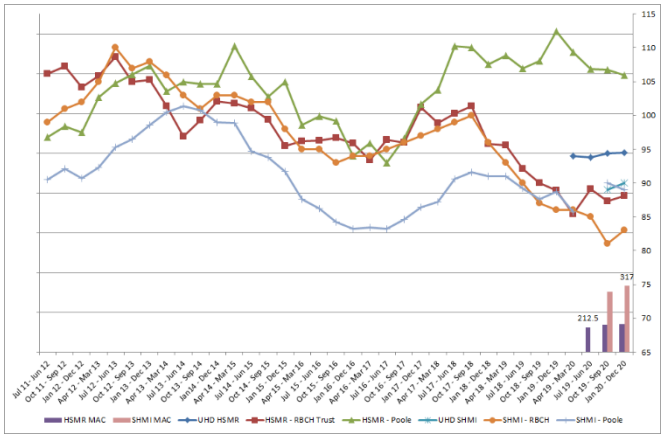
Committees/Meetings at which the paper has been submitted:	**Date**
Trust Management Group	22 November 2022
Quality Committee	29 November 2022

University Hospitals Dorset
NHS Foundation Trust

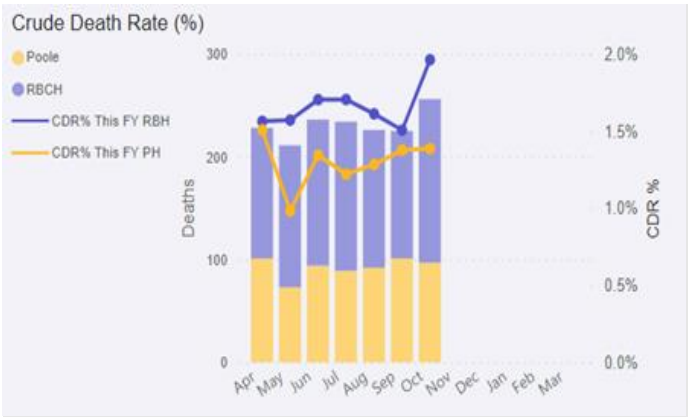
Chief Medical Officer's Report to the Board

Mortality Update

Most recent indicators for HSMR and SMR



Crude Death Rate 2022/23



HSMR & SMR August 2021 to July 2022 (UHD); SHMI Jan 2021 to Dec 2021

Indicator	Site	Value	Range
HSMR	RBH	93.1	Better than expected
	Poole	100.1	As expected
	UHD	104.2	As expected
SMR	RBH	92.4	Better than expected
	Poole	94.4	As expected
	UHD	101.2	As expected
SHMI	RBH	84	As expected
	Poole	88	As expected
	UHD	90	As expected

Mortality Ratios

HSMR mortality ratios have risen over the last two months where 12-month data includes months of June and July 2022. Analyses show a proportion of 'un-coded' episode submissions to the national system. This problem arose following merger of the PAS system in May 2022 from there on monthly submissions have a proportion of un-coded episodes. MSG is engaged with coding and IT department to rectify this issue.

MSG is reassured that this has been resolved from the September 2022 submission onwards. It is anticipated that the spike in ratios will be reversed with some early indicators of improvement in most recent data.

There is a new Dr Foster diagnostic alert in ‘peripheral arterial diseases and thrombosis’. This is a diagnostic alert in vascular surgery however in the diagnostic category; therefore patients may or may not have had vascular procedures. Patient level data is now available for a detailed review of mortality in this category led by vascular mortality chair Mr Dean Godfrey.

The crude mortality ratios show fluctuating trends with some variation across sites. Poole site is showing an upward trend this financial year (please see the graph). Operational pressures over the last few months are reflected in a shift from ‘winter’ variation to a consistent pattern over the calendar year.

Diagnostic and Procedural Alerts

Dr Foster’s Senior Analyst presented an intelligence report and alerts in the October MSG.

The detail of these is reviewed by the Quality Committee to provide assurance on the actions through escalation.

Mortality Review related QI projects

IV fluid management and prescription:

This trust wide QI group is in its last development phase. Electronic fluid balance chart development is on-going, IT development is nearly complete. There are some issues with roll out of fluid balance recording across UHD; QI group will escalate if additional support is needed.

Learning from Death Review QI project

This QI group is tasked to transition paper-based processes to electronic platform (e-fication) starting from death verification, mortuary transfer, Medical Examiner review and e-Mortality review across UHD. This will lead to an e-mortality review process being rolled out at Poole. A pilot has been launched successfully at specific sites in Poole and Bournemouth. The QI group aims to complete the Trust wide roll out by the end of this calendar year. MSG aims to provide ‘mortality review’ data at UHD level to the board from the next financial year.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 6.3

Subject:	Trust 2022/23 Winter Plan

Prepared by:	Sophie Jordan, Associate Director of Operations, Flow & Facilities
Presented by:	Mark Mould, Chief Operating Officer

Purpose of paper:	To request formal sign off and approval of the University Hospitals Dorset Winter Plan. The plan sets out the organisation's arrangements for the winter period and sits as part of the wider Dorset system plan.
Background:	Annually produced document to support the Trust response to the additional operational pressures that will occur during the winter months. Winter is going to be challenging for health and social care organisations. Winter is recognised as a period of increased pressure due to demand both in the clinical acuity of the patients and the capacity demands on resources within the Trust. In addition, the winter period often brings with it other events such as Covid, infectious diseases including Norovirus and there is the risk of the onset of the unusual, such as pandemic flu. The UHD Winter Plan recognises and anticipates these unique threats and sets out the organisational response to ensure the continuation of delivery of quality of services within a safe environment for patients, carers and staff alike. It is dependent on all system partners delivering against the system winter mobilisation plan.
Key points for members:	• Winter planning for 2022/23 is broader than planning for surge and high demand for services: the plan this year also considers the ongoing elective recovery programme. • It has considered the lessons learnt from winter 2021/22. • The Winter Plan will go through a formal assurance process with the ICB, assessing the plan against the Key Lines of Enquiry. • The plan summary document has been aligned to this assurance framework and feedback from the winter assurance exercise is planned in November 2022. • The General and Assessment Bed Capacity Plan for both sites vs bed forecast is in place to understand when the likely peaks will be, and currently shows a deficit for UHD.

	• Several options for creating additional bed capacity are currently being worked up with external schemes from partners funded to support the reduction in Medically Ready for Discharge (MRFD) levels across UHD. • All operational issues arising from the above will be initially managed through the UHD Joint Capacity Huddles and tactical meetings, escalation taking place as appropriate. • The specialty plans in place as part of planning for Q3 and Q4 2022/23. • To note the staffing and workforce plan which will be critical in maintaining services and the capacity needed to meet the operational challenges this winter. The Trust's Winter Plan focuses on four main areas: 1. Leading Well, including escalation processes 2. Looking after our people and patients 3. Creating capacity to meet the demand 4. Communication plan – preparing our people and communities. Communication of the plan will be through the presentation detailed in Appendix B.
Options and decisions required:	Approval of the Trust's Winter Plan 2022/23 (Appendix A).
Recommendations:	To approve the Winter Plan.
Next steps:	The organisational arrangements will be managed through the Trust winter planning group that will revert into a seasonal delivery group supported by the Care Group / Directorates /operational teams in the Trust. • Ongoing discussions will continue with Health and Social Care organisations to improve the MRFD. • Develop a detailed operational plan for the specific Christmas holiday period and will include any intelligence published through the national incident control room i.e. specific dates where the system can expect high and exceptional demand. • The Winter Plan will be shared internally with stakeholders though the presentation detailed in Appendix B. Oversight of delivery will be through TMG.

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.
BAF/Corporate Risk Register: (if applicable)	**UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak **UHD 1383** - COVID -19 risk relating to HCAI **UHD 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 1053** –Long Length of Stay / Discharge to Assess/NRTR **UHD 1460** – UEC national Metrics **UHD 1429** – Ambulance handovers **UHD 1074** Risks associated with breaches of Referral to Treatment and 52/104 week wait standards
CQC Reference:	All 5 areas of the CQC Framework

Committees/Meetings at which the paper has been submitted:	**Date**
Staff Partnership Forum (SPF)	November 2022
Trust Management Group (TMG)	October 2022
Trust Management Group (TMG)	November 2022

University Hospitals Dorset
NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust Operational Winter Plan 2022-23

DOCUMENT DETAILS	
Author:	Sophie Jordan
Job title:	Associate Director of Operations
Directorate:	Operations
Version no:	1.0
Target audience:	Trustwide
Approving committee / group:	TMG
Chairperson:	Siobhan Harrington
Review Date:	September 2023 (or if significant change required)

VERSION CONTROL						
Date of Issue	**Version No.**	**Date of Review**	**Nature of Change – (include section reference)**	**Approval Date**	**Approval Committee**	**Author**
11/10/22	1	1/9/23		17/10/22	TMG	S Jordan
15/11/22	2			TBC – 30/11/22	Trust Board	S Jordan

CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
21-22 - 1	13/10/22	Sophie Jordan	Care Groups/OPG
21-22 - 2	17/10/22	Sophie Jordan	Final Version to TMG
21-22 - 3	30/11/22	Sophie Jordan	Trust Board

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1. Introduction

1.1 The NHS has faced one of their busiest summers ever with record numbers of A&E attendances and, most urgent ambulance call outs, all alongside delivering on an Elective Recovery plan and another wave of COVID-19.

1.2 As a Trust and as a system it is essential that there are plans in place to rapidly increase capacity and resilience ahead of winter. NHS England have set 8 core objectives and key actions to support management of the increasing acute pressures;

1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.

2) Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.

3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.

4) Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.

5) Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.

6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.

7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100-day challenge'.

8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

1.3 This winter could be particularly difficult due to the impacts of COVID-19 on top of the usual increase in emergency demand and seasonal respiratory diseases such as influenza (flu). Impacting both the demand on our services and the staff available to support our patients. It is a realistic probability that the impact of flu (and other seasonal viruses) may be greater this winter due to very low levels of flu and therefore, immunity, over winter 2021-22. There is considerable uncertainty over how these pressures will interact with the impact of COVID-19.

1.4 Previously recognised internal mitigations and 'lessons learnt' during the winter of 2021-2022 may not fully address the risks posed to capacity and operational flow with the continuance of Covid prevalence and potential for concurrent influenza against a significant backlog of elective work, reduced bed capacity due to increased numbers of patients who are medically ready for discharge, that run alongside normal seasonal pressures. Therefore, ongoing monitoring, review and iteration of plans are likely to be

required. It is important to note that this policy has been developed for operational pressures and is applicable all year round, not just in response to winter pressures.

1.5 Meeting the clinical needs of the patients accessing UHD services will be achieved by the following principles;

- Building on learning from previous years
- Demand and capacity planning
- Sustainable on-going quality and service improvements;
- Specific planning and investment for winter and elective care recovery capacity;
- Clear escalation plans;
- Communication and engagement with our staff, partners patients and public;
- Partnership working to secure capacity & resilience across the Dorset System.

1.6 A plan is required to ensure the Trust is prepared and in the best position going into periods of pressure. It is also required to provide clinical and operational teams with clearly defined processes to follow when demands in urgent and emergency attendances/admissions exceed capacity in order to maintain patient safety and flow throughout the organisation.

The winter plan aims to provide a consistent approach in times of pressure by;

- Maintaining quality and patient safety
- Providing a consistent set of escalation processes across services and departments
- Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge in pressures across the Trust
- Setting consistent terminology across the merged organisation

1.7 The plan will concentrate on 4 aspects

a) Creating the capacity to meet increased demand
b) Looking after our people
c) Communicating well by preparing our people and our communities
d) Leading well

1.8 It will refer to the National Operational Pressures and Escalation Levels (OPEL) Framework produced by NHS England supporting decision making and communication of operational pressures across the Dorset system and beyond.

2. Key Risks

2.1 The Trust remains sighted on several perceived or additional risks detailed below which could impact on patient safety or outcomes, workforce and staff morale, delivery of the national Operational Planning Guidance and associated performance, or Trust reputation and public confidence, if not mitigated. The planning will need to remain under review throughout the winter period in order to respond to these challenges:

	Risk	Mitigation plans
1	Increased impact of further Covid-19 waves with associated risks to workforce, capacity, particularly Critical Care capacity and ongoing 'elective' and other reset/recovery plans	Bed capacity plan incorporating additional beds to flex and a robust IPC policy for manage outbreaks (Appendix 1)

2	Concurrent influenza - Point of care testing for flu. Critical in being able to differentiate from COVID 19. Concurrent Norovirus leading to bed closure/cohorting of affected patients.	Influenza Vaccination programme in place. Respiratory Pandemic Plan to be revised/updated. Current IPC guidance in place. Infection Control Team and CSMT to manage. To monitor local and regional outbreak and case data. Labs to support rapid testing when required. Wards having up to date risk assessment for patients in cubicles on shift by shift basis.
4	Significant increase in emergency admissions via A&E	Increased and enhanced SDEC capacity across all specialties
5	Higher acuity/delayed presentations contributing to complexity of care, bed requirements and length of stay	Clinical review of acuity report for each site
6	Increases in patients with 'No Reason to Reside' (NRTR) due to internal or external capacity and delays	Implementation of UHD Hospital Flow Improvement Strategy and Home First Board strategy
7	A shift in practice from GP referrals to 111 and ambulance conveyance	Increased SDEC capacity and improved access for primary care and SWAST. Link to system wide plan.
8	Insufficient number of Mental Health beds to meet increase in demand (adult and paediatric)	Link to system wide plan.
10	Backlog of elective work, delayed due to Covid-19 and capacity/workforce constraints.	Elective recovery plans will create additional bed demand and will require ring fencing/emergency flow mitigations as per plan
12	Workforce capacity, relating to wte/skills/productivity/Staff Moral and well being	Workforce planning underway.
13	Deviation from the planning assumptions that underpin the bed modelling. E.g. Plan is dependent on full delivery of a Dorset Wide discharge programme.	Planning assumptions that underpin the bed forecasting are measured against actuals to allow further refinement and re-calibration.
14	Ongoing population demographic – high frail & elderly population.	See OPS/Elderly Medicine Plans
15	Impact of implementation of CSR plans	This will be monitored by Joint Board.
16	Associated risks relating to ED processing/capacity (Hand over delays and system risks)	Monitored by the ED Recovery Group.
17	Impact of potential industrial strike action on clinical services	Close liaison with unions and business continuity at Trust and department level.

2.2 This following policies/plans support this document:

- UHD Capacity & Flow Plan (Appendix 4)
- UHD Discharge Policy (Appendix 6)
- Respiratory IPC Plan (Appendix 7)
- Cold Weather Plan (Appendix 8) Cold-Weather-Plan.pdf (rbch.nhs.uk)
- Outlier Policy (Appendix 9)
- Incident Response Plan (Appendix 10) Incident-Response-Plan.pdf (rbch.nhs.uk)

2.3 Departmental policies and escalation plans should also be referred to.

2.4 The Trust will be working in conjunction with system partners to ensure safe effective care for the people of Dorset

3. Current status of Winter planning

3.1 Winter is not an emergency or considered an unusual event but recognised as a period of increased pressure due to demand both in the clinical acuity of the patients and the capacity demands on resources within the Trust.

3.2 The focus of this plan is patient safety, ensuring each patient is cared for in a safe environment and care requirements are met. This plan has been developed to facilitate patient flow and manage elective and emergency demands within the Trust. It also outlines the key triggers for escalation to system partners

3.3 A detailed bed modelling exercise has been undertaken to understand the bed stock required to manage the elective and emergency inpatient demand. This was based on a required occupancy level of 92% in order to effectively and safely manage flow. It also factored in a 4% rise in elective and 1% rise in emergency activity compared to 2019-2020.

3.4 Internal processes have been reviewed, showing that the current average number of patients with No Reason to Reside (medically ready for discharge) equates to the equivalent of approximately 9 wards across both sites and has been increasing.

3.5 Occupancy is consistently above the 92% modelled resulting in challenges to flow, medical outlying and reassignment of beds to medical patients.

3.6 As a result of these findings a number of mitigations are in place to support the predicted gap in bed capacity throughout winter;

- Additional escalation beds have been funded from October 2022 to March 2023
- The SDEC improvement group have approved a number of schemes to increase the SDEC capacity and offer to external teams during the winter period
- IPC beds are regularly risk assessed to ensure that beds are reopened where safe to do so
- Review of referral and internal pathways to reduce length of stay
- Rapid decant initiatives with partners to support discharges to alternative settings/speed up assessments to community care/social care
- Care Groups are engaged in planning how to remain within their bed base as defined by the capacity plan and developing schemes that will reduce occupied bed days (OBDs) or prevent admissions.

4. Planning Assumptions and planned mitigations

4.1 In order to meet the projected capacity demand, the following planning assumptions will need to be met as a basis for winter planning:

- Sustaining a 30% reduction in Medically Ready patients across UHD
- A reduction in the average Length of Stay
- Planning against an occupancy rate of 92%;
- Emergency activity at pre-COVID levels;
- Elective activity increases and is aligned to the ambitions set out in Elective recovery plan;

- Ambulance conveyances predictions
- No change to usual pathways as per 2021/22 (noting a shift being seen from GP admissions to pathways via ED).

4.2 However, it should be noted that even if planning assumptions play out (noting this has not been the case 22/23 to date and requires mitigation), there remains a gap in capacity which requires even further mitigation.

5. Mitigation Plans - Quality and Service Improvement Plans

5.1 **ED Recovery Group** - Established meeting weekly with Director of Operations chairing. Action plan reviewed fortnightly with SWAST and ICB. Reporting to executive sponsors (CEO, COO) through monthly Enhanced Support sessions, and weekly to Trust Operational Performance Group

5.2 **The Transforming our Hospital Flow Improvement Group** - Established by and responsible to the Chief Operating Officer. The group reports to the Trust Management Group (TMG) and to the Operational Performance Group (OPG).

The Group serves to ensure that there is an effective framework within which assurances can be given for the delivery of the Transforming our Hospital Flow Improvement programme work streams. The workstreams are:

1. Emergency Department (ED)
2. Same Day Emergency Care (SDEC)
3. Operational Flow
4. Discharge

Supporting Streams:

- Communications
- Digital/IT
- Urgent Care Programme (NHS Dorset)
- DIUCS Partnership

5.3 **Bed Modelling Exercise –** Undertaken to support the capacity plan decision making process and is a tool to understand variation in the number of core beds (capacity) against predicated admissions (demand).

The final iteration of the bed model identified significant challenges across UHD with a potential gap of up to 120 beds if no action were to be taken. A number of schemes were approved across the clinical and operational departments to mitigate this risk for 22/23 to manage demand in non-elective admissions whilst protecting the elective recovery plan. For note there remains gap in the winter months and ongoing mitigation plans are required internally and across the Integrated Care System.

5.3 Agreed investment has minimised the risk for UHD, though a worst-case scenario of a deficit of 44 beds in January 2023.

5.4 **SDEC Development** - In line with the NHS 2021/2022 Priorities and Operational Planning Guidance, the benefits of the SDEC approach include:

- The ability for patients to be assessed, diagnosed and to start treatment on the same day, improving patient experience and reducing hospital admissions.
- Avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning for patients, financial benefits and cost savings for hospitals, and often for patients too.
- Patients don't need to stay in hospital overnight.

- Allows patients who need acute /critical care to be treated.
- Flow safer, efficient and much more intuitive.
- Important linkage with the Acute Frailty agenda.

The Trust SDEC Workstreams have agreed priorities for 22/23 which aim to both support the winter plan and capacity for this year, as well as overall, longer term strategic and delivery milestones along the way. It is expected that a minimum of 24 beds per day will be saved via development of the SDEC models across the Trust. A pilot of direct access to SDEC via SWAST is underway in a number of areas including Medicine, OPS and Surgery developing pathways to support this. This is expected to be further enhanced through a single point of access (SPOA) will support the system response from 111, SWAST and primary care and decompress the Emergency Departments.

Table 1 below identifies the financially agreed SDEC schemes for 22/23

Care Group	Directorate	Scheme	Expected Beds Impact	Deliverability/ Timing
Specialties	Acute Oncology	7-day enhanced OAU service	3 Beds	June 2022
Surgery	Orthopaedics	TOACU – 6-day service	4 Beds	June 2022
Medicine	Medical	Move to 7 days both sites	6 Beds	October 2022
Medicine	OPS	Robust 5-day service	1 Bed	October 2022
Surgery	Surgery	7-day cover and in reach to ED (both sites)	8 Beds	October 2022
Medicine	Cardiology	In reach to ED	2 Beds	October 2022
Medicine	Cardiology	Heart Failure SDEC	TBC	November 2022
			24 Beds	

5.5 **Virtual Ward development**

UHD@Home is preparing a virtual ward soft launch for winter 2022/23. Five UHD specialities are working with the Dorset System to deliver a new virtual ward model, within which elements of acute care can be delivered within a patient's usual home, using a combination of remote monitoring and face to face visits. The specialities are Child Health, Cardiology, Microbiology, Older Peoples Services and Respiratory. A business case is being developed, for approval within UHD in order to seek funding from NHS Dorset to deliver the model. The aim is to reach 70 to 75 virtual ward beds this winter.

Subject to the funding being approved, the soft launch will start around the first week of November, with initially a few patients being supported using the virtual ward approach, with numbers increasing as the teams grow in confidence of the process to support patients. The soft launch will enable teams to fully articulate the resource requirements, the potential number of patients who meet the eligibility criteria, the numbers of patients that can be managed and the savings in bed days, which will inform a system wide evaluation due in Spring 2023.

5.6 **IPC Plans** – UHD has reviewed national Infection Prevention and Control (IPC) guidance and has safely reinstated beds back into general capacity after pressures

during initial COVID waves now that physical distancing is no longer part of that advice. Some beds closed following earlier IPC recommendations should remain closed and only utilised following risk assessment.

5.7 **Escalation plans** – have been developed in adult areas, Critical Care, Maternity and Paediatrics. Below demonstrates where additional capacity can be opened throughout the Trust when required. Note that the majority of the beds listed have been opened in Quarter 3 (Further detail can be found in Appendix 1)

Ward Area	Site	Specialty	Escalation Beds
Lilliput	Poole	Older People Services	14 beds
Sandbanks	Poole	Oncology	3 beds
Ward 18	Bournemouth	Surgery	5 beds
Ward 9	Bournemouth	Surgery	6 beds
Ward 21 (CCU)	Bournemouth	Medicine	7 beds
			35 beds

5.8 **Discharge Schemes** - A number of schemes are in place or being worked up internally and across the system to improve the discharge rates across the Trust they include;

a) Expansion of Discharge Facilitators for a 7-day offer – UHD has been allocated 10 Band 3 posts to cover both sites permanently (aim to release 10 beds)
b) Funding has been agreed to open up Departure Lounges on both sites from September 2022 on a permanent basis (aim to release 7 beds)
c) Renewed focus on Golden Patients: Funding has been agreed to support some additional hours in the evening to timely prepare TTO's, Discharge letters and prepare patients to be discharged next day early morning. Work is ongoing with the Care Groups.
d) Rapid Discharge Team: System wide funding has been agreed to support a team focusing on discharges over the weekends. The team will include a clinician, Therapist, Pharmacist, Discharge facilitator and a Nurse.

5.10 **Weekly ward level reviews** to review stranded patients attended by

- Matron/Senior Nurse;
- Discharge Coordinator and/or Senior Discharge lead
- Divisional General Manager or deputy
- Therapist (optional if possible)

5.11 **Hold Joint Operational and Flow Safety Meetings (OFSM)** – These are a minimum of three-times daily safety/operational huddles at 08:00 (Morning Sitrep and Immediate priorities), 13:00 (Full Flow and Safety Huddle) and 16:30 (Handover meeting). This forum is designed to ensure that there is a coordinated approach to capacity, flow and associated patients safety concerns with a multi-disciplinary attendance and ethos.

Core meetings are supported by care group huddles which address speciality level demands, review elective activities and implement solutions to ensure safe care for incoming patients.

During periods of increased activity additional meetings are scheduled to coordinate and deconflict plans from the Care Groups and to support joint decision making.

A continued conversation about flow is encouraged with additional information being shared between senior operational and clinical leaders through a patient flow Teams channel and escalation WhatsApp channels.

6 Winter Capacity

6.1 The Bed Escalation Plan for Royal Bournemouth and Poole sites can be found under Appendix 1 with details of full bed compliment by ward in Appendix 2.

6.2 Bed modelling has been undertaken across both sites to forecast the bed requirements over the next 6 months. This study along with learning from last year will underpin the winter and workforce plans, which includes:

- Additional planned bed capacity in place to meet seasonal variation in demand;
- Increasing the SDEC and hot clinic offer across multiple specialties including the frail elderly, to prevent avoidable admissions into acute beds;
- Increased focus on reducing "No Criteria to Reside" patients across both sites. Introduced Rhythm of the Day on each site to expedite and progress discharge of each patient on a Complex pathway. Five big ticket items have been identified:
  1. Reducing patients waiting for assessment by linking/having SW for every ward.
  2. Reducing number of patients in brokerage by working with BCP and DC to have brokerage Staff on site.
  3. Reducing number of patients waiting for intermediate care and Community beds by working with DHC.
  4. Reducing number of patients on Self-funding pathways by working with BCP, DC and CHS.
  5. Internal Delays: Working with UHD Care Groups to reduce patients waiting for Discharge Planning or therapy assessments or medical reviews.
- Continued development of our flow management following the rollout of our Health of the Ward system across both Trusts;
- Reviewing and enhancing admission pathways to optimise flow and respond flexibly to Covid incidence;
- Continuing to work with community partners, BCP, DC, ICB and DHC and all other system partners, in further developing the discharge to assess model to ensure that patients medically fit for discharge are not delayed from being discharged home; or, to the most appropriate care setting;
- Plans in place to provide greater resilience within our Emergency Departments and access to The Urgent Treatment Centre, including moving to a 111 First and Booking offer.

6.3 In addition the Trust is developing a significantly expanded seasonal flu vaccination programme & Continuing to follow the National guidance on infection prevention and control.

7 Workforce and Wellbeing

7.1 All departments will need to ensure robust annual leave arrangements, particularly over the Christmas/New Year period. The organisation expects and therefore should plan for an increase in staff sickness during the winter months. Both sickness and vacancies are regularly monitored, at a department level and Trust wide to ensure full support to staff members and to ensure services remain operational.

7.2 Workforce remains a significant risk to winter planning. Safe staffing will be maintained through use of existing ward workforce (potential re-deployment) and specialist staff with the use of bank and agency where necessary. Whilst the aim is to keep outliers to a minimum, clinical nursing support and advice for patients receiving care off their specialty ward will be accessed through the matron workforce.

7.3 Workforce planning is underway, noting any requirement for additional bed capacity will be a significant 'ask' on nursing and medical workforce.

7.4 Managing this evolving clinical footprint, whilst maintaining staff morale, patient safety and satisfaction is complex; requiring both flexible and sustainable solutions. The following Safe Staffing initiatives are being implemented for 22/23:

- Bespoke advertisements and training support programmes are planned for specialist areas where additional staffing is required as a result of estate changes; for example, the Emergency Department and Critical Care.
- Daily safe staffing meetings where the Matrons report in with regards to reviewing up-coming clinical staffing levels and any adjustments/additions that may be required, based on clinical acuity or demand.

7.3 Occupational Health supports staff to keep safe and well at work through a number of different ways. One being the Autumn vaccination program, offering all staff the flu vaccination and covid booster vaccination. Occupational Health also give UHD staff the opportunity to discuss any concerns they may have with having the vaccinations and promote the importance of being protected against flu and COVID-19 throughout the trust.

7.4 Mental Health and Psychological Wellbeing - Covid-19 has placed a huge amount of pressure on all our valuable staff - clinical and non-clinical. The impact this may have on staff and those they love and care for is recognised and on-going support is available. The Organisational Development team provides a package of wellbeing support for all staff.

7.5 The Building Healthy Working Lives strategic framework is monitored through the Building Healthy Lives Group chaired by the UHD Wellbeing Guardian. Support will be provided to staff in a variety of ways;

- Winter information booklet for managers and staff – providing easy to read information pack for all line managers to help signpost and navigate all the various resources available
- Well-being conversations
- Face to Face support – OD response to 121 requests for resilience support and providing a safe space to share concerns
- Well-being ambassadors programme
- Mental Health First Aid (MHFA) - department MHF aiders
- Financial well-being support and counselling services
- UHD responder – Support and recognition of staff who move to help out in other areas
- Food and Hydration Offer – A package of daily cost friendly offers and hydration stations
- Recognising staff through funded initiatives and excellence awards
- You Matter Well Being Pages – supporting easy access to information through the intranet

Staff wellbeing is a key agenda item of the weekly winter planning meetings with representatives from the Organisational Development team present to support immediate responses when identified.

8 Infection Control

8.1 The Trust will be reviewing practice against the national guidance, with a view to full compliance, a joint Trust wide Flu Vaccine Coordination Group has been established to oversee the programme. All sites will aim to build on work last year;

- Board commitment ambition to achieve 100% staff vaccination;
- Nationally recommended flu vaccine will be ordered and provided for healthcare workers;
- Anonymous collection of data on reasons for staff who decides against uptake;
- Full communications plan in place;
- Drop-in clinics, 24-hour mobile vaccination schedule and flexible 'bleep' service;
- Department based trainers;
- Reviews of appropriate practice to support uptake in higher clinical risk areas.

8.2 Flu and Covid-19 vaccines this year will arrive in the Trust in October 2022 and will be delivered in 2 ways to our staff;

- A blend clinic approach, co administered with the COVID-19 Booster – Weekend clinics
- Separate flu clinics to be held within the Occupational Health Department

8.3 Management of any outbreak will be coordinated by the IPC Team. Daily outbreak meetings will assess the impact on patient safety and hospital flow assessing the safest and most effective options to use the ward and any empty beds contained within it.

8.4 Details of closures will be shared with all healthcare partners within Dorset including Dorset ICB with wider communications shared with the South West Region and South West Health Security Agency (HSA). The Outbreak plan can be seen in Appendix 7. Learning from previous outbreaks has been incorporated into plans and shared at key meetings to drive necessary change.

8.5 Patients should be promptly isolated on identification of any symptoms that indicate an infectious illness. Norovirus and influenza have had minimal impact on healthcare provision over the past two years. It is likely with the relaxation of social distancing and other public health measures these viral causes of illness will return to seasonal levels. Assessing the patients in isolation on each shift so that the co-ordinator knows which isolation/ side room is next for use will help prevent transmission. Appendix 7 contains the detailed response to a pandemic and increased levels of circulating viral illnesses, however in light of previous learning rapid changes in guidance and learning will be held on the IPC intranet pages for reference use by teams across UHD.

9 OPEL - Escalation Plans

9.1 The Operational Pressures Escalation Levels (OPEL) is a nationally mandated system, further developed internally last winter, which sets out a formal and transparent approach to the state of departments and the Trust. This improves consistency and speed of response in escalation and ensures the right people are supporting recovery plans. Internal action cards have been developed in order to provide clarity for individuals/teams at each level of escalation. (Appendix 5)

9.2 OPEL Levels are determined from a system agreed set of criteria which assign a score based on indicators relating to the emergency department, critical care, delayed discharge, infection control and occupancy. OPEL levels are assessed by CSMT four

times each day and are reported to the system each morning. OPEL scores from system partners are assessed and an overall OPEL position agreed.

10 Care Group Plans

10.1 Medical Care Group

Silver command in place by way of a senior point of escalation for each site on a daily basis who will coordinate, escalate and arrange extra-ordinary meetings needed to manage operational pressures. Summary of the daily operational rhythm is as follows;

TIME	MEETING	PURPOSE	ATTENDANCE
0800	OFSM meeting	UHD Operational view and escalation	Silver Manager At OPEL 4 Senior CG support will also attend.
09:30	Care Group Flow & Safety Huddle	Rapid escalation from Patient Flow Meeting. Confirm post board round discharges Confirm 'sit-outs' and transferred to discharge lounge Confirm times for patients from assessment areas/ED Escalations to Silver	Site Silvers (Chair) AMU Matron or Clinical Lead (RBH & PH) OPAU/RACE Matron or Clinical Lead Matron Medicine (RBH & PH) Matron OPS (RBH & PH) Matron or rep Cardiology Clinical Site teams A member of the Care Group Leadership will attend at OPEL 4 to provide additional help and support where able.
1030	UHD Staffing Meeting	To review staffing across organisation and plan for the night	Matrons of the Day; GDON / HON
12:30	Care Group Flow & Safety Huddle	Rapid escalation from Patient Flow Meeting. Confirm post board round discharges Confirm 'sit-outs' and transferred to discharge lounge Confirm times for patients from assessment areas/ED Escalations to Silver	Site Silvers (Chair) AMU Matron or Clinical Lead (RBH & PH) OPAU/RACE Matron or Clinical Lead Matron Medicine (RBH & PH) Matron OPS (RBH & PH) Matron or rep Cardiology A member of the Care Group Leadership will attend at OPEL 4 to provide additional help and support where able.
1300	OFSM meeting	UHD Operational view and escalation	Silver Manager At OPEL 4 Senior CG support will also attend.

1400	UHD Staffing Meeting	To review staffing across organisation and plan for the night	Matrons of the Day; GDON / HON
1430	Care Group Flow & Safety Huddle	Rapid escalation from Patient Flow Meeting. Confirm post board round discharges Confirm 'sit-outs' and transferred to discharge lounge Confirm times for patients from assessment areas/ED Escalations to Silver	Site Silvers (Chair) AMU Matron or Clinical Lead (RBH & PH) OPAU/RACE Matron or Clinical Lead Matron Medicine (RBH & PH) Matron OPS (RBH & PH) Matron or rep Cardiology A member of the Care Group Leadership will attend at OPEL 4 to provide additional help and support where able.
16:30	OFSM meeting	UHD Operational view and escalation	Silver Manager At OPEL 4 Senior CG support will also attend.

Emergency Department

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Sustain UTC/minor colocation as per COVID model	**AMBULANCE WAITS & ED CONGESTION** Additional isolation capacity to prevent congestion within the Emergency Department	Live
Increase UTC slots available for ED walk ins	**ED CONGESTION & ADMISSION AVOIDANCE** Additional 111 slots available to ED from October 22	Live
Ambulance Cohort SOP in place	**AMBULANCE WAITS & ED CONGESTION** Agreed SOP to support releasing Ambulance crews from ED	Live
Ambulance Corridor cohorting	**AMBULANCE WAITS & HOURS LOST TO DELAYED HANDOVER** ECS private crews in place to manage a corridor	Live
UHD Divert Policy in place	**AMBULANCE WAITS & ED CONGESTION** Agreed SOP with SWAST and ICB for divert between UHD sites to balance demand on both ED and capacity	Live

Reconfigure ED Resus to optimise flow and coordination RBH	**AMBULANCE WAITS & ED CONGESTION** Refurb RBH Resus and 2 additional major's spaces. Plus, children's area	Live
POCT Practitioner RBH	**EARLY DECISION MAKING IN ED** Allow early bloods and therefore decision to admit or discharge early in patients journey	TBC
FLOW CORDINATOR Both sites	**ED FLOW** Improved intra dept moves and transfers and reducing delays to progress within the dept	TBC
Manchester Triage Roll out	**ED FLOW** Early recognition of unwell pts and consistency and time through triage – improving average time triage	Live
ED Streaming	**ALTERNATIVES TO ED** Streaming directly to SDECS, reducing ED attendances	Live

Frail and Elderly Services

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
OPS PH Site		
Increased Same Day Emergency Care capacity on RACE now established. Continue to pull from Emergency Department.	**ADMISSION PREVENTION:** Increased number of admissions prevented through increased use of ambulatory care.	Live
Outlier buddy system in place to support patients residing outside of specialty.	**LOS OPTIMISATION** Optimised LOS through dedicated team	Live
Operationalising Lilliput ward area to provide additional OPS bed capacity Dedicated consultant cover (Bank)	**BED CAPACITY** Area to mitigate against discharge delays to maintain flow through frail and elderly bed base	Live
Risk assessment in place to facilitate extension of current funded escalation bed capacity on Kimmeridge	**BED CAPACITY** To provide additional bed space to offset, in part, bed capacity lost to ward distancing	Available now subject to risk assessment at time of need
Risk assessment in place to facilitate additional bed spaces on Brownsea ward as defined in Full Capacity Protocol >level 3	**BED CAPACITY** To provide additional bed capacity	Available now subject to risk assessment at time of need

One session per week of Geriatrician support to ED	**FRONT DOOR RESILIENCE** Senior Geriatrician decision maker at front door to prevent unnecessary admissions and to strengthen connections between ED	Live
LLOS review meetings	**OPTIMISED LOS** Refocus LLOS meetings in OPM	Nov 22
OPM RBCH Site		
24/7 Frailty Unit	**OPTIMISED LOS** Frailty short stay unit in place to provide dedicated support to the frailty – opened 2021, measurable impact on all metrics	Live
Dedicated SDEC area for frail elderly – Pull model from ED	**ADMISSION PREVENTION** SDEC for the frail and elderly to prevent admission and support patients continuing to reside within their usual place of residence	Live
Additional Consultant Sessions to support new Frailty SDEC service	**ADMISSION PREVENTION** Early access to senior decision maker, earlier access to complex diagnostics and plans	Nov 22
Complex stay ward	**OPTIMISED LOS** Focus expertise and specialist workforce	Nov 22
LLOS review meetings	**OPTIMISED LOS** Refocus LLOS meetings in OPM	Nov 22

Medical Specialities

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Medicine PH Site		
Consultant cover weekends	Retained additional cover following COVID rota changes	Live
Sustain TIU staffing at weekend	**ADMISSION AVOIDANCE & OPTIMISED LOS** Through increased weekend activity on TIU	Live
Same Day Emergency Care for Pleural conditions	**ADMISSION PREVENTION** SDEC respiratory area to provide urgent support for respiratory patients who would otherwise be admitted into the Trust	Live
Medicine RBCH Site		
Consultant cover within the AMU across a 7-day period until 18:00	**FRONT DOOR RESILIENCE** Additional senior decision making to help optimise LOS, admission avoid and support the emergency pathway.	Live
Increased use of Consultant Connect to provide access to consultants for GPs.	**ADMISSION AVOIDANCE** Early and timely access to specialist advice will reduce referrals to hospital and reduce avoidable admissions.	Live
Establish an outlier team to provide dedicated support to patients residing outside of specialty	**OPTIMISED LOS** Optimised LOS through specialty review and decision maker	Live
Additional beds funded in year – Ward 14	**BED CAPACITY** 28 substantive beds	Live
Consultant cover weekends	**FLOW** Retained additional cover following COVID rota changes	Live
Weekend PCI lists to maintain flow supported by consultants from SDH and DCH	**FLOW** Reducing elective services in a Monday to reduce bed pressures typically experienced immediately after weekend period	Live
Reconfigured Medical SDEC area built and commissioned, alongside AMU/ED	**ADMISSION PREVENTION** SDEC for admission and rapid assessment of all admissions plus ongoing support patients continuing to reside within their usual place of residence	Live
SDEC/AMU bay to increase SDEC spaces x	**ADMISSION PREVENTION** Treat all patients as SDEC until proven otherwise, increase senior cover and integration	TBC

10.2 Surgical Care Group

The Surgical Care Group has established daily band 7 briefings at each site to convey the ward position and escalate any issues impacting safety, quality and flow including status of theatres.

Silver command in place by way of a senior point of escalation across the Care Group who can coordinate, escalate and arrange extra-ordinary meetings needed to manage operational pressures. Summary of the daily operational rhythm is as follows;

TIME	MEETING	PURPOSE	ATTENDANCE
0800	OFSM meeting	UHD Operational view and escalation	Silver Manager At OPEL 4 Senior CG support will also attend.
0830	Daily Briefing	Separate site simultaneously chaired by Matron of the Day to convey the ward position and items for escalation (template and structured)	Band 7 ward managers Senior leadership team @ OPEL 4 status
0850	Flow & Safety Huddle	Connect with <>leads to brief on Care Group position and to take any areas of escalation to OFMS	Silver Manager with Matron of the day from either site. A member of the Care Group Leadership will attend at OPEL 4 to provide additional help and support where able.
1030	UHD Staffing Meeting	To review staffing across organisation and plan for the night	Matrons of the Day; GDON / HON
1300	OFSM meeting	UHD Operational view and escalation	Silver Manager At OPEL 4 Senior CG support will also attend.
1400	UHD Staffing Meeting	To review staffing across organisation and plan for the night	Matrons of the Day; GDON / HON
1450	Flow & Safety Huddle @ OPEL 3 (both sites) and above	Agree plans for the night and act as a point of escalation as required ahead of OFSM meeting. Any decisions around TCI reviews will be agreed at this meeting.	Silver Manager with Matron of the day from either site. A member of the Care Group Leadership will attend at OPEL 3 to provide additional help and support where able.
1630	OFSM Handover meeting	UHD Operational view and escalation	Silver Manager At OPEL 4 Senior CG support will also attend.

In addition, there is a daily TCI review meeting to ‘check in’, regarding current day position and a forward look to remaining TCI’s.

Generic Surgical Care Group Planning

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Plan to introduce clinical adjudicator role to provide oversight of clinical decisions needed in extremis i.e. allocation of beds and TCIs.	Ensure impartial clinical review and oversight of any challenging decisions needed as a result of extremis i.e. lack of beds.	Dec 22
Enhanced discharge planning through: • Cohorting patients to enable focussed discharge planning for patients no longer meeting criteria to reside. • Ongoing LLOS meetings to ensure all patients > 21 days have plans and EDD in place. Ongoing focus on ensuring effective board rounds in place.	Optimised length of stay and occupied bed days to ensure unnecessary delays are minimised where able.	Ongoing
All TCI cancellations captured and LERNs completed to support harm reviews.	Good clinical governance	Ongoing
Daily planning of elective activity to Ward 12 to ensure clear plan around outlying beds / escalation beds.	Minimise where able, impact to elective work which includes cancer and urgent treatments.	Ongoing

Trauma and Orthopaedics Directorate

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
T&O PH Site		
TOACU embedded within Ansty (AMU) to assess and review GP and ED referred patients aiming to avoid admission where possible. Ensure ringfenced space to preserve SDEC function. Service increased to 6 days service.	**BED CAPACITY** Reduction of OBDs used by patients who could be more appropriately managed via SDEC and other support services. **EMERGENCY DEPARTMENT / BED CAPACITY** Increase the decanting of ED by timelier access to SDEC services to avoid overcrowded ED department, whilst increasing the number of patients managed via ambulatory care. In-reach resource to support ED.	Sept 22 Sept 22

Daily trauma reviews in place to manage any variation / periods of high demand	**OPTIMISED LOS** Increased access to theatres to support emergency patients, reducing pre-op length of stay optimising patient outcomes.	Sept 22
Maximise trauma operating capacity to ensure access to theatre times for trauma patients are optimum	**Reduced pre op and post op LoS** Increased available admitting capacity to support front door flow.	Sept 22
Continue to provide flexible rotas and access to locums nest to support additional availability of decision makers being available in periods of escalation	**OPTIMISED LOS** Aim to reduce decision making time for admissions and discharge plans	Dec 22
Additional medical support over weekends and winter holiday to focus on discharge	**BED CAPACITY** Increase weekend discharge rate	TBC
Orthopaedic RBCH Site		
Maximise use of 3rd Derwent Theatre and elective orthopaedic theatre capacity.	**OPTIMISED LOS** Increased access to theatres to reduce the number of pre-op OBDs used, and optimising LOS.	Sept 22
Orthopaedics to focus on utilisation and effective pathways to maximise use of Derwent.	**OPTIMISED LOS, reduced waiting time for elective surgery.** NOTE: This will be critical as the Derwent will not be able to support additional winter capacity as planned to support backlog clearance and elective recovery activity.	Ongoing

Surgical Specialties

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
General Surgery PH Site		
Expanding SDEC services to weekend working to increase the access to SDEC across the weekend.	**ADMISSION AVOIDANCE / FLOW** • Reduction of GP attendances in ED • Secure streaming pathways from ED • Secure pulling from ED • Secure SWAST and 111 direct access into SDEC • Admission avoidance >80%	Nov 22
Extending day case opening hours to avoid patients needing additional recovery time, from being admitted into an overnight bed	**BED CAPACITY** Less avoidable bed demand going into the evening / night which typically are times of high bed demand	Nov 22

General Surgery RBCH Site		
Expanding SDEC services to weekend working to increase the access to SDEC across the weekend.	**ADMISSION AVOIDANCE / FLOW** • Reduction of GP attendances in ED • Secure streaming pathways from ED • Secure pulling from ED • Secure SWAST and 111 direct access into SDEC • Admission avoidance >80%	Nov 22

10.3 Specialties Care Group

Clinical Support Services

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Pharmacy		
During OPEL 4 escalation; Pharmacy Lead as single point of contact. MS Teams set up.	OPTIMISED LOS Targeted prioritisation for preparation of discharge medication and summaries.	Routinely in place
Pharmacy Lead needs access to discharge tracker or regular updates to co-ordinate pharmacy workforce.	Effective deployment of staff towards admissions and discharges.	Routinely in place
Clinical pharmacy to be redeployed to admissions areas to review patients for medicines reconciliation and supply.	Minimise omission of critical medicines. Correct prescribing early in stay.	Routinely in place
Pharmacy Lead to work with senior pharmacy team co-ordinating service to meet demands with twice daily huddles	Daily prioritisation in place for most urgent clinical issues and facilitation of discharge	Routinely in practice (workforce gaps)
Near patient dispensing with dedicated ward teams using mobile dispensing stations or pharmacy ward hubs.	Medicines labelled ready for discharge from early in stay, reduces time at discharge.	Routinely in practice
If available, pharmacist/technician to support medicines reconciliation in ED as directed by Pharmacy Lead. RBH allocated, PH priority dependent.	Minimise omission of critical medicines	Routinely in practice (workforce gaps)

Senior Cancer Pharmacist or Pharmacy Lead to link daily with GM Cancer services to review capacity for chemo preparation.	Optimised throughput for Cancer beds.	Routinely in practice
Radiology UHD		
Respond to peaks in demand by flexing booking patterns for inpatients and outpatients. Backed up with additional evening or weekend WLI's to recover deferred outpatient activity.	Support early decision making to enable effective patient flow	Routinely in practice
Maintain radiographer theatre availability for T&O	Reduce LOS	Routinely in practice
Pathology UHD		
Respond to peaks in demand by flexing phlebotomy provision (as directed by clinical site teams) agreed with where appropriate to ensure timely sample collection and ensure rapid result turnaround. Recruit additional phlebotomy staff on fixed term contract to support winter ward.	Support early decision making to enable effective patient flow	On-going recruitment
Provide testing for respiratory and GI (e.g. Noro etc.) virus testing to meet demand	Support early decision making to enable effective patient flow	Ongoing
Provide rapid respiratory virus testing in line with national guidance and Trust policy	Support early decision making to enable effective patient flow	Ongoing
Inpatient Therapies (UHD)		
UHD Inpatient Therapy Service Specification launched October 2021: Clarifies referral and prioritisation criteria for inpatient OT and PT	Support patient flow through most appropriate use of finite therapy resource	Ongoing
Focus on discharge tasks which can only be completed by registered therapists	Support patient flow through most appropriate use of finite therapy resource	Ongoing
Recruitment into winter money funded posts for Poole site medical wards	Support early appropriate therapy assessment and treatment to prevent deconditioning and enable discharge	Ongoing
Recruitment into winter money funded posts for Bournemouth site medical/ OPS	Difficulties recruiting. Additional Bank Band 4 shifts in place.	Ongoing

11. Communication and Engagement

11.1 Circulation of this plan, to staff groups and partners will be undertaken via a series of Teams presentations across both sites, which can then be subsequently shared. This will also be supported by clinical workshops and presentations to key staff groups in November. A plan will be developed to ensure regular updates throughout the winter period, including in the Core Brief, Staff Bulletin and other media (e.g. screensavers, posters, targeted emails, SMS messages and social media). Furthermore, key aspects of the plan will be shared at the Dorset-wide winter planning workshop.

11.2 Internally engagement of staff and teams will take place to provide feedback and learning throughout the period to enable a response/alternation of the plan if required.

11.2 This paper will be submitted to the Trust Management Board and Board of Directors, as well as the Dorset CCG. Key elements will be fed into relevant system groups such as the Tactical Resource Group, System 'Silver' and UEC Board. It remains an iterative plan and further updates will be provided by exception to both committees over the remainder of 2022/23.

11.3 The Clinical Site Teams have committed to attending the joint operational and flow safety meetings on a twice daily basis.

11.4 Communications to patients and public are led by the Dorset ICB, working jointly with partner communication leads and building on the national comms plan as per the 10 Point UEC Action Plan.

11.5 Dorset System wide communication plan will be led by the ICB.

12. System Resilience and SITREP Reporting

12.1 Multi-agency weekly safety huddles will take place via the Tactical Resource Group (formerly known as Operational Delivery Group). The Group meet in order to;

- Provide intelligence to system in terms of demand over a 24-48 period
- Articulate pressures or issues that are likely to impact system wide
- Agree mitigating steps
- Provide a summary to the Strategic Resource Group with any recommendations or escalations

12.2 ICB Safety and planning huddles will be increased to daily when demand increases. In addition, there is an established process for calling an extraordinary teleconference via the System Single Point of Access (SPoA).

12.3 Resilience alerts are expected be submitted at any time by ICB partner organisations via the SPoA where the is an interruption to business as usual and at least daily when the Trust has declared OPEL 4

12.3 Daily Sitreps (indicating operational pressures, performance, ED diverts, cancelled operations etc) will be submitted to the ICB – these will be signed off by the Associate Director Operations, Deputy COO or nominated deputy on behalf of the Chief Operating Officer. Arrangements will be reviewed as required for any weekend/bank holiday reporting.

12.4 A NHSE/I Red Flag trigger report is required on a daily basis if the Trust fails to meet performance targets in Urgent and Emergency Care, there are cancellations within the elective programme or there is an escalation to a Business Continuity, Critical or Major Incident. NHS E/I are in the process of reviewing the metrics that we report on and are expected to release revised Winter UEC Targets that we will be required to report on by exception.

12.5 Specific operational plans will be developed for Christmas/New Year/Bank Holiday periods across all sites due to the expected surge of patients attending the hospitals following the bank holiday and reduced available staffing. This will detail departmental plans, contacts, staff availability, reporting responsibilities and management oversight for each day; reporting in line with OPEL and assurance on plans.

13. Emergency Preparedness

13.1 The Trust's Winter Plan should also be read in conjunction with relevant Emergency Preparedness policies and plans e.g. Incident Response Plan (Appendix 10). In particular the Cold Weather Plan (Appendix 8) lists the actions to be taken in times of extended cold weather and the effect on patient conditions.

13.2 The Trust is required to respond to a major or internal incident at any time, including when the hospital is experiencing capacity challenges.

13.3 In addition to this, the Head of ERPRR leads on severe weather planning. This remains as a risk on the risk register due to the potential to impact services, along with mitigating factors.

14. Partnership Working

14.1 There is a shared 'Winter' Plan for the Dorset system, this will be reviewed considering potential impact and/or opportunities. Key existing areas of current partnership include;

- Home First Board
- Urgent and Emergency Care Board
- Tactical Resource Group (Dorset System)
- Collaboration with the East Cluster and East Integrated
- Same Day Emergency Care Workstream
- IUCS Programme
- Mental Health Improvement Programme

14.2 Social care and capacity across community services remains a risk for the winter period, particularly during holiday season.

15. Governance, Monitoring and Reporting

15.1 Opening of additional capacity will be identified through operational meetings where capacity will not meet demand and escalation capacity is needed. The escalation areas are as per Appendix 1. The Matron of the Day or Clinical Site Management Team out of hours will identify the safe staffing requirements for authorised escalation as detail in the site escalation.

15.2 The strategic and operational teams will regularly review metrics to aid 'horizon scanning' of issues through the winter, escalation and response. Metrics include:

- Number of Covid-19 patients
- Time to initial assessment in ED, 12 hour waits in ED (including for Mental Health patients)
- Time to decision to admit / discharge from ED (Clinically Ready to Proceed)
- Over 14, 21day LoS
- Number of patients who do not meet Criteria to Reside (including those over 21 days)
- Same Day Emergency Care activity
- ED attendances and ambulance conveyances
- Activity and occupancy levels (92% max, 88% stretch) against predictor
- NEWS (acuity)
- Readmissions
- Cancelled on the day admissions
- Outliers out of the care group
- Days at OPEL 3 and 4
- SIs, LERNs, mortality
- 111 and UTC streaming capacity
- ITU bed days and delays
- Trauma escalation levels

15.2 Monitoring will take place through the following internal groups/committees: -

- Winter planning Group
- Trust Management Group (meets on a fortnightly basis)
- Operational and Performance Group (meets weekly)
- Tactical Group (when stood up)

15.3 The 24/7 leadership arrangement for the Trust includes an on-call manager on both sites and Joint on call Executive. These teams are sighted on escalation to Dorset ICB where appropriate.

15.4 As well as internal groups, progress will be overseen by the Dorset Urgent & Emergency Care Delivery Board.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 6.4

Subject:	Risk Register

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk Janey Harbord, Head of Governance & Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	To provide details of the risks rated 12+ on the UHD NHS Foundation Trust risk register.
Background:	The report is provided in accordance with the UHD Risk Management Strategy.
Key points for members:	

Current risks rated at 12 and above on the risk register	37
Risk(s) increased to 12 and above for review	1
Reduced, closed or refreshed risk(s)rated at 12 and above to note	1
Potential new risks for review	0

Risks increased to 12 and above for consideration

Risk no:	Title	Proposed Grading	Update	Exec Lead	Papers
1378	Lack of Electronic results acknowledgement system	15	Escalated to ICS following a SI. UHD and ICS do not have an effective results acknowledgement process for results. There are a variety of ways in which results are delivered and teams are variable in the way in which requested tests are tracked This impacts primary community and secondary care. Risk should be held at Trust and system level with a strategic approach to mitigating the risk or removing it through the commissioning of	Chief Information & IT Officer - Peter Gill	Williamson, Ruth - Interim Chief Medical Officer Verbal update (previously accepted 12+ risk 22/02/21)

			electronic patient records which address the issue		

To note - Current 12+ Risks decreased in month			
Risk no:	Title	Risk Owner	Risk Trend
1642	Midwifery Staffing	Jones, Frances - Interim Director of Midwifery	Decreased from 15 to 8

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
193	150	78%	⇧**1%**

Options and decisions required:	For approval.
Recommendations:	For approval.
Next steps:	• New and existing risks graded at 12+ will reflect acceptance (or not) on the current (live) Trust risk register • Actions identified in relation to current risks to be communicated and facilitated by Risk Owners • Acceptance of closure and downgrade of risks to be reflected on the current (live) Trust Risk register

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)	N/A
CQC Reference:	All Domains

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Management Group	22 November 2022
Quality Committee	29 November 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 6.5

Subject:	CQC update report

Prepared by:	Kelly Ambrose, Quality Governance Lead
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	To provide an update on recent CQC inspections at UHD. The paper is for noting.
Background:	The Care Quality Commission's role is to make sure services provide people with safe, effective, compassionate, high-quality care whilst encouraging services to improve. They monitor, inspect and rate services as well as taking action to protect people who use the service.
Key points for Board members:	The CQC undertook an unannounced inspection of medical care (Older Peoples Services wards only) and surgical care (including Theatres) on Wednesday 28 and Thursday 29 September respectively. As part of the inspection process, the Trust received two data requests for each core service area and information was returned within the three-day timescale. The CQC provided verbal feedback to the Chief Executive and Chief Nursing Officer and sent a high-level feedback letter on 6 October. It was noted that staff were caring for patients with compassion, kindness and patience and, good MDT working where discussions on how best to support individuals and their next of kin before discharge were observed. Areas of concern included: • Staff shortages on the wards visited which impacted on the ability to meet the needs of individuals, patient safety and patient experience. Staff also spoke about the impact on morale and culture. • Some medicines were not locked away when they should have been, fridge temperatures were not always being monitored and some medicines were found that were past their expiry date. • The processes for the granting of authority of deprivation of liberty safeguards on Ward 5 (RBH) meant all patients were restricted from leaving the

	ward because of the screen that was positioned across the entrance. (note this is a movable curtain screen on wheels and CQC were obtaining guidance on this). On 21 October, the Trust received a letter from the CQC detailing a requirement to provide specified information and documentation in relation to patients on the Fractured Neck of Femur (#NOF) pathway. The information was submitted to the CQC on Monday 24 October 2022. There have been further information requests since this return, which the trust is responding to. A draft inspection report will be sent once the CQC have completed their due processes and will aim to provide this within 50 working days of the end of the inspection phase. The CQC undertook an unannounced focused inspection for maternity services at Poole Hospital on 8 November. This is part of the national programme of maternity inspections for all units which have not been inspected from April 2021. This inspection focused on the safe and well led key lines of enquiry. As part of the process, information was submitted to fulfil the CQC data request on 11 November 2022. Additional interviews and information requests have also been responded to.
Options and decisions required:	To note the CQC inspections and initial findings
Recommendations:	
Next steps:	At time of writing the inspection process is underway, and a further update will be provided at the Board.

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

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

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Siobhan Harrington
CEO University Hospitals Dorset
Longfleet Road
Poole
BH15 2JB

Date: 6 October 2022

CQC Reference Number: INS2- 138140693311

Dear Siobhan

Re: CQC inspection of Poole Hospital and The Royal Bournemouth Hospital

Following your feedback meeting with Lisa Layton, Claire Drakeford and Victoria Ives on Thursday 29 September 2022. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you, Paula Shobbrook and Joanne Sims at the feedback meeting.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back on Thursday 29 September 2022 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

- We observed there were staff shortages on the wards we visited. This impacted on the ability to meet the needs of individuals, patient safety and patient experience.
- Staff told us about the impact of staff shortages on moral and culture. Some staff told us they were not being listened to when they raised concerns.
- We found some medicines that were not locked away when they should have been, fridge temperatures were not always being monitored and we found medicines that were past their expiry date.
- We discussed the processes for the granting of authority of deprivation of liberty safeguards and that on Ward 5 (RBH) all patients were restricted from leaving the ward because of the screen that was positioned across the entrance. We told you we were taking further advice on this.

However,

- We also observed staff caring for patients with compassion. We heard staff spoke with patients with kindness and patience.
- We observed good MDT working when this was a schduled regular meeting and when staff came together to discuss how best to support individuals and their next of kin before discharge.

We discussed the process for setting up additional interviews with key core service leads and that information requests would be shared Friday 30 September 2022 and the following week. Joanne confirmed the designated portal for the submission of information has been set up.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Benjamin Coe at NHS England and NHS Improvement.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Catherine Campbell

Head of Hospitals Inspection

c.c. Mr Robert Whiteman – University Hospitals Dorset NHS Foundation Trust
Benjamin Coe of NHS England and NHS Improvement
John Scott - CQC regional communications manager

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 6.6

Subject:	Independent investigation into East Kent Maternity Services

Prepared by:	Paula Shobbrook, Chief Nursing Officer
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	For noting.
Background:	In February 2020, NHS England and NHS Improvement (NHSE/I) commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. This followed concerns raised about the quality and outcomes of maternity and neonatal care. The investigation reviewed 202 cases, spanning 2009 – 2020. Families were asked to participate with the purpose of identifying the truth on what happened. The report was published on 19 October 2022.
Key points for Board members:	There were missed opportunities at East Kent, which sadly led to significant harm. This included: • Failures in teamworking • Failures in professionalism • Failures of compassion • Failures of listening. Dr Kirkup has identified four areas of action: • Identifying poorly performing units • Giving care with kindness and compassion • Teamworking with a common purpose • Responding to challenge with honesty. Reading the signals: Maternity and neonatal services in East Kent – the report of the independent investigation.
Options and decisions required:	N/A
Recommendations:	For review and endorsement of the next steps.
Next steps:	The briefing on the report has been shared with Trust Management Group members to consider, with the recommendation that learning should be discussed at the governance group. The Interim Director of Midwifery and maternity leadership team are reviewing the recommendations and actions, which will be reviewed at Quality Committee.

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 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.
BAF/Corporate Risk Register: (if applicable)	N/A
CQC Reference:	All domains

Committees/Meetings at which the paper has been submitted:	Date
Trust Management Group	22 November 2022
Quality Committee	29 November 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 6.7

Subject:	Maternity baseline assessment of final Ockenden report (2022)

Prepared by:	Frances Jones, Interim Director of Midwifery
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	This paper is for information and noting. The paper gives a baseline assessment of the Maternity position against the final Ockenden report (2022). This is work in progress and further submissions regarding these standards will be submitted to Specialty Care Group and the Quality Committee.
Background:	The Maternity Safety Self-Assessment tool, which forms part of this compliance, has been reviewed at Patient Safety Champions meetings and shared with the Quality Committee and LMNS. This tool was highlighted to the Board of Directors on 12th Oct 2022, by the Chief Midwife of NHS England during the meeting with UHD Trust Board members, as part of the national programme of engagement with Boards. The Ockenden intermediate report ' Emerging Findings and Recommendations' (December 2020, often referred to as Ockenden one) which included 7 immediate and essential actions, was presented to Trust Board and the South West region through the Local Maternity System for Dorset, by the substantive Director of Midwifery Lorraine Tonge in 2021. The UHD maternity service was recently visited on 8th October 2022, by the NHSE South West region and the LMNS for an insight visit to review progress on completing these actions. Our local presentation was reassuring that no actions previously rated green had deteriorated. We received a verbal feedback and await formal feedback from the Insight visit once the LMNS have completed their report.
Key points for Board members:	The Board are asked to familiarize themselves the domains for reporting future safety assurances in maternity services.

	Since this paper was written there has been communication from NHS England that a single site/portal will be developed to assist Trusts in reporting all safety and assurance requirements to be reported in once place.
Options and decisions required:	For Board members information and understanding to monitor future progress with compliance of all domains in the final Ockenden report.
Recommendations:	To note the initial self-assessment against the final Ockenden 15 IEAs. To note the update and the work of the LMNS, particularly in relation to safety and compliance in maternity services, alongside assurance and transformation.
Next steps:	To consider the suggestion of a Board Seminar focused upon clinical outcomes normally viewed in the perinatal surveillance dashboard and patient safety champion feedback (reports, safety walkarounds, safety champion meetings) and progress the plan for further Board engagement with the maternity team.

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.
BAF/Corporate Risk Register: (if applicable)	Maternity staffing is included in the risk register and these risks have recently been mitigated to move from red to amber. Further discussions regarding staffing on the risk register are in progress
CQC Reference:	All domains

Committees/Meetings at which the paper has been submitted:	**Date**
Specialty Care Group Board Quality Committee – baseline assessment within August 2022 Safety Champions report	August 2022

Contents

1. Purpose

1.1. This paper is to inform the Maternity services (Women's Health directorate), Maternity Safety Champions, Specialty Care Group Board and the Quality Committee of our progress in meeting the Immediate and Essential Actions from both the first and second Ockenden reports.

1.2. The publication of the interim report by Donna Ockenden in December 2020 stipulated that all maternity Trusts in England and Wales must comply with seven Immediate and Essential Actions (IEAs)1 as detailed in Appendix 1.

1.3. As required by NHS England the level of compliance with the seven IEAs was assessed as of 15 April 2022. UHD provided evidence of good compliance with the expected actions and received funding via the LMNS to support our compliance. This included a significant investment in midwifery and obstetric staffing.

1.4. Along with Trust Boards, The Local Maternity and Neonatal System (LMNS) has a critical role in ensuring that the Integrated Care Board (ICB) is able to respond to the recommendations made in the Ockenden report and any subsequent reports which require evidence of high quality safe standards in maternity care within Dorset.

2. Background

2.1. The report into failings at Telford and Shrewsbury Foundation Trust Maternity unit has been labelled the largest review of its kind in NHS history. Over 1400 families were impacted in the 20 years of the review, with over 1500 incidents of poor or dangerous practice, resulting in dire outcomes. These include the deaths and serious, life-changing injuries of mothers and babies. It includes detailed descriptions of the experiences of women and families in these cases; it is devastating, for the families who have suffered from these incidents. Coming at a time where the NHS is short of midwives and doctors, whilst still in the pandemic, Ockenden is likely to have the most significant impact on maternity care ever.

2.2. For the Southwest Region, the first self-assessment of compliance with the seven IEAs from the interim report, was June 2021, with a further assessment at the end of 2021. As of 15th April 2022, the date set by NHSE for trusts to state their levels of compliance with the seven IEAs, UHD's position is as shown in Appendix 1.

3. UHD Compliance with 15 IEAs from the interim Ockenden report (as of end July 2022)

3.1. The multi-professional team within UHD maternity and neonatal services have undertaken a self-assessment against the Final Ockenden Report that was published on 30 March 2022 which contains a further 15 IEA.

3.2. There is an expectation of a Trust Safety Self-Assessment which has been enhanced with additional standards in line with Ockenden 1 expectations. Previously this self-assessment tool was used for maternity services requiring improvement as it links with CQC key lines of enquiry. However, the standards included were demonstrated by well performing maternity services, so this tool is now an expectation of compliance with the latest Ockenden immediate actions.

The progress of UHD maternity self-assessment is included in Appendix 2 and can be used for informing future developments including safety and quality improvement plans. The self-assessment will be reviewed as part of the maternity safety champions regular meeting to ensure improved compliance can be demonstrated with safety improvement plans.

3.3. The self-assessment below will require scrutiny and assessment by the system assurance team with ongoing review in line with NHSE expectations. This is the initial baseline assessment provided against the recent additional 15 immediate essential actions.

July 2022		
	Essential Action	**UHD rating**
1. Workforces Planning and Sustainability	Financing a safer workforce: The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	National Recommendation
	Training: Ockenden states that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	The Trust undertake a training needs analysis for all professions and there is funding allocated for midwifery staff in the uplift costs. UHD workforce plans suggest enhancing this from 23% to 27% for midwives in line with training demands for A and E nurses (further detail to follow in midwifery safe staffing report against Birthrate Plus recommendations). Trusts have been advised to reinvest savings made through the MIS year 3 rebate and this is particularly useful for training and equipment bids as it is time limited (annual submissions)
2. Safe Staffing	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	UHD have a staffing escalation policy. Clarity is needed in relation to a systematic approach to medical staffing escalation for any staffing issues, they experience. The safety huddles include neonatal membership and the neonatal team also have a dedicated escalation and mitigation policy. Communication with UHD CMT (clinical management team) twice daily and with other trusts in region daily, seven days per week.
3. Escalation and Accountability	Staff must be able to escalate concerns if necessary.	Good evidence of maternity staff using the UHD Freedom to speak up Guardian, maternity FTSU guardian and Professional midwifery advocates along with staff side partners. These are additional routes where line managers are not responding or not acting in response to

		concerns raised. Staff engagement and away days have also taken place to support future ' you said we did' evidence.
	There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.	Yearly competence review with education supervisor (ES) is suggested. Register of progression points for non-training grade doctors.
	If not resident there must be clear guidelines for when a consultant obstetrician should attend.	Compliant with the RCOG 'Roles and Responsibilities of the consultant providing acute care in obstetrics and gynaecology' . Further evidence of Consultants assessing women outside of the delivery suite through case review or snapshot audit is required for complete assurance.
4. Clinical Governance-Leadership	Trust boards must have oversight of the quality and performance of their maternity services.	A maternity dashboard has been available, however this is being updated and improved to provide clarity and effective review of quality and performance following changes to the maternity data system. The monthly safety champions report gives detailed reporting against the key criteria in the perinatal surveillance model.
	In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	Demonstrated in organograms and reports including the maternity risk strategy (currently under review). Lead roles delegated by Clinical Director and Director of Midwifery.

5. Clinical Governance - Incident Investigation and Complaints	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	UHD engage regularly in meaningful incident investigations through tripartite meetings with Healthcare Safety Investigation Board (HSIB) and pan Dorset perinatal mortality reviews. Lessons learned are demonstrated via the maternity Safety Champions report. further review of neonatal input suggests a need for a dedicated neonatal clinician to undertake more incident investigation work in partnership with the maternity risk team (this is currently provided by a senior nurse with a special interest, out of clinical time).
6. Learning from Maternal Deaths	Nationally all maternal post- mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.	Royal College of Pathologists guidance on maternal deaths is currently under review. There are two specific consultants who conduct autopsies in cases of maternal death, the autopsy/pathology report sent to Her Majesty's Coroner (HMC) +/- the consultant obstetrician looking after mother (with permission of HMC). The postmortem (PM) reports are not available on Electronic Patient Records (EPR) because sensitive, confidential, medicolegal reports. The Coroner's PM reports are owned by HM Coroner. After inquest/HMC investigation/HMC permission, the Consultant Obstetrician can discuss autopsy report findings with family/clinical & governance teams at maternal mortality meeting.
	In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	Maternal deaths are referred to HSIB within criteria guidance. Discussed as Serious Incidents Requiring Investigation (SIRI) Forum.

7. Multidisciplinary Training	Staff who work together must train together	Multidisciplinary training days for Obstetric Emergencies, known as the PROMPT course and fetal wellbeing. As UHD have a level 2 neonatal unit, compliance with qualifying speciality has been reached. Neonatalolgists and neonatal ANPs attend Prompt also. **Amber status** as plans and compliance have been a concern where medical staff have not been able to attend their allocated MDT training days despite good notice.
	Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.	Reviewing alternative models of training for medical staff to ensure compliance eg training weeks, training on induction as well as training attendance at forward planned dates (can be disrupted due to escalation status or sickness absence) Risk of highest concern for MIS year 4 evidence.
	Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	Training undertaken prior to commencing on Delivery Suite either face to face or via K2
8. Complex Antenatal Care	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care	There is no standalone pre-conception clinic available for women at UHD. There are condition specific clinics where pre-conception care is available for example women with hypertension or a history of premature birth. This compliance will be developed further with maternal medicine networks and the Dorset LMNS

	Trusts must provide services for women with multiple pregnancy in line with national guidance.	The trust has a dedicated clinic for women with multiple pregnancy in line with national guidance.
	Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	Compliance reported but guidelines waiting for detailed review for assurance
9. Preterm Birth	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.	The preterm birth clinic and the pre and post pregnancy sessions of the consultants involved in preterm labour birth ensures this is compliant. With acute presentations of hitherto low risk women, review in Maternity Assessment Unit/Delivery Suite is routine.
	Trusts must implement NHS Saving Babies Lives Version 2 (2019)	Reported through the Maternity Incentive Scheme, the LMNS and existing UHD governance processes.

10. Labour and Birth	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.	South West Ambulance Service are currently unable to provide accurate transfer times for women to consider due to a range of variables on any one day. This is a national problem not specific to our region. This is mitigated by women having this information at the beginning of their pregnancy when choosing where to have their baby. Any women with a planned homebirth are updated daily when any escalation of services or ambulance pressures are known, via the safety huddle team.
	Centralised CTG monitoring systems should be mandatory in obstetric units	In situ on Delivery Suite. Telemetry monitoring ordered to supplement existing provision and provide more options for women to mobilise or use the birthing pool on delivery suite.
11. Obstetric Anaesthesia	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.	The current position for antenatal clinic review has capacity to support postnatal patients. Anaesthetic input is also available via the postnatal obstetric clinic
	Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record keeping that more accurately reflects events	Standard paper assessments used for all theatre and epidural interactions. Additional notes can be added to either badgernet or the UHD electronic patient record. Audit evidence required to ensure UHD meet core datasets.
	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	National Team Recommendation

12. Postnatal Care	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.	Women who require Postnatal readmission will attend the maternity assessment unit or delivery suite. New guidance has been drafted to ensure UHD consultant review is compliant within a 14-hour window or sooner if more urgent. Ward rounds under review and audit indicated to provide assurance.
	Postnatal wards must be adequately staffed at all times	Birthrate plus and health roster templates demonstrate midwifery compliance overall but opportunities for better skill mix being reviewed as part of work force plans for safe staffing. Confirmation of compliance with obstetric rotas to be reviewed as part of obstetric workforce planning.
13. Bereavement Care	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Spring suite and UHD maternity Bereavement team (midwives and counsellors) provide dedicated care 7 days per week. The gynae (early pregnancy loss) and maternity bereavement surveys undertaken in 2022 demonstrate that UHD have a bereavement service to be proud of.

14. Neonatal Care	There must be clear pathways of care for provision of neonatal care.	UHD neonatal services work in partnership with Wessex and Thames Valley Neonatal Operational Delivery network. UHD workforce for neonatal staffing using the DINING tool is scheduled for compliance review in October 2022 via this network. A comprehensive safe staffing paper with future aspirations has been undertaken by the network and is available as part of the maternity safe staffing compliance.
	This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	
15. Supporting Families	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision	Neonatal nursing has a nominated a senior nurse as the lead for family experience and wellbeing. Views of service users are captured via this lead through parentcraft and feedback sessions. There is also a neonatal safeguarding and discharge planning lead nurse to support vulnerable families. The Oasis team provide continuity of support for more vulnerable families including the postnatal period.
	Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.	Dorset LMNS host the Maternity Voices Partnership (MVP). UHD has excellent working relationship with the East Dorset Chair and wider MVP team. UHD support the MVP and maternity team in engaging local communities through links with the UHD Deputy Head of Patient Experience Feedback from friends and family tests, complaints and compliments are also taken into consideration when designing and delivering services to ensure service user's views are taken into account. UHD have a part time patient experience midwife to support this domain.

3.4. National Health Service England (NHSE) SW Region will be conducting assurance visits to all the region's maternity trusts between May and October 2022. The team plan to visit UHD for an insight visit of progress against the Ockenden essential actions on 11 October 2022.

3.5. The Region has set up an Ockenden Support Group which has had two meetings to date. This is known as the South West Response group and is aimed at LMNS leads, who are then expected to cascade learning and assurance expectations to individual Trusts through their maternity networks.

3.6. Each LMNS & Integrated Care System has been given funding for implementation of Ockenden1 IEAs. The LMNS has agreed the funding from the initial investment in maternity and is currently working with the two Dorset Trusts to agree where further Ockenden funds might be best invested once the allocation for Ockenden 2 is known. There is an unmet needs assessment from the initial bid and ongoing dialogue with future needs and existing needs are underway, identifying any remaining resource from underspent workstreams. Much of the funding was targeted at specialist roles and Consultant PA time to deliver safety and quality improvements at pace.

3.7. There will be an expectation that each trust appoints a Designated Ockenden Lead, who has operational responsibility for ensuring the Trust is compliant with IEAs, but also to be the voice of impartiality by holding trusts to account and reporting to LMNS. This will include speaking directly to staff to test strategies and improvements in practice. The role will also include the requirement for peer review across Dorset NHS and wider clinical networks. This role is being reviewed currently through regional assurance reviews and plans.

3.8. The final Ockenden report gave a clear steer that trust plans to roll out Maternity Continuity of Carer (CoC), as the default model of care by March 2023, could be paused if staffing did not meet safe standards. UHD had a very gently phased implementation plan so we continue to report progress against this to the LMNS and region. The first team is scheduled for roll out in 2023 with training and recruitment in quarter 3 (September – Dec 2022). The Head of Midwifery holds the action plan for review of progress and a Lead Obstetrician has been nominated to support the programme implementation and as a point of expertise for the new team once in place.

3.9. Nationally, Board level safety champions are expected to have an overview on maternity safety – the CNO and NED Caroline Tapster undertake the roles of Maternity and Neonatal Board safety champions. The redrafted UHD and LMNS dashboards will support swift oversight of key safety indicators.

3.10. A clinical outcome board seminar is suggested to take place with key learning from Ockenden to be considered as our self-assessment continues.

4. Role of the LMNS

4.1. The Perinatal Surveillance Strategy requirements states that Quality Surveillance for maternity should sit with LMNS's. Ockenden reinforced this and submissions to NHSE for assurance have been navigated through the LMNS. Dorset LMNS buddy with Somerset NHS to provide external assurance and shared learning.

4.2. As part of Quality Surveillance, Dorset NHS is included in both regional networks and clinical networks that may span other regions. Dorset LMNS are progressing well with the perinatal quality surveillance model and the current focus is the delivery of the model dashboard which has been on hold pending the implementation of the new maternity data system at UHD, known as Badgernet. Outcomes for this model are reported via the maternity safety champions report as the interim measure.

4.3. The Wessex Maternal Medicine Network (hosted by University Hospitals Southampton) are working on plans to deliver dedicated expertise to maternity service providers. The Wessex Maternal medicine network will provide a skilled resource highlighted in both Ockenden and Transformation deliverables.

4.4. The Wessex Academic Health Science Network lead the Safety Improvement Programme for maternity and neonatal safety (MatNeoSIP)

4.5. Maternity is significantly featured in Core20PLUS5, consideration needs to be given as to how UHD access appropriate support and resource to deliver this strategy.

4.6. A committed structure that oversees maternity at ICB level is necessary to ensure Ockenden, Core20PLUS5, Perinatal Quality Surveillance, Maternity Transformation Plan (as part of the Long-Term Plan) and they are all able to develop robustly across Dorset.

4.7. The Dorset LMNS implements the Maternity Transformation Programme which includes deliverables from the LTP and Better Births. Currently the capacity and capability framework is being reviewed along with the support for Maternity Voices Partnership and Maternity Strategy.

4.8. Future workstreams including workforce, Continuity of Carer, phase 2 of the maternity digital strategy are expected to be supported by the work of Dorset LMNS working in partnership with UHD NHS Trust our service users and the Integrated Care Board.

5. Maternity Staffing

5.1. England is approximately 2000+ midwives short and so the impact of the report on staff confidence and morale is concerning. All trusts in the region are experiencing significant pressures on their maternity services and continue to see the impact of Covid absences. Sickness absence and vacancy rates, including unfilled shift percentages are included monthly in the maternity safety champions report and reported to the workforce strategy committee.

5.2. UHD have relocated staff as per their escalation plan, from all areas of the service, to keep women and families safe during their antenatal, intrapartum, and postnatal journey. Periodically our alongside birth centre and Home birth service are closed and this is recorded in our sitrep records following safety huddles to assess risk and shortfalls across all areas of the service.

5.3. There are also challenges filling the Obstetric Consultant and middle grade rotas due to sickness and leave resulting in the possibility of Consultants acting down to middle grade shifts.

5.4. Staff survey report/results (from the trusts maternity workforce) in 2021, which are based on nine areas of staff satisfaction have been received very recently. The heatmaps and results of the survey reflect the challenges faced during the pandemic and the 2022 survey will ensure staff wellbeing is a key focus of any future workforce plans in maternity.

6. Freedom to Speak Up

6.1. After the Mid Staffordshire NHS Foundation Trust investigation in 2013, all NHS trusts were requested to appoint a Freedom to Speak Up (FtSU) Guardian. Guardians work with all staff to help NHS trusts become more open and transparent, and for employees to feel able to 'speak up' without fear of the consequences. They offer support and advice for staff who speak up, or are supporting a colleague who is speaking up, feedback on investigations and the conclusions, immediate action if patient safety is compromised. The CQC considers as part of the well led domain the adequacy of a trust's freedom to speak up arrangements. The maternity leadership team have received feedback regarding support provided to staff and it appears that this service is well used.

6.2. UHD maternity services has taken part in staff forums requested by the CQC in May 2022 as well as a Maternity Core Service meeting. There is an expectation that the maternity service will be subject to a CQC inspection in the near future.

6.3. Maternity staff engagement is an ongoing process to ensure staff are listened to when there are safety concerns or service redesign plans for consideration. The collaborative working between the multidisciplinary teams is evident in many of the Directorate meetings such as labour ward forum.

7. Service user Feedback

7.1. Maternity Voice Partnerships (MVPs) engage with the LMNS Board to review complaints and themes as well as positive feedback. Live issues that are of concern are discussed at weekly Touchpoint meetings which are attended by the Interim Director of Midwifery, the LMS leads and one of the Dorset MVP chairs.

7.2. MVPs are being further funded to ensure there is adequate resource to hear service user feedback. At the time of this report the MVP chairs have undertaken 15 steps visits with the most recent one incorporating feedback from women on the antenatal ward. The MVP chairs have found this exercise very helpful now that Covid restrictions have eased and they are permitted to visit the maternity unit. The Interim Director of Midwifery is supporting them to make monthly visits to continue engaging with service users and for monitoring all action plans arising from quarterly 15 steps visits.

8. Recommendations

- To receive the Final Ockenden Report.
- To note the initial self-assessment against the Final Ockenden 15 IEAs.
- To note the update and the work of the LMNS, particularly in relation to safety and compliance in maternity services, alongside assurance and transformation.
- To consider the suggestion of a Board Seminar focused upon clinical outcomes normally viewed in the perinatal surveillance dashboard and patient safety champion feedback (reports, safety walkarounds, safety champion meetings) and progress the plan for further Board engagement with the maternity team.

Appendix 1

1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Partial
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant
2) Listening to Women and their Families	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Compliant
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Partial
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant
5) Risk Assessment throughout pregnancy	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	Partial
6) Monitoring Fetal Wellbeing	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Compliant
7) Informed Consent	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	Partial

Appendix 2 – Safety Self-Assessment

Live RAG
maternity-self-assessr

Resources

Interim Ockenden report (Dec 2020)
OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITALNHS TRUST (donnaockenden.com)

Final Ockenden Report (March 2022)
Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust - final Ockenden report (publishing.service.gov.uk)

Core 20PLUS5 – An approach to reducing health inequalities
NHS England » Core20PLUS5 – An approach to reducing health inequalities NHS England » Equity and equality: Guidance for local maternity systems Maternity

Transformation Programme (2020, previously Better Births 2016) NHS England » Maternity Transformation Programme

Patient Safety Strategy (updated 2021)
Report template - NHSI website (england.nhs.uk)
MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | NPEU (ox.ac.uk)
Maternity investigations | HSIB

Maternity self-assessment tool (expectation of completion within Ockenden)
NHS England » Maternity self-assessment tool

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 6.8

Subject:	Board Assurance Statement: Elective Care Letter: Next steps on elective care for Tier One and Tier Two providers

Prepared by:	Judith May, Director of Operational Performance and Oversight
Presented by:	Siobhan Harrington, Chief Executive Officer Mark Mould, Chief Operating Officer

Purpose of paper:	To note the submission of the Trust's response to the national letter outlining the next steps on elective care for Tier One and Tier Two providers dated 25 October 2022.
Background:	In October, NHS England wrote to Trusts in Tier one and two of the elective recovery programme to ensure that the phase two objectives around 78 week waiters and 62 day cancer waits are met and to ask for each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by 11 November 2022. The letter contains ten areas for self-certification.
Key points for Board members:	Enclosed is a copy of the Trust's response to the letter, which includes assurance against each of the ten areas of self certification. The review against the areas for self-certification identified the following areas as requiring further action: 1. The Trust Board is asked by NHSE to receive a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in the letter. Whilst the Board receives a summary of cancer performance through the Integrated Performance report specifically, Dorset Cancer Partnership are working together to develop a FIT dashboard via the Dorset Information and

	Intelligence Service (DiiS) which will enable us to report on the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT in our regular updates to the Board. The ICB Elective Care Oversight Group have received and agreed a proposal to implement the changes to the 2ww referral pathway for FIT in the LGI suspected cancer pathway. Tele dermatology is in place for routine referrals but not suspected cancer 2ww referrals therefore the Board has not at this time received a report on the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; as we develop this pathway we will ensure this is included in our reporting. With regards to the prostate pathway, plans are being developed to capture triage timeframe data as part of the Best Practice Timed Pathways (BPTP) workstream led by the Dorset Cancer Partnership. The BPTP data will support any changes in the pathway which can enable delivery of the target for prebiopsy mpMRI and biopsy procedures. 2. It is proposed that performance against the maximum timeframes for diagnostic tests within each tumour-specific best practice timed pathway is reviewed monthly at the Finance and Performance Committee via an updated integrated performance report demonstrating current turnaround times against each subset. 3. It is suggested that the Board considers the designation on a Non-Executive Director to act as a sponsor for theatres. The Board is asked by NHSE to routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates. More advanced board reporting around our theatre productivity and improvement programme is under development.
Options and decisions required:	The Board is asked to review the content of the letter and note the three areas outlined above, including the proposed options for action.
Recommendations:	To ratify the contents of the letter which was submitted to NHSE on 11 November 2022 and agree further development of the IPR to capture the areas listed above as data becomes available. A request is made to Board for a Non-Executive Director to be designated to act as a sponsor for theatres.
Next steps:	Actions are ongoing to deliver upon the phase two objectives around 78 week waiters and 62 day cancer waits.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	**To ensure that all resources are used efficiently to establish financially and environmentally sustainable services** and deliver key operational standards and targets. **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)	**UHD 1074** - Risks associated with breaches of 18-week Referral to Treatment and 52 week wait standards. **UHD 1386** - Cancer waits increasing due to increased referrals.
CQC Reference:	Not applicable

Committees/Meetings at which the paper has been submitted:	Date
Trust Management Group	22 November 2022

University Hospitals Dorset
NHS Foundation Trust

Poole Hospital
Longfleet Road
Poole
Dorset
BH15 2JB

11 November 2022

Elizabeth O'Mahony
Regional Director
NHS England – South West
South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

Sent via email: tracey.hall@nhsdorset.nhs.uk

Dear Elizabeth,

Next Steps on Elective Care

Thank you for your letter dated 25th October and for your continued support in relation to our elective recovery programme.

Our Board remains fully committed to doing everything it can to ensure our patients receive timely, safe and effective care; and that this is provided within the financial resources available. We are very proud of the way in which our staff have risen to the challenges through each wave of Covid, working tirelessly to protect elective and cancer care for patients in the most demanding of circumstances.

Thank you for this opportunity to highlight where we are having the greatest challenges. You will appreciate the immense pressure we have been under within our hospitals over the last two and a half years. As you are aware, despite the reduced prevalence of Covid, we continue to see a high bed occupancy, raised suspected cancer referrals and a large number of patients who no longer meet the criteria to reside in an acute trust. Nevertheless, we are committed to meeting the challenges of recovering our elective and cancer backlog in a timely manner and maintaining a focus on quality and safety, working within UHD and across the system to improve the financial plans and delivery. Attached is the UHD elective recovery infographic that details the five areas of recovery that we are focussed on to get the best outcomes for patients and our people,

Your letter has provided a very helpful opportunity to review where we are against the fundamentals of recovery actions and we are pleased to be able to share with you the areas where we are demonstrating best practice. We have very much valued the constructive challenge and support we have received from your team during the Tier 2 meetings and are pleased that we have been able to improve our recovery trajectory for long waiters.

The revised 78-week trajectory represents a decrease of 40 from our previous trajectory, whilst we are forecasting an increase in cancer backlog compared to that previously within our plan. It is important to highlight however that the current trajectories are high risk and will require all our

collective efforts to ensure we can achieve everything that we aspire to within Dorset and within our Trust.

The trajectories submitted last month assume that conditions within the system would support us deliver this level of activity including:

- COVID levels not increasing above their current rate
- Workforce impacts because of COVID do not escalate
- Mutual aid within the system and externally can be secured
- Non-elective bed occupancy and MRTL numbers are reduced
- Further recruitment to specialist posts in key areas e.g. Orthodontics

Despite the challenges, our Board remains optimistic and focused on safety and quality within providing patients with timely access to services. Responses to your specific areas requiring self certification are set out below.

a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery?
a) Mark Mould, Chief Operating Officer has specific responsibility for elective and cancer services performance and delivery and is supported by as a triumvirate by Professor Paula Shobbrook, Chief Nursing Officer and Deputy Chief Executive and Dr Ruth Williamson, Acting Chief Medical Officer. Our Chief Executive, Siobhan Harrington is also chair of the ICB Elective Care Oversight Group and the Dorset Cancer Partnership.

b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.
b) The Integrated Performance Report received by Board monthly includes escalation reports for diagnostics, cancer and elective performance. The report is a standing agenda item at the Finance and Performance Committee where the detail of current performance is monitored, and recovery is reviewed, and assurance gained. The quality element of the recovery plan is discussed through the care group submissions to the Quality committee.

c) Has an agreed plan to deliver the required 78ww and 62-day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.
c) The trajectories for 78ww and over 62-day cancer recovery that were submitted to the SW NHSE regional team on 11 October 2022, have been agreed with the Trust Board and the risks to delivery as outlined above have also been shared. We continue to put in place plans in the areas we highlighted in September which, if not resolved, would present a requirement for mutual aid. We welcome the additional funding to support these areas and will continue to take a system approach to managing risks and agree mutual aid across the system where capacity is available to facilitate this.

d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.
d) Six priority tumour site cancer plans were agreed across the Dorset system earlier this year in Colorectal, Gynaecology, Skin, Head and Neck, Urology, and Breast. Progress against delivery of

these plans is monitored through our partnership arrangements as Dorset Cancer Partnership. In UHD a cancer improvement programme is part of our elective portfolio of improvement programmes and a group led by the Group Director of Operations for Surgery is tracking delivery of the actions within these plans. Cancer performance, including that of Lower GI, Skin and Prostate cancer pathways, is reviewed regularly as part of our governance structures both at Operational Performance Group (monthly) and at quarterly Trust Care Group performance reviews. Weekly cancer reports are shared with Directorates. The Board receive a summary of cancer performance through the Integrated Performance report. Dorset Cancer Partnership are working together to develop a FIT dashboard via the Dorset Information and Intelligence Service (DiiS) which will enable us to report on the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT in our regular updates to the Board.

Tele dermatology is in place for routine referrals but not suspected cancer 2ww referrals therefore the Board does not at this time receive a report on the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images as we develop this pathway we will ensure this is included in our reporting. We have scheduled attendance at the SW tele dermatology conference in November and we are also taking learning from the Isle of Wight pilot for integrating EPR and tele dermatology to inform our approach.

With regards to the prostate pathway, plans are being developed to capture triage timeframe data as part of the Best Practice Timed Pathways (BPTP) workstream led by the Dorset Cancer Partnership. Precision point template biopsy went live at UHD in summer this year to enable the transfer of GA activity to LA. The BPTP data will support any changes in the pathway which can enable delivery of the target for prebiopsy mpMRI and biopsy procedures to take place no later than 9 days from the date the referral is received.

The ICB Elective Care Oversight Group have received and agreed a proposal to implement the changes to the 2ww referral pathway for FIT in the LGI suspected cancer pathway including FIT<10 safety netting pathway. This action will be communicated through the Trust committee process in October and plans are being developed to roll out the agreed process.

e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking

e) The system has an established outpatient transformation programme in place, supported by the Dorset Outpatient Transformation Programme Board which monitors the impacts at Trust and system level. At Trust level our outpatient transformation programme is part of the elective portfolio of programmes supporting elective recovery. We are actively pursuing the opportunities to accelerate recovery presented by outpatient transformation alongside GIRFT and other productivity, performance and benchmarking data.

We have partnered with the outpatient portal provider DrDoctor and we are undertaking a phased implementation. Once fully implemented the digital outpatient journey will lead to benefits including: a reduction in DNAs; patients will receive timely digital letters and reminders of their upcoming appointments; we anticipate improved slot utilisation; a reduction in paper and printing costs as letters become digitalised, increased PIFU, increased patient feedback- through utilising the broadcast messaging features of DrDoctor.

Further to this platform, the Trust is investigating other digital solutions to maximise clinical time. We have introduced virtual consulting pods to increase capacity for virtual consultations, Dragon medical one dictation to speed up the turnaround time of clinic letters, expanded the use of a room booking system – Bookwise, to improve clinic room utilisation and reduce administrative burden and rolled out InTouch digital check-in to support flow of patients through clinics.

A secondary package of work within the outpatient transformation programme is enabling excellence in the way our current electronic systems interact with each other and improve access to outpatient utilisation and performance data.

f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.

f) Information on the impacts of the initiatives which took place under the banner of Super September including our Wait-in-line project and validation hubs have been shared with the Board's Finance and Performance Committee. These initiatives are now being rolled out across the organisation.

g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.

Regular reports on the Trust's waiting list validation project have been received by the Finance and Performance Committee, including updates on the single PAS programme. Our extensive validation project forms part of the elective recovery programme portfolio. Routine technical, administrative and clinical validation of the waiting list occurs in line with the Trust's access policy and plans are being progressed to meet the new expectations and deadlines whilst making best use of clinical resources. This represents a significant volume of patients to validate however existing processes and solutions in place will support our delivery.

h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

h) The Trust Board and its relevant committees regularly challenge and receive assurance from the lead Executive Director, and other Board colleagues in relation to the clinical prioritisation of capacity to support delivery of our elective and cancer objectives. This includes regular reporting against the cancer faster diagnosis standard and backstops position; monitoring of activity trends and performance on reducing long waiters. Specifically, a report on cancer pathology turnaround times was received by the Dorset Cancer Partnership Steering Board in September 22, of which the Chief Executive, Siobhan Harrington is chair. Turnaround times data for pathology, histopathology and radiology is regularly reviewed by the Trust's Operational Performance Group and actions agreed.

i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.

i) Theatre utilisation rates for day case and main theatres is included within our current Integrated Performance Report and received by the Trust Board monthly. We have an established theatre improvement programme and have been engaging in the regional NHSE Theatre Improvement programme since earlier this year, including working with FourEyes Insights to maximise theatre capacity based on ongoing theatre optimisation analysis.

We are also progressing the appointment of clinical improvement leads by specialty to further enhance clinical engagement and the scale of improvement work around theatres. The designation on a Non-Executive Director to act as a sponsor for theatres is in discussion.

j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.

j) Following significant development in our theatre reporting and the implementation of the CCS smart theatres scheduling tool last month, we are in the process of developing more advanced

board reporting around our theatre productivity and improvement programme. Data to underpin theatre opportunity realisation is overseen by Theatre Improvement Group and elective programme board.

k) Confirm your SROs for theatre productivity.

k) Our SRO for theatre productivity is Mark Major, Deputy Care Group Director for Operations – Surgery.

l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

l) Our greatest challenge in ensuring that our diagnostics services reach the minimum optimal utilisation standards is access to a sustainable workforce and we are actively looking at ways to attract and retain workforce in this area. Performance against the maximum timeframes for diagnostic tests within each tumour-specific best practice timed pathway will be reviewed monthly at the Finance and Performance Committee via an updated integrated performance report demonstrating current turnaround times against each subset.

Yours sincerely,

Signed by CEO Date: 11 November 2022

Signed by Chair Date: 11 November 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 7.1

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:

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.

Background:

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.

The Q2 report (1 July 22 – 30 September 2022) provides full details of the risks linked to the Board objectives.

The table below provides a Q2 summary:

	Q1	Q2	Q2 details
New BAF Risks added in Quarter	3	0	
BAF Risks rated 12-25 in Quarter	20	21	
BAF risks increased in Quarter		2	1378, 1429
Downgraded BAF Risks in Quarter	1	3	1439, 1207, 1739
Closed BAF Risks in Quarter	5	4	1605, 1603, 1602, 1434

BAF Risks Increased in Q2

Board objective	Risk Ref	Risk title	Risk rating
Digital transformation strategy	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	Increase from 9 to 15 Increased number of related patient safety incidents. Recognised need to escalate as a ICS IT issue.
Deliver a Covid restoration programme for emergency care patients	1429	Ambulance handover delays	Increased from 16 to 20. Ambulance handovers continue to be a challenge, with deterioration in performance in September. ECS have struggled to recruit resulting in reduced capacity to provide consistent services. Decompression meetings continue, led by COO weekly.

BAF Risks Downgraded in Q2

Board objective	Risk Ref	Risk title	Risk rating
Improve against Trauma pathways standards Deliver a covid restoration programme for elective patients	1439	Orthopaedics operational pressures and capacity	Reduced from 10 to 6
Improve against Trauma pathways standards	1207	Trauma and Otho medical staffing	Reduced from 9 to 6
Agree and deliver a sustainable budget	1739	Financial control total 22/23	Reduced from 20 to 16

BAF Risks Closed in Q2

Board objective	**Risk Ref**	**Risk title**
Deliver quality priorities	1605	Management of the deteriorating patient – developing a unified UHD policy. Completed
Work with partners to address health inequalities, work with partners to develop ICS	1603	Establishment of the ICS in timescale. Completed
Develop the reconfiguration plan	1602	Risk of delays in FBC approval. On track, closed.
Create the Strategic Outline Case and Outline Business Case for the Dorset Electronic Patient Records system	1434	Risk that the Graphnet EPR degrades in its functionality and performance over the next 3 to 5 years. Insufficient detail to retain as current live risk on risk register.

Key points for members:	For noting.
Options and decisions required:	For noting.
Recommendations:	For noting.
Next steps:	For noting at the Board.

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)	N/A
CQC Reference:	Well Led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	20 October 2022

Ref	Specific Objective	BAF Risk Executive Lead	Risk Ref.	Risk Title	Risk Lead	Qtr 1 Rating	Qtr 2 Rating	Consequence	Likelihood	Severity	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	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	0	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	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.	Williamson, Ruth - Acting Chief Medical Officer	9		3	3	Moderate	⇔	[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	
1.1.2	Deliver quality priority - **standardised safety checklists**	Chief Medical Officer	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 standardisation across sites for same specialities, including staff training, will impact on compliance and culture .	Williamson, Ruth - Acting Chief Medical Officer	9	9	3	3	Moderate	⇔	[08/08/2022 15:50:38 Janey Harbord (UHD)] This risk has been closed as reaching target grading (in line with policy)	Quality Committee Quality Governance Group	6
1.1.3	Deliver quality priority for 2022/23 - **acute kidney injury/dialysis management**	Chief Medical Officer												
1.1.4	Deliver quality priority for 2022/23 - **blood glucose management**	Chief Medical Officer												
1.1.5	Deliver quality priority for 2022/23 - **the deteriorating patient in ED**	Chief Medical Officer	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	9	0				⇩ **Closed**	[08/08/2022] This risk has been closed as reaching target grading (in line with policy). Policy and QI group established. **RISK CLOSED**	Quality Committee Quality Governance Group	0
1.1.6	Deliver quality priority for 2022/23 - medical/pharmacy communication	Chief Medical Officer												
1.1.7	Improve against **Stroke pathway quality standards**	Chief Operating Officer	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	9	9	3	3	Moderate	⇔	[09/08/2022] Risk and actions remain current	Stroke Governance Group	2
1.1.8	Improve against **Trauma pathway quality standards**	Chief Operating Officer	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	9	9	3	3	Moderate	⇔	[23/09/2022] no change to risk	Trauma and Orthopaedics Governance Group	4
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	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	6	6	2	3	Low	⇔	[21/09/2022] 21/09/22 no change to risk or mitigations	Trauma and Orthopaedics Governance Group	3
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	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	10	6	2	3	Moderate	⇩	[23/09/2022] access to theatre template is restricted by theatre and anaesthetic staffing gaps. ringfencing of bed base in place risk reduced but remains	Trauma and Orthopaedics Governance Group	6

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1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	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	15	15	3	5	High	⇔	[23/09/2022] updated action plan, risk remains unchanged.	Trauma and Orthopaedics Governance Group	2
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	1207	T&O Medical Staffing Shortage at Junior and Middle Grade Level	West, John - General Manager, Trauma and Orthopaedics	9	6	2	3	Moderate	⇩	[23/09/2022] no change to risk [29/07/2022] changes to locums nest approvals and locum rates reduce time to plan and fill gaps increasing the risk of uncovered shifts. escalated to care group. [04/07/2022] recurrent recruitment underway, work with HR to reduce/remove fixed term contracts where possible.	Trauma and Orthopaedics Governance Group	2
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	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	20	20	4	5	High	⇔	[04/10/2022] Risk rating remains the same. High bed occupancy impacting on emergency flow and the ability to offload ambulances and transfer patients to specialty wards. High number of MRFD patients across the organisation impeding flow. A rapid decant initiative is planned at system level to reduce the number of patients with delayed transfers by 100 by the end of October. Internal improvements are implemented and monitored via the Hospital Flow Improvement Group and the ED rapid decompression plan. A system mobilisation group is in place to focus on capacity gaps and has national funding associated to reduce the bed gap e.g. increase/enhancement of SDECs at UHD. There remains a capacity gap and this is the priority of the system to bridge prior to further impact of winter pressures. [05/08/2022] Continued bed pressures impacting on emergency flow, in particular on ambulance handovers and ability to transfer patients to inpatient beds against the 12 hour decision to admit metric. System responses include increase focus on delayed discharge position via the 100 day plan and the Home First Board. Internally the ED Rapid Decompression Plan and Hospital Flow Programme focuses on the internal processes vital for ensuring robust capacity management. The Trust continues to experience high occupancy levels and high (220+) MRFD delays. Mitigations in place to support discharge e.g. increase in care hours for intermediate care pathways though a private provider.	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	1387	Demand & Capacity: Demand will exceed capacity for acute inpatient beds	Sophie Jordan - Associate Director - Operations, Flow and Facilities	20	20	4	5	High	⇔	[04/10/2022] High occupancy levels experienced across both sites impacting on operational flow and ED ambulance handover performance. The Hospital Flow Improvement Group continues to focus on the 4 key areas to support flow. However significant pressures placed on the inpatient areas due to high number of MRFD patients per day and an increase in Covid prevalence. Action plans are updated weekly and shared via the Trust Governance structure. External mobilisation group in place to enact the system capacity plan with national monies to fund winter initiatives. [05/08/2022] Both sites continue to experience high occupancy levels which is significantly impacting on ED performance and flow. Throughout July the Trust has been reporting OPEL 4 and this has been mirrored across the system. The Hospital Flow Improvement Group is focussing on ED, SDEC, Operational flow and Discharge processes and is supported by the Rapid ED Decompression Plan. Externally the systemwide 100 day challenge is directed at internal and external plans to manage the MRFD challenges (averaging 220+ per day) Action plans are updated weekly and further initiatives have been shared with the regional team for funding support. This includes enhancing SDEC, escalation beds in Q3 & Q4 and enabling schemes.	Finance and Performance Committee	6

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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	1053	Lack of capacity for elective & non elective activity and risk to patient harm due to LLOS and NRTR patients	Jones, Jackie - Associate Director Partnership Integration and Discharge	20	20	4	5	High	⇔	[05/10/2022] System discussion and planning for circa 40 beds across Dorset and BCP LA's to support placements for NRTR patients, Becky Whale leading as part of the ICB 2 week 'Do something different'. COO has secured agreement with the ICB to increase the level of fee for patients who require placements through brokerage, this will support a number of patients given there are beds available within the system but at a higher fee. Plan the proposal for the 7 day working model for the Complex Discharge team for approval by week end. [04/10/2022] UHD Wide Harm Dashboard developed for incidents relating to NCRTR and CTR. Engagement across the trust starting with Hospital Flow improvement programme, workstream 3 and 4 and with the nursing and midwifery forum. 100 day plan contains actions to develop and strengthen the governance relating to potential harm, which is raised through existing LERN protocol at present, to ensure that this meets all requirements of the 100 day plan. Regular review and escalation of potential and actual harm undertaken with discharge team for complex discharges. MRFD list highlighting patients at risk of potential harm is circulated daily and discussed with partners. [01/09/2022] The position for the number of patients with No Reason to Reside (NRTR) has deteriorated over recent months following the termination of the national D2A funding and removal of bock-booked interim care home beds. MRFD patients increased to a high of 262 at the end of August. Three priority areas agreed as part	Finance and Performance Committee	6
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	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	20	20	4	5	High	⇔	[03/10/2022] Attendances in August reported a material reduction compared to July with just under 13800 attendances (c500 less at RBH and c200 less at Poole). However, waiting time standards have not been delivered and crowding in the Emergency Departments remains a daily operational challenge. There was an reduction in the number of patients waiting more than 12 hours in the department (100 fewer equally split between the sites). The total number waiting for more than 12 hours from referral increased marginally (n=6). Wait times for beds marginally reduced at RBH and increased at Poole, but remains a significant challenge - 7 hours ant RBH and over 8.5 at PH as an average in month. Non admitted times reduced by c8 minutes at Poole, but increased at RBH by 40 minutes. Despite the overall reduction in attendances conveyances by ambulance remained comparable to July (>3800). There was a marked reduction in Ambulance handovers waiting more that an hour, with almost 200 fewer than the previous month. This was delivered by funding additional Ambulance handover crews at both sites allowing 4 additional crews to hand over if the main emergency department becomes full. UHD recorded an improvement of over 1000 hours returned to the Ambulance Service compared with July - total time lost 2272 hours in August	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, DOO Specialities Care Group	9	9	3	3	Moderate	⇔	[09/08/2022] Following a recommendation from PA Consulting the admin staff are currently under consultation to restructure.	Finance and Performance Committee	4

Ref	Specific Objective	BAF Risk Executive Lead	Risk Ref.	Risk Title	Risk Lead	Qtr 1 Rating	Qtr 2 Rating	Consequence	Likelihood	Severity	Movement	Last Update	Monitoring Group	Target risk rating
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	1493	Absence, Burnout and PTSD - Risk of medium and lon	Carla Jones Deputy Director of Workforce & Organisational Development Deborah Matthews Director of Improvement and OD	12	12	4	3	Moderate	⇔	[03/10/2022] OH Referrals remain high. Appointment wait times to see an OH Nurse Adviser or Doctor currently around 4/5 weeks. All waiting referrals are reviewed and prioritised. No delays being experienced with pre-employment checks. Recruitment to 4 x B6 OH Specialist nursing roles to increase the staffing template has been unsuccessful to date despite advertising several times. The B6 role remains an important requirement to support recruitment and onboarding processes and reducing and managing staff sickness absence levels. Given the national shortage of this role, alternative staffing options are being considered. PSC service now fully staffed and there is minimal delay to support. A number of services are now offered through the PSC service which is supporting staff.	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											0	
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	12	12	4	3	Moderate	⇔	15/09/2022] Staff in post and budgeted establishment data for HCSW, as verified by ward leads via Group Directors of Nursing, now available on ESR and will be used by Business Intelligence in monthly PWR reporting going forward. Open Day 10 Sept focusing on HCSW vacancies resulted in 60 offers being made and further day of interviewing scheduled for remaining 30 or more applicants, which is expected to greatly improve the HCSW vacancy rate. Verification of Midwives and Maternity Support Workers in the process of being verified; it is hoped this data will also be included in PWR reporting this month. Objective is for BI to be able to use verified data for reporting vacancies for all staff groups in the PWR by end of this year. Vacancy data by cost centre and staff group expected to be available to managers at end of calendar year, once the data warehouse facility is fully operational. Cleansing of Right to Work, Visa and DBS data held on ESR is progressing, although slower than hoped due to pressure of work priorities in Workforce Systems team, updating carryover annual leave, re-implementing parking charges, new pay and pension rates, and correcting high numbers of payroll and rostering errors. [08/09/2022] All actions within the action plan have been reviewed and updated.	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											0	
2.4.1	Implement the National Patient Strategy requirement to develop a just culture across UHD as part of a ICS workforce plan	Chief People Officer											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											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 Officer	1416	GIRFT and Model Hospital Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision.	Helen Rushforth - Head of Productivity & Efficiency	16	16	4	4	High	⇔	[30/09/2022] Reviewed, no change	Finance and Performance Committee	6
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	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	12	12	4	3	Moderate	⇔	[04/10/2022] The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same.	Finance & Performance Committee	6
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	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	16	16	4	4	High	⇔	[04/10/2022] The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same.	Finance & Performance Committee	6
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	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	20	20	4	5	High	⇔	[04/10/2022 The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same.	Finance & Performance Committee	8
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	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	20	16	4	4	High	⇩	[04/10/2022] The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same.	Finance & Performance Committee	8

Ref	Specific Objective	BAF Risk Executive Lead	Risk Ref.	Risk Title	Risk Lead	Qtr 1 Rating	Qtr 2 Rating	Consequence	Likelihood	Severity	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 Nursing Officer	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	9	9	3	3	Moderate	⇔	23.9.2022 - Reviewed by MH/BP - Emergency and Urgent care demand continues, with with significant occupancy pressures through the summer months, remained on OPEL4, but largely out of 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) Management of Covid-19 Contacts in bay SOP continues (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. reduced testing/staff/management and reduction in mask wearing as per national guidance. Outbreak Management and oversight continues Regular learning from incidents shared and PIR process Fit Testing Process in place (policy due for ratification). IPC Cell meetings frequently including update on Epicell data	Quality Committee Infection, prevention & control group	6
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	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	16	16	4	4	High	⇔	[04/10/2022] Longwaits over 52ww continue to be below the operational planning trajectory. Reduction in the total waiting list means the denominator for RTT performance and the proportion of long waits as a proportion of the waiting list will also be reduced. Weekly Tier 2 meetings to review performance with the SW Regional team continue. [05/09/2022] 52ww continuing to reduce 78ww trajectory for August met 104ww above planned trajectory Super September focused actions initiated to reduce non-admitted long waiters Weekly Tier 2 meetings held with the South West Region	Quality Committee Infection, prevention & control group	6
3.2.1	**Deliver a Covid restoration programme for elective patients**	Chief Operating Officer	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	20	20	4	5	High	⇔	[04/10/2022] Longwaits over 52ww continue to be below the operational planning trajectory. Reduction in the total waiting list means the denominator for RTT performance and the proportion of long waits as a proportion of the waiting list will also be reduced. Weekly Tier 2 meetings to review performance with the SW Regional team continue. [05/09/2022] 52ww continuing to reduce 78ww trajectory for August met 104ww above planned trajectory Super September focused actions initiated to reduce non-admitted long waiters Weekly Tier 2 meetings held with the South West Region	Finance and Performance Committee	6
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	10	6	2	3	Moderate	⇩	[23/09/2022] access to theatre template is restricted by theatre and anaesthetic staffing gaps. ringfencing of bed base in place risk reduced but remains	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	12	12	3	4	Moderate	⇔	[04/10/2022] Ongoing delivery of improvement actions taking place. Reprofile of recovery trajectory requested by the SW Region and due for submission 10 October 22.	Finance and Performance Committee	4

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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)	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	Finance and Performance Committee, Operations and Performance Group	0
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	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.	Finance and Performance Committee, Operations and Performance Group	0
3.2.4	**Deliver a Covid restoration programme for emergency care patients**	Chief Operating Officer	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)	16	20	4	5	High	⇧	[03/10/2022] Ambulance handovers continue to be a challenge, with deterioration in performance in September. ECS have struggled to recruit resulting in reduced capacity to provide consistent services. Decompression meetings continue, led by COO weekly. [18/08/2022] 18/8/22 Ambulance handovers continue to be significant challenge due to ED overcrowding and poor outflow from acute site. Weekly ambulance cell meetings continue. Increased internal focus around safety and focus on handover process. External provider ECS cohorting in corridor. SOP in place. Some positive improvement in long delays week 1, close monitoring of progress.	Finance and Performance Committee, Operations and Performance Group	3
3.2.4	Deliver a Covid restoration programme for emergency care patients	Chief Operating Officer	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)	20	20	4	5	High	⇔	[03/10/2022] Attendances in August reported a material reduction compared to July with just under 13800 attendances (c500 less at RBH and c200 less at Poole). However, waiting time standards have not been delivered and crowding in the Emergency Departments remains a daily operational challenge. There was an reduction in the number of patients waiting more than 12 hours in the department (100 fewer equally split between the sites). The total number waiting for more than 12 hours from referral increased marginally (n=6). Wait times for beds marginally reduced at RBH and increased at Poole, but remains a significant challenge - 7 hours ant RBH and over 8.5 at PH as an average in month. Non admitted times reduced by c8 minutes at Poole, but increased at RBH by 40 minutes. Despite the overall reduction in attendances conveyances by ambulance remained comparable to July (>3800). There was a marked reduction in Ambulance handovers waiting more that an hour, with almost 200 fewer than the previous month. This was delivered by funding additional Ambulance handover crews at both sites allowing 4 additional crews to hand over if the main emergency department becomes full. UHD recorded an improvement of over 1000 hours returned to the Ambulance Service compared with July - total time lost 2272 hours in August compared to 3343 hours in July.	Finance and Performance Committee, Operations and Performance Group	6
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	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	0					⇩ Closed from RR 4	04/05/2022 RISK CLOSED, on trajectory for sustainability	Sustainability Committee	0
4.1	To improve partnership and engagement with staff, governors, patients, local people and key stakeholders	Chief Strategy & Transformation Officer											0	0
4.1.1	Implement a communication and engagement plan, delivered over the year	Chief Strategy & Transformation Officer											0	0
4.1.2	Further develop our BU partnership and tangible benefits	Chief Strategy & Transformation Officer	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	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	0
4.1.3	Host the Dorset Innovation Hub on behalf of Dorset partner supporting spread of proven innovations	Chief Strategy & Transformation Officer											0	0

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4.2	Work with partners to address Health inequalities and improve population health management, preventing ill health and promoting health lifestyles	Chief Executive	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 compliance.	Renaut, Richard - Chief Strategy and Transformation Officer	4	0				⇩ Closed	[01/09/2022] ICS established by July 1st with most executive posts filled. Further work required by ICS in order to effectively discharge statutory duties with provider collaborative work at minimum levels. Loss of organisational memory and further internal restructuring could hamper delivery of duties. There could remain an ongoing risk regarding the effectiveness of the ICS in discharging statutory duties however the recommendation is to close this current risk given the successful establishment of the ICS.	Board of Directors	0
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	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	8	0				⇩ Closed	[02/08/2022] Risk now closed As this risk focused on FBC approval and associated in year delays if Wave 1 STP funding/deliverables went off track, this is now under control and can be closed. A new timeline risk associated with critical path deliverables has now been opened	Transformation Committee	0
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	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	12	12	3	4	Moderate	⇔	[04/10/2022] - assessment of aggregated controls show positive progress acros all dimensions of the risk. With the exception of Electrical infrastructure survey at Poole (due to lack of contractor availability), however mitigation will increase as contractor commissioned Opportunities optimised during reconfiguration and upgrade activity : [26/08/2022] Works raised with contractors (Fire) for further progress review next month and update to aggregated controls score card	Quality Committee	4
5.1.1	**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	1604	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds	Killen, Stephen - Programme Director	20	20	4	5	High	⇔	[04/10/2022]Risk remains unchanged. With OBC for NHP submitted and accepted for fundamental criteria review (FCR). Next review due end of October 2022. [08/09/2022] No change. OBC submitted but still awaiting approval. FBC submissions from November 2022 to July 2024. Risk to be monitored as part of ongoing programme governance [08/08/2022] Risk remains unchanged. With OBC for NHP submitted and accepted for fundamental criteria review (FCR). Next review due end of September 2022	Quality Improvement and Digital Information Group Transformation and Innovation Committee	8
5.2	W**ork with system partners in establishing the Dorset ICS** and within that develop the Dorset provider collaborative	Chief Executive	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 compliance.	Renaut, Richard - Chief Strategy and Transformation Officer	4	0				⇩ Closed	[01/09/2022] ICS established by July 1st with most executive posts filled. Further work required by ICS in order to effectively discharge statutory duties with provider collaborative work at minimum levels. Loss of organisational memory and further internal restructuring could hamper delivery of duties. There could remain an ongoing risk regarding the effectiveness of the ICS in discharging statutory duties however the recommendation is to close this current risk given the successful establishment of the ICS.	Board of Directors	0
5.3	**Implement the UHD Digital Transformation Strategy**	Chief Informatics & IT Officer	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	10	10	5	2	Moderate	⇔	[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 months.	Information Governance Group	8

Ref	Specific Objective	BAF Risk Executive Lead	Risk Ref.	Risk Title	Risk Lead	Qtr 1 Rating	Qtr 2 Rating	Consequence	Likelihood	Severity	Movement	Last Update	Monitoring Group	Target risk rating
5.3	Implement the UHD Digital Transformation Strategy	Chief Medical Officer	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.	Ayer, Dr Ravi - Consultant Radiologist and Clinical Director	9	15	3	5	Moderate	⇧	[06/10/2022] escalated to ICS following a SI as no effective results acknowledgement process for results. There are a variety of ways in which results are delivered and teams are variable in the way in which requested tests are tracked This impacts primary community and secondary care. To request risk is held at system level with a strategic approach to mitigating the risk or removing it through the commissioning of electronic patient records which address this [06/09/2022] Reviewed at panel, 4 linked moderate incidents in last 4 months. risk remains 9 Possible (monthly) 3x3 moderate- requiring professional intervention e.g. impact of injury in excess of a year but not life altering	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											0	0
5.3.2	**Progress a Digital Dorset Shared Service**	Chief Informatics & IT Officer	1434	Delays to the implementation of the Dorset Care Record	Hill, Sarah - Assistant Director IT Development	6	0				⇩ **Closed**	[08/08/2022] This risk has been closed as reaching target grading (in line with policy) [04/08/2022 Pathology testing delayed due to resource issues in Pathology - due to commence at the end of August. Document feed being developed.	Information Governance Group	0
5.3.3	Procure and implement the Strategic Integrated Imaging Service: a digital diagnostics image sharing platform for Dorset	Chief Informatics & IT Officer											0	
5.3.4	**Create the Strategic Outline Case and Outline Business Case for the Dorset Electronic Patient Records system**	Chief Informatics & IT Officer	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	12	0				⇩ Closed	[19/08/2022] Closed - open in excess of 60 days without being made live	Information Governance Group	0
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	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	10	10	2	4	Moderate	⇩	[11/08/2022] This is an ongoing risk so has been reopened with a new target risk score of 5. [08/08/2022] This risk has been closed as reaching target grading (in line with policy) [04/08/2022] This is an ongoing risk to remain open due to the ever present risk of a threat or vulnerability, both known and unknown, being used to affect the resilience of the Trust's IT systems and data. There have been no incidents or additional risks or mitigations to change the current risk rating.	Information Governance Group	5
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	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	6	6	2	3	Low	⇔	[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 the single Data Centre and its physical resilience needs to be reassessed.	Information Governance Group	1
5.3.6	Achieve a **compliant Data Protection and Security Toolkit submission**	Chief Informatics & IT Officer	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	12	12	3	4	Moderate	⇔	[04/10/2022] Progress continues due to the diligent work of the IG team. Greater than 60% of high priority assets are now compliant to DPSG [05/09/2022] as of 1 Sep 2022 52% of high priority assets have been signed off as compliant to the DSPT requirements. Risk rating unchanged [03/08/2022] Recruitment of Directorate Digital leads remains underway. An action/improvement plan has been submitted to NHS Digital with regard to the DSP Toolkit, with a completion date of 30/09/2022. [04/07/2022] The corporate and care group performance of IAO work has not been sufficient to achieve a compliant DPST toolkit at the submission date of 30.6.22. Recruitment of Directorate Digital leads is underway	Information Governance Group Quality Improvement and Digital Information Group Transformation and Innovation Committee	4

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 7.2

Subject:	Standing Financial Instructions - Annual Review

Prepared by:	Pete Papworth, Chief Finance Officer
Presented by:	Pete Papworth, Chief Finance Officer

Purpose of paper:	This paper seeks approval for the Trust's Standing Financial Instructions, following the scheduled annual review.
Background:	The Trust's Standing Financial Instructions were prepared and implemented immediately upon merger, in October 2021. They reflect the model NHS FT SFIs amended as appropriate for UHD. They were last updated in October 2021 following the implementation of the UK Public Procurement Regulations (PPR).
Key points for members:	The SFIs have been reviewed with only trivial, formatting updates being made. More substantial changes have been made as follows: • A new approval level has been introduced whereby the Chief Executive has authority to approve up to a maximum of £500,000. The previous £300,001 threshold for Finance and Performance Committee approval has therefore been increased to £500,001. • The tender thresholds have been updated to reflect the latest Public Procurement Regulations thresholds (£138,760 inclusive of VAT for supply and service contracts, £5,336,937 inclusive of VAT for works contracts, and £663,540 inclusive of VAT for contracts under the light touch regime). Whilst a more comprehensive review of the SFIs including consideration of separate capital approval limits would be beneficial; following discussion with the Trust Chair, it is felt that this would be better conducted in tandem with a full review of the Trust's Scheme of Delegation following agreement and implementation of the proposed new Committee Structure.
Options and decisions required:	Members are asked to consider and approve the updated Standing Financial Instructions.

Recommendations:	It is recommended that the Board approve the updated Standing Financial Instructions.
Next steps:	Following approval, the document will be updated on the Trust's intranet. Interim amendment to the current Scheme of Delegation to align to the new CEO delegated approval limit. Full review of the wider Scheme of Delegation and Standing Financial Instructions following approval of the proposed new Committee structure.

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)	Not applicable.
CQC Reference:	Well led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	20 October 2022

University Hospitals Dorset
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

University Hospitals Dorset
NHS Foundation Trust

A) SUMMARY POINTS
•
•
ASSOCIATED DOCUMENTS
•
•

B) DOCUMENT DETAILS	
Author:	Pete Papworth
Job title:	Chief Finance Officer
Directorate:	Board of Directors
Version no:	2
Target audience:	All Trust staff
Approving committee / group:	Board of Directors
Chairperson:	~~David Moss~~
Review Date:	~~October 2021~~

C) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
1	July 2020	Jill Hall	
2	October 2021	Pete Papworth	
3	October 2022	Pete Papworth	Audit Committee

D) VERSION CONTROL						
Date of Issue	**Version No.**	**Date of Review**	**Nature of Change**	**Approval Date**	**Approval Committee**	**Author**
October 2020	1	October 2021	Updated to reflect Public Procurement Regulations (previously OJEU).	November 2021	Board of Directors	Pete Papworth
October 2021	2	October 2022	Addition of new CEO approval limit and corresponding increase to FPC approval threshold; update to reflect Public Procurement Regulations thresholds.	November 2022	Board of Directors	Pete Papworth

CONTENTS

1. Introduction

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They apply to everyone working for the Trust and its constituent organisations.

1.1.2. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Delegation (**SD**) adopted by the Trust.

1.1.3. They do not provide detailed procedural advice. They should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

1.1.4. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5. Failure to comply with standing financial instructions and standing orders is a disciplinary matter which could result in dismissal.

1.1.6. These Standing Financial Instructions shall have effect as if incorporated in the Standing Orders of the Trust.

1.1.7. This document should be reviewed by the Chief Finance Officer at least annually.

1.2. Terminology

1.2.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions and the following words shall have the following meanings:

2006 Act	means the National Health Service Act 2006.
2012 Act	means the Health and Social Care Act 2012.
Accounting Officer	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
UK PPR	United Kingdom Public Procurement Regulations

Auditor	means the person appointed to audit the accounts of the Trust who is called the auditor in the 2006 Act.
Board	means the Board of Directors of the Trust.
Budget	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
Budget Holder	means the director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chief Executive or CEO	means the Chief Executive of the Trust.
Director	means a member of the Board of Directors.
CFO	means the Chief Finance Officer of the Trust.
Chief Officers	means an executive director on the Board of Directors of the Trust.
Financial Year	means each successive period of twelve months beginning with 1 April.
Funds held on Trust	means those funds which the Trust holds on date or incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under section 218 of the 2006 Act, as amended. Such funds may or may not be charitable.
Governor	means a member of the Council of Governors.
Members' Meeting	means the Annual Members' Meeting or any Special Members' Meeting.
NHS Improvement (NHSI)	is the body corporate known as NHSI, as provided by section 61 of the 2012 Act which acts as regulator to NHS foundation trusts.
NHS Body	means an NHS foundation trust, the NHS Commissioning Board, an NHS trust, a clinical commissioning group, a special health authority or a Local Health Board.
Non-Executive Director	means a non-executive director on the Board of Directors of the Trust.
Scheme of Delegation or SD	means the Reservation of Powers and Scheme of Delegation as approved by the Board which sets out those powers reserved to the Board and those powers which it has delegated.
Secretary	means the secretary of the Trust.
SFIs	means these Standing Financial Instructions.
Standing Orders or SO	means the Standing Orders of the Board of Directors of the Trust.
Trust	means University Hospitals Dorset NHS Foundation Trust.

1.2.2. Wherever the title CEO, CFO, Director or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them in their absence.

1.2.3. Wherever the term **employee** is used and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

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

1.3. Responsibilities and Delegation

1.3.1. The Board exercises financial supervision and control

by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation.

1.3.2. The Board of Directors has resolved that certain powers and decisions may only be exercised by them in formal session. These are set out in the Scheme of Delegation.

1.3.3. The Board of Directors will delegate responsibility for the performance and its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4. Within the SFIs, it is acknowledged that the CEO is ultimately accountable to the Board and, as Accounting Officer of the Trust has a statutory duty to ensure that the Board meets its obligation to perform its functions within the available financial resources. The CEO has overall executive responsibility for the Trust's activities and is accountable to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5. The CEO and CFO will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6. It is a duty of the CEO to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7. The CFO is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

1.3.8. Without prejudice to any other functions of directors and employees to the Trust, the duties of the CFO include:

(a) the provision of financial advice to the Trust and its directors and employees;

(b) the design, implementation and supervision of systems of financial control;

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.9. All directors and employees, severally and collectively, are responsible for

(a) the security of Trust property

(b) avoiding loss

(c) exercising economy and efficiency in the use of resources

(d) conforming to the requirements of the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

1.3.10. Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the CEO to ensure that such persons are made aware – this would normally be done by adding reference to the SFIs to the tender document.

1.3.11. For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

2. Audit

2.1. Audit Committee

2.1.1. In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing internal audit, external audit and counter fraud services and reviewing the reports produced;

(b) reviewing the effectiveness of internal control, risk management, corporate governance and financial systems and the assurance framework;

(c) monitoring compliance with SO and SFIs;

(d) reviewing the annual financial statements and making recommendations to the Board of Directors;

(e) reviewing the Annual Report and Accounts and the Quality Account.

2.1.2. Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the chairman of the Audit Committee should raise the matter at a meeting of the Board of Directors. Exceptionally, the matter may need to be referred to NHSI or to the CFO in the first instance.

2.1.3. It is the responsibility of the CFO to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

2.2. Fraud, Bribery and Corruption

2.2.1. The Chief Executive and CFO shall monitor and ensure compliance with good practice to counter fraud, bribery and corruption.

2.2.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS counter fraud manual and NHS Counter Fraud Authority standards and guidance.

2.2.3. The Local Counter Fraud Specialist shall report to the Trust's CFO and shall work with staff in NHS Counter Fraud Authority.

2.2.4. The CFO shall be responsible for the implementation of anti-bribery controls.

2.3. Chief Finance Officer (CFO)

2.3.1. The CFO is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(d) ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

(i) a clear statement on the effectiveness of internal control

(ii) major internal financial control weaknesses discovered

(iii) progress on the implementation of internal audit recommendations

(iv) strategic audit plan covering the coming three years

(v) a detailed plan for the coming year.

2.3.2. The CFO, the auditors (both external and internal) and the Local Counter Fraud Specialist are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control;

(d) explanations concerning any matter under investigation.

2.4. Role of Internal Audit

2.4.1. Internal Audit will:

(a) review the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) review the adequacy and application of financial and other related management controls;

(c) review the suitability of financial and other related management data;

(d) review the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,

(ii) waste, extravagance and inefficient administration,

(iii) poor value for money or other causes,

(iv) risk;

(e) report upon the adequacy of follow-up action on audit reports;

(f) carry out investigative/project work as agreed with and under a plan and the terms of reference laid down by the CFO and agreed by Audit Committee.

2.4.2. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately.

2.4.3. The Internal Auditor has a right of access to all Audit Committee members, the Chairman and CEO of the Trust.

2.4.4. The Internal Auditor shall be accountable to the CFO. The reporting system for internal audit shall be agreed between the CFO, the Audit Committee and the Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.5. External Audit

2.5.1. The external auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service.

3. Business Planning, Budgets, Budgetary Control and Monitoring

3.1. Finance and Performance Committee

3.1.1. The Board shall establish a Finance and Performance Committee with clearly defined terms of reference.

3.1.2. The role of the Finance and Performance Committee is to review in detail, on behalf of the Board of Directors, the financial performance and controls reporting as necessary and to take decisions on such financial matters that may be remitted to the Committee for decision from time to time by the Board of Directors.

3.2. Preparation and Approval of Business Plans and Budgets

3.2.1. The CEO will compile and submit to the Board of Directors an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is

based; (b) details of major changes in workload, delivery of services or

resources
required to achieve the plan.

3.2.2. Prior to the start of the financial year the CFO will, on behalf of the CEO, prepare and submit budgets for approval by the Board of Directors. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget

holders; (d) be prepared within the limits of available funds;

(e) identify potential risks.

3.2.3. The Finance and Performance Committee shall monitor performance against budget and business plan and report to the Board of Directors.

3.2.4. All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.2.5. The CFO has a responsibility to ensure that adequate training is delivered to budget holders to help them manage successfully.

3.3. Budgetary Delegation

3.3.1. The CEO and delegated budget holders must not exceed the budgetary total or

virement limits set by the Board of Directors.

3.3.2. The CEO may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose of each budget heading;

(c) individual and group responsibilities;

(d) authorities to exercise virement;

(e) planned levels of service;

(f) provision of regular reports.

3.3.3. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to any authorised use of virement.

3.3.4. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the CEO.

3.4. Budgetary Control and Reporting

3.4.1. The CFO will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board of Directors in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) capital project spend and projected out-turn against plan;

(iv) explanations of any material variances from plan;

(v) details of any corrective action where necessary and the CEO's and/or CFO's view of whether such actions are sufficient to correct the situation;

(vi) such other information that Board may require.

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers.

3.4.2. Each budget holder is responsible for:

(a) any likely overspending or reduction of income which cannot be met by virement is reported to the Finance Committee;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the CFO other than those provided for in the budgeted establishment as approved by the Board of Directors.

3.4.3. The CFO is responsible for ensuring cost improvements are identified and implemented and income generation initiatives in accordance with the requirements of the annual Business Plan and a balanced budget.

3.5. Capital Expenditure

3.5.1. The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Section 11).

3.6. Monitoring Returns

3.6.1. The CFO is responsible for ensuring that the appropriate financial monitoring forms are submitted to the requisite monitoring organisations. The Chief Operating Officer is responsible for ensuring that the appropriate governance returns are submitted to the relevant monitoring organisation.

4. Annual Accounts and Reports

4.1. Accounts

4.1.1. The CFO on behalf of the Trust will

(a) keep accounts, and in respect of each financial year must prepare annual accounts, in such form as NHSI may, with the approval of the Treasury, direct. This will be in accordance with paragraphs 24 and 25 of Schedule 7 of 2006 Act.

(b) ensure that, in preparing the annual accounts, the Trust complies with any directions given by NHSI with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

(c) ensure that a copy of the annual accounts and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHSI.

4.2. Annual Report

4.2.1. The Trust will publish an Annual Report, in accordance with paragraph 26 of the 2006 Act. This will be presented to the Board for formal approval and then presented to a general meeting of the Council of Governors. The document will also be presented to the members of the Trust at a Members' Meeting. The document will comply with the NHSI's Annual Reporting Manual.

5. Bank Accounts

5.1. General

5.1.1. The CFO is responsible for managing the Trust's banking arrangements and for advising the trust on the provision of banking services and operation of accounts. This advice will take into account any guidance and directions issued by NHSI.

5.1.2. The Finance and Performance Committee shall approve the banking arrangements.

5.2. Bank Accounts

5.2.1. The CFO is responsible for:

(a) bank accounts;

(b) reporting to the Board any arrangements made with the Trust's bankers for accounts to be overdrawn;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) establishing separate bank accounts for the Trust's non-exchequer funds.

5.3. Banking Procedures

5.3.1. The CFO will prepare detailed instructions on the operation of bank accounts which must include:

(a) those authorised to sign cheques or other orders drawn on the Trust's accounts and the limitation on single signatory payments;

(b) the limit to be applied to any overdraft;

(c) the conditions under which each bank account is to be operated.

5.3.2. The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3. All funds shall be held in accounts in the name of the Trust. No officer other than the CFO shall open any bank account in the name of the Trust.

5.4. Tendering and Review

5.4.1. The Finance and Performance Committee will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2. Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Finance and Performance Committee.

6. Income and Security of Cash and Cheques and other Negotiable Instruments

6.1. Income Systems

6.1.1. The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2. The CFO is also responsible for the prompt banking of all monies received.

6.1.3. Any new business enterprise activities which fall within NHSI's definition of high risk investments (which includes significant capital expenditure, acquisitions, joint ventures, equity stakes, and major property transactions) must be reviewed by the Finance and Performance Committee and approved by the Board of Directors.

6.2. Fees and Charges

6.2.1. The Trust shall follow NHSI's advice in establishing reference costs and Payment by Results tariffs in setting prices for NHS contracts.

6.2.2. The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by statute.

6.2.3. All employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, Trust sponsorship, tenancy agreements, private patient undertakings and other transactions.

6.3. Debt Recovery

6.3.1. The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2. Overpayments should be detected (or preferably prevented) and recovery initiated.

6.3.3. Income not received should be dealt with in accordance with losses and compensations procedures.

6.3.4. The Audit Committee should receive reports of debts that are overdue by three months or more.

6.4. Security of Cash, Cheques and other negotiable instruments

6.4.1. The CFO shall be responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and cheques on behalf of the Trust.

6.4.2. Official money shall not, under any circumstances, be used for the encashment of private cheques.

6.4.3. All cheques, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the CFO.

6.4.4. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. NHS Contracts for Provision of Services

7.1. Commissioning

7.1.1. The CFO is responsible for commissioning NHS service agreements for the provision of services to patients in accordance with the business plan, and for establishing the arrangements for out of area treatment. In carrying out these functions, the CFO should take into account the following:

(a) costing and pricing of services;

(b) payment terms and conditions;

(c) amendments to NHS contracts and out of area arrangements.

7.2. Contract Pricing and Reporting

7.2.1. NHS contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. NHS contract prices should comply with Payment by Results guidelines.

7.2.2. The CFO shall produce regular reports detailing actual and forecast NHS income with a detailed assessment of the impact of the variable elements.

7.2.3. Any pricing of NHS contracts at marginal cost must be undertaken by the CFO and reported to the Board of Directors.

8. Terms of Service

8.1. Remuneration and Terms of Service

8.1.1. In accordance with SO the Board of Directors shall establish an Appointments and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2. The Committee will:

(a) decide and keep under review the remuneration and terms of service for the CEO and other Chief Officers and other senior employees, including:

(i) all aspects of salary (including any performance-related elements/bonuses;

(ii) provisions for other benefits, including pensions and cars;

(b) arrangements for termination of employment and other contractual terms;

(c) determine the remuneration and terms of service of Chief Officers and other senior employees to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3. The Committee shall report in writing to the Board of Directors the reasons for its recommendations and report on its activities in the Trust's annual report.

8.1.4. The Board of Directors will approve proposals presented by the CEO for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.2. Funded Establishment

8.2.1. The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2. The funded establishment of any department may not be increased without the approval of the CFO.

8.3. Staff Appointments

8.3.1. No director or employee may engage, re-engage or re-grade employees, either of a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration that would exceed the approved staff budget unless authorised to do so by the CFO.

8.3.2. The Board of Directors will approve procedures presented by the CEO for the determination of commencing pay rates and conditions of service for

employees

8.4. Processing of Payroll

8.4.1. The CFO is responsible for

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay;

(c) making payment on agreed dates;

(d) agreeing method of payment.

8.4.2. The CFO will issue instructions regarding

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act 2018;

(g) methods of payment available to various categories of employee;

(h) procedures for payment by cheque or bank credit to employees;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3. Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the

CFO's instructions and in the form prescribed by the CFO;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the CFO must be informed immediately.

8.4.4. Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5. Contracts of Employment

8.5.1. The Board of Directors shall delegate responsibility to a manager for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

9. Non-Pay Expenditure

9.1. Delegation of Authority

9.1.1. The Board of Directors will approve the level of non-pay expenditure on an annual basis and the CFO will determine the level of delegation to Budget Managers.

9.1.2. The CFO will set out:

(a) the list of managers who are authorised to raise requisitions and/or place orders for the supply of goods and services;

(b) the maximum financial level for each requisition/order and the system for authorisation above that level.

9.1.3. The CFO shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2. Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1. The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always seek to obtain the best value for money for the Trust. In so doing, the advice of the Trust's Commercial Services Department shall be sought. Where this advice is not acceptable to the requisitioner, the CFO (and/or the CEO) shall be consulted.

9.2.2. The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3. The CFO will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) and/or formal tenders must be obtained; once approved, the thresholds should be incorporated in these standing financial instructions and regularly reviewed, and refer to the schedule of levels depending on speciality/service/category of goods;

(b) prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) a list of Directors/employees, (including specimens of their signatures), authorised to certify invoices.

(ii) certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the timesheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4. Prepayments are only permitted where appropriate circumstances apply. In such instances:

(a) prepayments are only permitted where the financial and/or commercial advantages outweigh the disadvantages (e.g. cash flows must be discounted to NPV);

(b) the appropriate Director must provide a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the CFO will need to be satisfied with the proposed arrangements before contractual arrangements proceed;

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or CEO if problems are encountered.

9.2.5. Official Purchase Orders must:

(a) be allocated a unique identifier;

(b) be in a form approved by the CFO;

(c) state the NHS Standard Terms and Conditions and/ or the Trust's terms and conditions as appropriate;

(d) be held securely, issued to and used only by those duly authorised by the CEO;

(e) Digital electronic trading applies;

(f) be priced (firm or estimate).

9.2.6. Budget Managers must ensure that they comply fully with the guidance, policies and limits specified by the CFO and that:

(a) all contract and purchase orders (other than as permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with Public Procurement Policy, its directives and regulations, EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the NHSI;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits.

(e) no requisition or subsequent order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the CEO;

(f) all goods, services, or works are ordered on an official order additional to any covering contract for the same aprt from categories and circumstances as set out in the Trust Purchase Order Exemption Policy or purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the CFO and only in cases of emergency or urgent necessity. These must be confirmed within one working day by an official order which is clearly marked "Confirmation Order";

(h) orders are not split (disaggregated) or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on a trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of Directors/employees authorised to certify invoices are notified to the CFO;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

(l) petty cash records are maintained in a form as determined by the CFO.

9.2.7. The Chief Strategy and Transformation Officer (CSTO) and CFO shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE
The technical audit of these contracts shall be the responsibility of the relevant Director.

10. Tendering Procedure

The following procedures will apply for all goods and services, as set out in these SFI's, and as undertaken using a Trust approved e-tendering, evaluation & award system. By exception, (eg temporary lack of access to cloud based systems), the use of manual processes will be adopted as set out in Annex 3 – Manual Tendering procedures.

10.1. Scope of Activity:

10.1.1. This applies to all areas of Trust non-pay expenditure inclusive of Estates and Pharmacy purchases for:

- capital requirements
- revenue purchases
- supply of goods and services
- works contracts
- lease, hire and loan of equipment and goods.

10.1.2. It excludes categories of property rent, rates and utilities expenditure.

10.2. Invitation to Tender (ITT)

10.2.1. Invitations to tender will be undertaken utilising the Trusts approved e-tendering software package providing a secure and auditable process at all stages in the tender cycle through to award of contract. The supplier's response will be completed online and uploaded into a secure electronic mailbox until the opening time.

10.2.2. Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Sections 10.2.3 and 10.2.4 below.

10.2.3. Every tender for building and engineering works, except for maintenance work only where Estate code guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the CFO or Department of Health and Social Care.

10.2.4. Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given an electronic undertaking not to engage in collusive tendering or other restrictive practice.

10.2.5. Levels of expenditure (Annex 1)– the following table shows the levels at which either quotations or tenders are mandatory with the exception of compliant framework agreements where the conditions of the framework are fulfilled in the instance of single source selection and verified by Commercial Services as providing value for money (**VFM**) and appropriate competition. It also excludes works, utilities and 'Light Touch Regime' for services. The value is deemed as the estimated total life cycle cost (**TLC**) – noted that tenders will be sought at any value if deemed appropriate by Commercial Services to do so in order to provide VFM outcomes and rigour required.

(i) Exclusive of VAT
(ii) Subject to specific product/market considerations as verified by applicable procurement officer

10.3. Receipt, Safe Custody and Record of Formal Tenders

10.3.1. Tender documents will be securely stored in the electronic mailbox until the closing date and time. An audit log within the e-tendering system will record the data and time the offer documents are received.

10.4. Opening Formal Tenders

10.4.1. The details of the designated Trust Officers opening the documents will be recorded in the e-tender system audit trail together with the date and time of the document opening.

10.4.2. All actions by both procurement staff and suppliers are recorded within the system audit reports.

10.5. Admissibility and Acceptance of Formal Tenders

10.5.1. In considering which tender to accept, if any, the designated Officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

10.5.2. Tenders received after the due time and date may be considered only if the Chief Executive or the relevant Executive Director decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or the relevant Executive Director shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board of Directors at its next meeting.

10.5.3. Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

10.5.4. Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 10.5.2.

10.5.5. Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

10.5.6. Necessary discussions with a tenderer of the contents of his tender, in order to elucidate technical points etc., before the award of a contract, need not disqualify the tender.

10.5.7. Where only one tender/quotation is received the Chief Executive shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

10.5.8. In the event of a payment being made by the Trust, the Board of Directors will normally approve the best value for money unless satisfactory justification is provided to accept an alternative offer and the decision is recorded in their minutes and in the record referred to in 10.4 above. In the event of a payment to be received by the Trust, the Board of Directors will normally approve the highest tender unless satisfactory justification is provided to accept an alternative offer and the decision is recorded in their minutes and in the record referred to in 10.4 above.

10.5.9. All Tenders should be treated as confidential and should be retained for inspection.

10.6. Authority to buy protocol:

10.6.1. Authorisation will be at the ‘authority to buy’ stage and will be via the purchase requisition authorisation or via the ‘Request for Commercial Support’ (**RCS**) document as appropriate.

10.6.2. At the RCS stage, the relevant authorisation, according to value of expenditure, will be sought from the internal budget manager, countersigned by the appropriate Finance Business Partner.

10.6.3. The Scheme of Delegation will detail aggregated values above which contracts will require Finance Committee or Board of Directors approval prior to award of contract.

10.7. Procurement Reporting Protocol:

10.7.1. Purchases and/ or contracts for which the award value is in accordance with the original authorised value and that the aggregated value is below that requiring subsequent approval in accordance with contract approval

thresholds below will not require further authorisation to proceed to purchase.

10.7.2. If the value of expenditure is of a higher level than initially authorised then re- authorisation will be required in accordance with Standing Financial Instructions.

10.7.3. If an offer other than the best value offer is recommended then approval to recommend will be required via submission to the CFO. Contracts for the supply of goods and/or services (arising from competitive and compliant procurement) will be submitted for approval in accordance with Annex 1 prior to award of contract being made:

10.7.4. Following the above, contracts will be reported to the CFO, the Finance Committee and/or Board of Directors in accordance with values listed in above section (Contract Approval Thresholds) for final approval.

10.8. Waiver of Standing Financial Instructions

10.8.1. The above regulations may only be varied by the Chief Executive or the CFO as set out below and within the limits described in the Annex.

10.8.2. On receipt of a completed 'Standing Financial Instructions Waiver' (**SfiW**) form signed by the originating authorised officer and countersigned by a manager designated by the CFO.

10.8.3. A central Trust register of SfiW for tenders/ Quotations will be maintained by Procurement and reported to the CFO. The Audit Committee should also receive information on these.

10.8.4. Waiver of procurement procedures above UK PPR levels will require authorisation by the CEO or CFO on behalf of the Board of Directors.

10.9. UK PPR Regulations and Aggregation

10.9.1. UK PPR regulations as implemented and applicable in the UK under the laws of England and Wales will be applied to specified values, which are reviewed and published currently bi-annually. At these published levels for defined categories or types of product/service, prescribed processes apply.

10.9.2. UK PPR promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs.

10.9.3. Formal Competitive Tendering - The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and for disposals.

10.9.4. Formal quotation or tender, up to the prevailing UK PPR tender values, may be

waived by either the Chief Executive or CFO on submission of a fully completed SfiW where:

a. the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for SfiW; or

b. specialist expertise is required and is available from only one source; or

c. the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

d. there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

e. provided for in the NHS Foundation Trust Annual Reporting Manual (ARM)

10.9.5. The limited application of the SfiW rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

10.9.6. Such SfiW must be numbered, entered onto a register and retained for inspection in the Commercial Services Department.

10.9.7. It should be noted that the financial limits imposed at the various authorisation levels include VAT and have to be aggregated in the event of a contract covering a given number of months or years, i.e. full life commitment.

10.10. IN-HOUSE SERVICES

10.10.1. In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a. Specification group, comprising the Chief Executive or Nominated Officer(s) and specialist(s);

b. In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support; and

c. Evaluation group, comprising normally a specialist officer, a procurement specialist and a finance specialist.

10.10.2. For services having a likely annual expenditure exceeding £170,000 the approval of the Finance and Performance Committee of the Board of Directors will be required.

10.10.3. All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

10.10.4. The evaluation group shall make recommendations to the Board of Directors.

10.10.5. The Chief Executive shall nominate an officer to oversee and manage the

contract.

11. External Borrowing and Investments

11.1. External Borrowing

11.1.1. The CFO will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by NHSI. The CFO is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans and overdrafts.

11.1.2. Any application for a loan or overdraft will only be made by the CFO or by an employee so delegated by him/her. External loan applications (i.e. not NHSI loans/financing), require Finance and Performance Committee approval.

11.1.3. The CFO must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.1.4. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5. All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

11.2. Investments

11.2.1. Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Finance and Performance Committee and subject to any guidance issued by NHSI.

11.2.2. The CFO is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

11.2.3. The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

11.3.1. The CEO shall:

(a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;

(b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including depreciation and interest payable.

11.3.2. For every capital expenditure proposal the CEO shall ensure:

(a) that through the management of capital schemes policy a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements.

(b) that the CFO has endorsed the cost and revenue assumptions made in the business case.

11.3.3. For capital schemes where the contracts stipulate stage payments, the CEO will issue procedures for their management, incorporating the recommendations of ESTATECODE.

11.3.4. The CFO shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.3.5. The approval of a capital programme shall not constitute approval for expenditure on any scheme. The CFO shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

11.3.6. The CEO will issue a scheme of delegation for capital investment management in accordance with ESTATECODE guidance and the Trust's Standing Orders.

11.3.7. The CFO shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.4. Asset Registers

11.4.1. The CEFO is responsible for the maintenance of registers of assets, taking account of the advice of the CFO concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.4.2. The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Annual Reporting Manual issued by NHSI.

11.4.3. The Trust may not dispose of any protected assets without the approval of NHSI. This includes disposal of part of the property or granting an interest in it.

11.4.4. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

11.4.5. Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices.

11.4.6. The CFO shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.4.7. The value of equipment shall be indexed to current values in accordance with methods specified in the Annual Reporting Manual.

11.4.8. The value of each asset shall be depreciated using methods and rates as specified in the Annual Reporting Manual.

11.5. Security of Assets

11.5.1. The overall control of fixed assets is the responsibility of the CEO.

11.5.2. Asset control procedures (including fixed assets, cash, cheques, negotiable instruments and donated assets) must be approved by the CFO. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques and negotiable instruments.

11.5.3. All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the CFO.

11.5.4. Whilst each employee has a responsibility for the security of property of the

Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

11.5.5. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and employees in accordance with the procedure for reporting losses.

11.5.6. Where practical, assets should be marked as Trust property.

12. Stores and Receipt of Goods

12.1. General

12.1.1. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to regular stock-take - perpetual and/or annual;

(c) valued at the lower of cost and net realisable value;

(d) be kept as secure as practically possible.

12.2. Control

12.2.1. Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the CEO. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/ keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of fuel oil of a designated estates manager.

12.2.2. The responsibility for security arrangements and the custody of keys/electronic swipe access for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer. Wherever practicable, stocks should be marked as Health Service Property.

12.2.3. The CFO shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4. Stocktaking arrangements shall be agreed with the CFO and there shall be a physical check covering all items in store at least once a year.

12.2.5. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the CFO.

12.2.6. The designated manager/pharmaceutical officer shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the CFO any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13. Disposals and Condemnations, Losses and Special Payments

13.1. Disposals and Condemnations

13.1.1. The CFO must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

13.1.2. When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the CFO of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3. All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

(b) recorded by the Condemning Officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose of the CFO.

13.1.4. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO who will take the appropriate action.

13.1.5. Any asset that is condemned or otherwise marked for disposal shall be removed from the asset register and departments responsible for maintenance of these assets must be informed. This is to ensure we do not pay for maintenance etc. of assets not in use.

13.2. Losses and Special Payments

13.2.1. The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The CFO must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

13.2.2. Any employee discovering or suspecting a loss of any kind must immediately inform their head of department, who must immediately inform the CEO and the CFO or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the CFO and/or CEO. Where a criminal offence is suspected, the CFO must immediately inform the police if theft or arson is involved.

13.2.3. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO must immediately notify:

(a) the Board of Directors; and

(b) the External Auditor.

13.2.4. Within limits agreed by the Board of Directors, the CFO shall approve the

writing-off of losses.

13.2.5. The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in personal and company insolvencies.

13.2.6. For any loss, the CFO should consider whether any insurance claim can be made.

13.2.7. The CFO shall maintain a Losses and Special Payments Register in which write-off action is recorded. The Audit Committee should receive regular reports on losses and special payments.

14. Information Governance

14.1. Controls

14.1.1. The Director of Informatics, (who is also the Senior Information Risk Owner (SIRO)) has overall responsibility for accuracy and security of computerised data in the Trust supported by a network of Information Asset Owners who have this responsibility for their individual systems. The CFO has responsibility for Financial Systems.

14.1.2. The Director of Informatics/SIRO shall

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulation and the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the live computer environment is separated from development, testing and training environments wherever possible;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out;

(e) prepare and maintain an Informatics Strategy for regular approval by the Board of Directors. He/she will also ensure that all purchases of hardware/software are in compliance with the Trust's Informatics Strategy.

14.2. System Development

14.2.1. The CFO shall satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled

manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3. Data Security and Integrity

14.3.1. The Director of Informatics shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.3.2. Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation

14.3.3. Where computer systems have an impact on corporate financial systems the CFO shall satisfy himself that

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Informatics Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) CFO staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

14.4. Archives

14.4.1. The CEO shall be responsible for maintaining archives for all documents required to be retained under the storage retention and disposal of records policy

14.4.2. The documents held in archives shall be capable of retrieval by authorised persons.

14.5. Destroyed Documents

14.5.1. Documents shall only be destroyed in accordance with the Health Records Policy.

15. Patients' Property

15.1. Responsibilities

15.1.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereinafter referred to as **property**) handed in by patients or in the possession of confused or unconscious patients.

15.1.2. The CEO is responsible for ensuring

(a) that patients or their carers, as appropriate, are informed before or at admission by:

(i) notices and information booklets,

(ii) hospital admission documentation and property records,

(iii) the oral advice of administration and nursing staff responsible for admissions;

(b) that the Trust will not accept responsibility or liability for patients' property brought into health service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.1.3. The CFO must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patient's money in order to maximise the benefits to the patient.

15.1.4. Where Department of Health and Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

15.1.5. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of signed indemnity shall be obtained.

16. Charitable Funds

16.1. Introduction

16.1.1. Standing Orders identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the dual accountabilities to the Charity Commission for charitable funds held on trust and to NHSI for all funds held on trust.

16.1.2. The reserved powers of the Board of Directors and the Scheme of Delegation make clear where any decision regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

16.1.3. As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

16.1.4. The overriding principle is that the integrity of each trust must be maintained, and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16.2. Existing Charitable Funds

16.2.1. The CFO shall arrange for the administration of all charitable funds and ensure that a governing document exists. Detailed procedures covering the financial management of charitable funds must be produced for the guidance of Directors and employees.

16.2.2. The CFO shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3. The CFO may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g. designation for specific Wards or Departments.

16.3. New Funds

16.3.1. The CFO shall, in conjunction with the Secretary, arrange for the creation of a new trust where funds and/or other assets, received in accordance within this Trust's policies, cannot adequately be managed as part of existing charitable fund arrangements.

16.3.2. Governing documents for any new funds shall be presented to the Charitable Funds Committee by the Secretary.

16.4. Source of New Funds

16.4.1. In respect of donations the CFO shall:

(a) provide guidelines to Officers of this Trust as to how to proceed when offered funds. These will include:

(i) the identification of the donors' intentions;

(ii) where possible, the avoidance of new funds;

(iii) the avoidance of impossible, undesirable or administratively difficult objects;

(iv) sources of immediate further advice.

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Trust's charitable funds and that the donor's intentions have been noted and accepted.

16.4.2. In respect of legacies and bequests, the CFO shall:

(a) provide guidelines to officers of the Trust covering any approach regarding:

(i) the wording of wills;

(ii) the receipt of funds/other assets from executors;

(b) if necessary, obtain grant of representation, where the Trust has an interest.

(c) be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a Will with executors and to discharge them from their duty.

(d) be empowered, subject to appropriate legal advice, to enter into any agreement with the personal representative of the estate relating to the treatment of legacies and bequests.

16.4.3. In respect of fund raising, the CFO shall:

(a) be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge.

(b) be responsible, for alerting the Board of Directors to any irregularities regarding the use of the Trust's name or its registration number.

(c) no income will be raised from trading activities without the prior and express permission of the Charitable Funds Committee.

16.4.4. In respect of investment income, the CFO shall be responsible for the

appropriate treatment of all dividends, interest and other receipts from this source (see below).

16.5. Investment Management

16.5.1. The CFO shall be responsible for all aspects of the management of the investment of charitable funds. The issues on which he shall be required to provide advice to the Charitable Funds Committee shall include:

(a) the formulation of investment policy within the legal powers of the Trust and to meet its requirements with regard to income generation and the enhancement of capital value.

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the CFO shall agree, the terms of such appointments; and for which

(ii) written agreements shall be signed by the CEO.

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme.

(d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds.

(e) that the use of charitable assets shall be appropriately authorised in writing and charges raised within policy guidelines.

(f) the review of the performance of brokers and fund managers.

(g) the reporting of investment performance.

16.6. Use of funds

16.6.1. The exercise of the Trust's discretion to use funds shall be managed by the CFO in conjunction with the Charitable Funds Committee. In so doing he shall be aware of the following.

(a) the objects of various funds and the designated objectives,

(b) The availability of liquid funds within each charitable fund,

(c) the powers of delegation available to commit resource,

(d) the avoidance of the use of exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by charitable funds at the earliest possible time,

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust,

(f) the definitions of "charitable purposes" as set out by the Charity

Commission.

16.7. Banking Services

16.7.1. The CFO shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each Trust where this is deemed necessary by the Charity Commission.

16.8. Asset Management

16.8.1. Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The CFO shall ensure:

(a) in conjunction with the Trust's legal adviser, that appropriate records of all assets owned by this Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account.

(b) that appropriate measures are taken to protect and/or to replace assets including decisions regarding insurance, inventory control, and the reporting of losses.

16.9. Reporting

16.9.1. The CFO shall ensure that regular reports are made to the Charitable Funds Committee on the receipt of funds, investments and the disposition of resources.

16.9.2. The CFO shall prepare annual accounts in the required manner which shall be submitted to the Board of Directors within agreed timescales.

16.9.3. The CFO shall prepare an annual trustees' report (separate reports for charitable and non-charitable Trusts) and the required returns to NHSI and to the Charity Commission for adoption by the Board of Directors.

16.10. Accounting and Audit

16.10.1. The CFO shall maintain all financial records to enable the production of reports as above and to the satisfaction of Internal and External Auditors.

16.10.2. The CFO shall ensure that the records, accounts and returns receive adequate scrutiny by Internal Audit during the year. He will liaise with External Audit and provide them with all necessary information.

16.10.3. The Board of Directors shall be advised by the CFO on the outcome of the annual audit. The CEO shall submit the Management Letter to the Board of Directors.

16.11. Administration Costs

16.11.1. The CFO shall identify all costs directly incurred in the administration of

funds held on Trust and, in agreement with the Board of Directors, shall charge such costs to the appropriate charitable funds.

16.12. Taxation and Excise Duty

16.12.1. The CFO shall ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17. Risk Management and Insurance

17.1. Risk Management Programme

17.1.1. The CEO shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

17.1.2. The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit, clinical audit, health and safety review;

(f) arrangements to review the risk management programme.

17.1.3. The existence, integration and evaluation of the above elements will provide a basis to make a statement on internal control within the Annual Report and Accounts as required by the Annual Reporting Manual.

17.1.4. The CFO shall ensure that insurance arrangements exist in accordance with the risk management programme.

Annex 1 – Contract Approval Thresholds

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
CONTRACT APPROVAL THRESHOLDS

Proposed contracts require formal approval before they can be entered into. The approval route is defined by the financial value of the proposed contract, as follows:

Contract Value *(See Note 1)*	**Authorising Officer/ Committee**
£0 to £100,000	Associate Director of Commercial Services
£100,001 to £200,000	Deputy Chief Finance Officer
£200,001 £300,000	Chief Finance Officer
£300,001 to £1,000,000	Finance and Performance Committee
Over £1,000,000	Board of Directors

Note 1:
This is the total agreed contract value, or forecast contract value based on expected purchases over the full contract duration/ lifecycle; and is exclusive of VAT.

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

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£100,001 to £200,000	Deputy Chief Finance Officer
£200,001 to £300,000	Chief Finance Officer
£300,001 to £500,000	Chief Executive Officer
£500,001 to £1,000,000	Finance and Performance Committee
Over £1,000,000	Board of Directors

Note 1:
This is the total agreed contract value, or forecast contract value based on expected purchases over the full contract duration/ lifecycle; and is exclusive of VAT.

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
TENDER THRESHOLDS

The following table shows the levels at which either quotations or tenders are mandatory:

Expenditure Value *(See Note 1)*	**Minimum Number** *(See Note 3)*	**Quotation or Tender**
£1 to £20,000	1	Quotation
£20,001 to £50,000	2	Quotation
£50,001 to UK PPR threshold *(See Note 2)*	3	Quotation
UK PPR threshold and over	4	Tender

Note 1:
This is the total expenditure value based on expected purchases over the full contract duration/ lifecycle; and is exclusive of VAT.

Note 2:
From 16 August 2021 the UK Public Procurement Regulations (PPR) threshold is £122,976 exclusive of VAT.

Note 3:
The minimum number may be subject to specific product and/ or market considerations as verfiried by Commercial Services.

Note 4:
Compliant framework agreements are exempt from these minimum numbers where single source selection is permitted under the framework and this has been verified by Commercial Services as representing Value for Money.

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
TENDER THRESHOLDS

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£50,001 to UK PPR threshold *(See Note 2)*	3	Quotation
UK PPR threshold and over	4	Tender

Note 1:
This is the total expenditure value based on expected purchases over the full contract duration/ lifecycle; and is exclusive of VAT.

Note 2:
From 1 January 2022 the UK PPR threshold for supply and service contracts is £138,760 inclusive of VAT. The threshold for works contracts is £5,336,937 inclusive of VAT. The threshold for contracts under the light touch regime is £663,540 inclusive of VAT.

Note 3:
The minimum number may be subject to specific product and/ or market considerations as verfiried by Commercial Services.

Note 4:
Compliant framework agreements are exempt from these minimum numbers where single source selection is permitted under the framework and this has been verified by Commercial Services as representing Value for Money.

Annex 2 – Levels of Expenditure

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
AUTHORISED NON-PAY EXPENDITURE LIMITS

Personal delegated limits must be agreed before an individual is authorised to commit or approve non pay expenditure. Personal authorisation limits will be confirmed in writing once approved and included within the Trust's Authorisation Database. Limits will be set based on the specific role profile of the individual and the needs of the service, however individual limits cannot exceed those noted below.

All Staff	
AfC Band 2	£0
AfC Band 3	£0
AfC Band 4	£0
AfC Band 5	£5,000
AfC Band 6	£5,000
AfC Band 7	£5,000
AfC Band 8a	£25,000
AfC Band 8b	£50,000
AfC Band 8c	£75,000
AfC Band 8d	£100,000
AfC Band 9	£250,000
Trust Board	
Chief Executive	Unlimited
Chief Finance Officer	Unlimited
Chief Medical Officer	£1,000,000
Chief Nursing Officer	£1,000,000
Chief Operating Officer	£1,000,000
Chief People Officer	£1,000,000
Chief Informatics and IT Officer	£1,000,000
Chief Strategy and Transformation Officer	£1,000,000
Finance	
Deputy Chief Finance Officer	£1,000,000
Associate Director of Finance	£500,000
Pharmacy	
Chief Pharmacist	£250,000
Estates	
Associate Director of Estates and Capital development	£250,000

Annex 3 – Manual Tendering Procedures

The following manual intervention procedures apply in instances where the approved Trust electronic tendering, evaluation & award system is not/cannot be used

18.1 Invitation to Tender

18.1.1. Invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

(a) a plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

(b) in an envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

18.1.2. Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Sections 18.1.3 and 18.1.4 below.

18.1.3. Every tender for building and engineering works, except for maintenance work only where Estate code guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the CFO or Department of Health and Social Care.

18.1.4. Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

18.2. Receipt, Safe Custody and Record of Formal Tenders

18.2.1. Formal competitive tenders shall be addressed to the Trust Secretary.

18.2.2. The date and time of receipt of each tender shall be written on the unopened tender envelope/package at the time of receipt.

18.2.3. The Company Secretary shall receive tenders on behalf of the Trust and be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 18.3 (Opening Formal Tenders).

18.3 Opening Formal Tenders

18.3.1. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened in the presence of two senior Officers designated by the Chief Executive and not from the originating department.

18.3.2. On the envelope for every tender received shall be written the date of opening and this shall be initialled by two of those present at the opening.

18.3.3.A permanent record shall be maintained to show for each set of competitive tender invitations despatched:

(a) The names of firms/individuals invited;

(b) The names of and the number of firms/individuals from which tenders have been received;

(c) Closing date and time;

(d) Date and time of opening.

18.3.4. The persons present at the opening shall sign the record.

18.3.5. The two Officers opening the tender shall each sign pages within the tender that show price information on one copy of the received tenders.

18.4 Admissibility and Acceptance of Formal Tenders

18.4.1. See section 10 of the SFI's as above

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 7.3

Subject:	Composition of Board of Directors: Amendment to Trust's Constitution

Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Purpose of paper:	For approval.
Background:	<u>Responsibilities of the Nominations, Remuneration and Evaluation Committee and Appointments and Remuneration Committee:</u> Further to Annex 5, clause 19.9.3 of the Trust's Constitution, the Nominations, Remuneration and Evaluation Committee (the Committee) is to review the structure, size and composition of the Board of Directors from time to time and make any recommendation to the Council of Governors. This is additionally reflected in section 1.2 of the Committee's Terms of Reference, which provides that the Committee is responsible for advising and/or making recommendations to the Council of Governors relating to the composition of the Board of Directors and the skill mix of the Non-Executive Directors. In addition, the Appointments and Remuneration Committee is to review the structure, size and composition of the Board and make recommendations to the Board with regards to any changes. <u>Composition of the Board: Code of Governance and Trust's Constitution</u> Under NHSE's (formerly Monitor's) Code of Governance, paragraph B.1.2, includes the following "comply or explain" requirement: "At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent". This is also reflected in the draft Code of Governance for provider trusts published by NHS England in May 2022. In view of the number of the Trust's Non-Executive Directors (excluding the Trust Chair) comprising less than half the board, the Trust included in its 2021/2022 Annual Report a disclosure explaining the departure from the current Code. The Trust's Constitution provides at clause 21 as follows: 21.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors. 21.2 The Board is to comprise:

21.2.1 a non-executive Chairman (who shall have a casting vote);

21.2.2 No more than seven other Non-Executive Directors; and

21.2.3 No more than eight Executive Directors.

It is important to note that the approach of the Trust Chair having a casting vote instead of half of the Board of Directors, excluding the Chairman, being non-executive directors is recognized by the NHS Model Core Constitution, on which the Trust's Constitution was based (footnote 27, page 16 to the Model Core Constitution).

Separately, there is an anomaly between Clause 21 (providing for no more than seven other Non-Executive Directors) and Annex 7 (Standing Orders for the Practice and Procedure of the Board of Directors) which provides for a minimum of seven other Non-Executive Directors as follows:

3.1.1 In accordance with Clause 21 of the Constitution, the composition of the Board shall be:

(a) a non-executive Chairman; (Chairman to have a casting vote to ensure majority)

(b) a minimum of seven other Non-Executive Directors (one of which may be nominated as the Senior Independent Director).

which therefore requires correction.

Current composition of the Trust's Board

The Trust's Board is currently comprised of a Non-Executive Chairman, six other Non-Executive Directors and eight Executive Directors. One vacant Non-Executive Director position exists following a retirement in December 2021.

Following on from the discussions at the Committee in July 2022, the directors have discussed (at Board Development sessions in August 2022 and October 2022) the benefits of seeking to recruit two Non-Executive Directors (one to fill the current vacancy plus an additional Non-Executive Director) to enhance and complement the existing diversity and skill mix. Aligned to the Committee's reflections in July 2022, the directors also raised the importance of having a specific focus on currently under-represented demographics within the cadre.

The Trust Chair has proposed a recruitment of two Non-Executive Directors being coupled with a Constitutional change to remove his casting vote for Board composition purposes. (For the avoidance of doubt, this is not proposed to affect the casting vote of the person presiding at a meeting of the Board of Directors in the case of an equality of votes, as provided for under Clause 5.9 of the Standing Orders for the Practice and Procedure of the Board of Directors.).

Amendments to the Trust's Constitution

At its meeting held on 27 October 2022, the Council of Governors supported the recruitment of two Non-Executive Directors (and therefore the increase of the size of the Board to a maximum of 17), in view of the revised composition of the Board, recognizing this would require amendments to the Trust's Constitution: This was also supported by the Appointments and Remuneration Committee at its meeting held on 26 October 2022.

Under its terms (clause 41), the Trust may make amendments to its Constitution only if:

	• More than half of the members of the Council of Governors of the Trust voting approve the amendments; and • More than half of the members of the Board of Directors of the Trust voting approve the amendments. In addition, the Council of Governors should present to the Trust's Annual Meeting any proposed changes to the policy for the composition of the Non-Executive Directors (Annex 8, clause 7.7.3 to the Trust's Constitution).
Key points for members:	The proposal is: • To consider the recruitment of two Non-Executive Directors (one to fill an existing vacancy and another additional Non-Executive Director); • To focus upon currently under-represented demographics when recruiting such additional Non-Executive Directors; • To increase the size of the Board to a maximum of 17; • To amend the Trust's Constitution to reflect the above.
Options and decisions required:	The Board of Directors are asked to consider, and if thought fit, to approve the amendments to the Constitution.
Recommendations:	The Board is invited to consider the changes outlined above. The amendments proposed to the Trust's Constitution are as follows: 21.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors. 21.2 The Board is to comprise: 21.2.1 a non-executive Chairman ~~(who shall have a casting vote)~~; 21.2.2 No more than eight ~~seven~~ other Non-Executive Directors; and 21.2.3 No more than eight Executive Directors. And to Annex 7 – Standing Orders for the Practice and Procedure of the Board of Directors as follows: 3.1.1 In accordance with Clause 21 of the Constitution, the composition of the Board shall be: (a) a non-executive Chairman; ~~(Chairman to have a casting vote to ensure majority)~~ (b) ~~a minimum of~~ no more than eight ~~seven~~ other Non-Executive Directors (one of which may be nominated as the Senior Independent Director) …
Next steps:	Following approval of the amendments to the Trust's Constitution, the updated Constitution will be published on the Trust's website.

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.

Committees/Meetings at which the paper has been submitted:	Date
Nominations, Remuneration and Evaluation Committee	20 October 2022
Council of Governors	27 October 2022
Appointments and Remuneration Committee	26 October 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 30 November 2022

Agenda item: 7.4

Subject:	Board Schedules for 2023 and 2023

Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Purpose of paper:	For approval.
Background:	Draft dates for the Trust Board and its Committees were presented at the September 2023 Board Part 1 meeting.
Key points for Board members:	It is proposed that for 2024, that the dates of the Board meetings will be moved back by one week, with them taking place on the first Wednesday of each month.
Options and decisions required:	Approval of dates for 2023 and 2024 Board and Committee meetings.
Recommendations:	N/A
Next steps:	Following approval of the dates for the 2023 and 2024 Board and Committee meetings, these will be published on the Trust's website.

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)	N/A
CQC Reference:	Well Led.

Committees/Meetings at which the paper has been submitted:	**Date**
Board of Directors, Part 1 (draft schedule, since updated)	28 September 2022

University Hospitals Dorset NHS Foundation Trust

Board of Directors & Committee Meetings Schedule 2023— DRAFT

University Hospitals Dorset NHS Foundation Trust

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUGUST	SEPT	OCT	NOV	DEC
BOARD OF DIRECTORS PART 1 (VIRTUAL)	25/01/23 13:15	-	27/03/23 13:15		24/05/23 13:15	-	26/07/23 13:15	-	27/09/23 13:15	-	29/11/23 13:15	-
BOARD OF DIRECTORS PART 2	25/01/23 15:30 (V)	*22/02/23 9:30 (confidential/ urgent only) (F)*	27/03/23 11:45 (V)	*26/04/23 9:30am (confidential/urgent only) - (F)*	24/05/23 15:30 (V)	*28/06/23 9:30am (confidential/ urgent only) - (F)*	26/07/23 15:30 (V)	-	27/09/23 15:30 (V)	*25/10/23 9:30 am (confidential/ urgent only) (F)*	29/11/23 15:30 (V)	-
BOARD DEVELOPMENT	-	22/02/23 11:00 (F)	-	26/04/23 11:00 (F)	-	28/06/23 11:00 (F)	-	-	-	25/10/23 11:00 (V)	-	-
BOD & COG DEVELOPMENT	-	22/02/23 13:30 (F)	-	26/04/23 13:30 (F)	-	28/06/23 13:30 (F)	-	-	-	25/10/23 13:30 (F)	-	-
AUDIT *(2nd Thursday, except May)*	12/01/23 14:00	-	9/03/23 14:00	-	18/05/23 14:00 *24/05/23 (Jt FPC)**		13/07/23 14:00	-	-	12/10/23 14:00	-	-
FINANCE & PERFORMANCE *(3rd Monday, other than Feb & Aug)*	16/01/23 9:00	13/02/23 9:00	20/03/23 9:00	17/04/23 9:00	15/05/23 9:00	19/06/23 9:00	17/07/23 9:00	14/08/23 9:00	18/09/23 9:00	16/10/23 9:00	20/11/23 9:00	18/12/23 9:00
POPULATION HEALTH & SYSTEM			TBC			TBC			TBC			TBC
PEOPLE & CULTURE *(2nd Wednesday, other than Dec)*	-	8/02/23 11:00	-	-	10/05/23 11:00	-	-	9/08/23 11:00	-	-	8/11/23 11:00	-
QUALITY *(3rd Tuesday, other than Feb & Aug)*	17/01/23 14:00	14/02/23 14:00	21/03/23 14:00	18/04/23 14:00	16/05/23 14:00	20/06/23 14:00	18/07/23 14:00	15/08/23 14:00	19/09/23 14:00	17/10/23 14:00	21/11/23 14:00	19/12/23 14:00
CHARITABLE FUNDS	-	6/02/23 9:00	-	-	4/05/23 9:00	-	-	7/08/23 9:00	-	-	13/11/23 9:00	-
TRUST MANAGEMENT GROUP	10/01/23 & 24/01/23— 14:00	7/02/23 & 21/02/23— 14:00	7/03/23 & 21/03/23— 14:00	11/04/23 & 25/04/23— 14:00	9/05/23 & 23/05/23— 14:00	13/06/23 & 27/06/23— 14:00	11/07/23 & 25//07/23 - 14:00	8/08/23 & 22/08/23— 14:00	12/09/23 & 26/09/23— 14:00	10/10/23 & 24/10/23— 14:00	14/11/23 & 28/11/23— 14:00	12/12/23 14:00

University Hospitals Dorset NHS Foundation Trust

Board of Directors and Committee Meetings Schedule 2024 - DRAFT

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
BOARD OF DIRECTORS PART 1 (VIRTUAL) *(1st Wednesday, other than Jan)*	10/01/2024 9:30	-	6/03/2024 9:30	-	1/05/2024 9:30	-	3/07/2024 9:30	-	4/09/2024 9:30	-	6/11/2024 9:30	-
BOARD OF DIRECTORS PART 2 *(1st Wednesday, other than Jan)*	10/01/2024 11:45 (V)	7/02/2024 9:30 *(confidential/ urgent only)* (F)	6/03/2024 11:45 (V)	3/04/2024 9:30 (F)	1/05/2024 11:45 (F)	5/06/2024 9:30 (F)	03/07/2024 11:45 (F)	-	4/09/2024 11:45 (V)	2/10/2024 9:30 (F)	6/11/2024 11:45 (V)	-
BOARD DEVELOPMENT *(1st Wednesday, other than Jan)*	-	7/02/2024 11:00 (F)	-	3/04/2024 11:00 (F)	-	5/06/2024 11:00 (F)	-	-	-	2/10/2024 11:00 (F)	-	
BOD/COG DEVELOPMENT *(1st Wednesday, other than Jan)*	-	7/02/2024 13:30 (F)	-	3/04/2024 13:30 (F)	-	5/06/2024 13:30 (F)	-	-	-	2/10/2024 13:30 (F)	-	-
AUDIT (*3rd Thursday)*	18/01/2024 9:00	-	21/03/2024 9:00	-	16/05/2024 9:00	-	18/07/2024 9:00	-	-	17/10/2024 9:00	-	-
FINANCE & PERFORMANCE *(4th Monday, other than July and Dec)*	22/01/2024 9:00	26/02/2024 9:00	25/03/2024 9:00	22/04/2024 9:00	27/05/2024 9:00	24/06/2024 9:00	29/07/2024 9:00	26/08/2024 9:00	23/09/2024 9:00	28/10/2024 9:00	25/11/2024 9:00	16/12/2024 9:00
PEOPLE AND CULTURE *(2nd Wednesday)*	-	14/02/2024 11:00	-	-	8/05/2024 11:00	-	-	14/08/2024 11:00	-	-	13/11/2024 11:00	-
POPULATION HEALTH & SYSTEM	-	-	TBC	-	-	TBC	-	-	TBC	-	-	TBC
QUALITY *(4th Tuesday, other than July and Dec)*	23/01/2024 9:00	27/02/2024 9:00	26/03/2024 9:00	23/04/2024 9:00	28/05/2024 9:00	25/06/2024 9:00	30/07/2024 9:00	27/08/2024 9:00	24/09/2024 9:00	29/10/2024 9:00	26/11/2024 9:00	17/12/2024 9:00
CHARITABLE FUNDS *(1st Monday)*	-	5/02/2024 9:00	-	-	6/05/2024 9:00	-	-	5/08/2024 9:00	-	-	4/11/2024 9:00	-
TRUST MANAGEMENT GROUP	9/01/2024 23/01/2024 14:00	6/02/2024 20/02/2024 14:00	5/03/2024 19/03/2024 14:00	2/04/2024 16/04/2024 30/04/2024 14:00	14/05/2024 14:00	4/06/2024 18/06/2024 14:00	2/07/2024 16/07/2024 30/07/2024 14:00	13/08/2024 14:00	3/09/2024 17/09/2024 14:00	1/10/2024 22/10/2024 14:00	5/11/2024 19/11/2024 14:00	3/12/2024 17/12/2024 14:00

Key
Green text indicates known school holidays

Appendix - Attendance at Part 1 Board Meetings

Part 1		25 May 2022	27 July 2022	28 September 2022
Present	Karen Allman			
	Pankaj Dave			
	Peter Gill		A	
	Philip Green			
	Siobhan Harrington			
	John Lelliott			
	Stephen Mount			A
	Mark Mould	A		
	Alyson O'Donnell	A	D	
	Pete Papworth			
	Richard Renaut			
	Cliff Shearman		A	
	Paula Shobbrook			
	Caroline Tapster			
	John Vinney			
	Rob Whiteman			
	Ruth Williamson			
In Attendance	James Donald			
	Yasmin Dossabhoy			
	Ewan Gauvin			
	Fiona Hoskins			
	Sarah Locke			
	Helen Martin			
	Judith May			
	Matt Thomas			
	Karen Uphill			
	Ruth Williamson			

Key

	Not in Attendance		In attendance
A	Apologies		N/A
D	Delegate Sent		