University Hospitals Dorset
NHS Foundation Trust

# UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

## BOARD OF DIRECTORS – PART 1 MEETING

**Wednesday 25 January 2023**

**13:15 – 15:15**

**Via Microsoft Teams**

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

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC**

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 13:15 on Wednesday 25 January 2023 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 25 January 2023**

| Time | Item | | Method | Purpose | Lead |
|---|---|---|---|---|---|
| **13:15** | **1** | Welcome, Introductions, Apologies & Quorum | **Verbal** | | **Chair** |
| | **2** | Declarations of Interest | **Verbal** | | **Chair** |
| | **3** | Patient Story | **Verbal** | **Discussion** | **CNO** |
| **13:25** | **4** | **MINUTES AND ACTIONS** | | | |
| | **4.1** | For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 30 November 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** | **Information** | **Chair** |
| | **5.2** | Chief Executive Officer's Report | **Paper** | **Information** | **CEO** |
| | **5.3** | ICB Minutes – 3 November 2022 | **Paper** | **Information** | **CEO** |
| **13:45** | **6** | **INTEGRATED PERFORMANCE REPORT AND RISK** | | | |
| | **6.1** | Integrated Quality, Performance, Workforce, Finance and Informatics Report<br>*Questions to the Executive Team by exception* | **Paper** | **Assurance** | **EDs** |
| | **6.2** | Risk Register Report | **Paper** | **Approval** | **CNO** |
| | **6.3** | Trust Annual Objectives 2022-2023: 6 month review | **Paper** | **Review and Discussion** | **CSTO** |

| | | | | | |
|---|---|---|---|---|---|
| **14:05** | **7** | **ASSURANCE FROM COMMITTEES** | | | |
| | **7.1** | Finance and Performance Committee – Chair's Report | **Paper** | **Assurance** | **Committee Chair** |
| | **7.2** | Quality Committee – Chair's Report | **Paper** | **Assurance** | **Committee Chair** |
| | **7.3** | Audit Committee – Chair's Report | **Paper** | **Assurance** | **Committee Chair** |
| **14:30** | **8** | **STRATEGY AND PLANNING** | | | |
| | **8.1** | 2023/24 Priorities and Operational Planning | **Paper** | **Information** | **CSTO** |
| | **8.2** | Freedom to Speak Up Strategy | **Paper** | **Approval** | **Freedom to Speak Up Guardian** |
| **14:35** | **9** | **QUALITY AND PERFORMANCE** | | | |
| | **9.1** | Maternity Incentive Scheme | **Paper*** | **Approval** | **CNO** |
| **14:45** | **10** | **GOVERNANCE** | | | |
| | **10.1** | Enabling Accountability Framework | **Paper** | **Approval** | **COO** |
| | **10.2** | Terms of Reference:<br>• Appointments & Remuneration Committee<br>• Audit Committee<br>• Charitable Funds Committee<br>• Finance and Performance Committee<br>• People and Culture Committee<br>• Quality Committee | **Paper** | **Approval** | **Chair** |
| | **10.3** | Composition of Board Committees | **Paper** | **Approval** | **Chair** |
| | **10.4** | Policy Approvals:<br>• Managing Conflicts of Interest Policy<br>• Anti-Fraud, Bribery & Corruption Policy | **Paper** | **Approval** | **CFO** |
| | **10.5** | Catering – Charity Business Case December 2022 | **Paper** | **Approval** | **CSTO** |
| **14:55** | **11** | **ITEMS FOR INFORMATION** | | | |
| | **11.1** | Update from the Council of Governors | **Verbal** | **Information** | **Lead Governor** |
| **15:00** | **12** | Questions from the Council of Governors and Public arising from the agenda.<br><br>Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 22 January 2023 to company.secretary-team@uhd.nhs.uk | | **Receive** | **Chair** |

| | | | | | |
|---|---|---|---|---|---|
| | **13** | Any Other Business | **Verbal** | **Discussion** | **Chair** |
| | **14** | **Date and Time of Next Board of Directors Part 1 Meeting:**<br>Board of Directors Part 1 Meeting on Monday 27 March 2023 at 13:15. | | | |
| | **15** | **Resolution Regarding Press, Public and Others:**<br>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** | **16** | **Close** | **Verbal** | | **Chair** |

* Late paper

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

**Items for Next 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 (January 2023)

Quarterly Reports

- Quality Impact Assessment Overview Report
- Mortality Report (Q3)
- Guardian of Safe Hours Report (Q3)

Bi-annual Reports

- Nursing Establishment Review (summary)

Annual Reports

- Quality Improvement Programme
- Scheme of Reservation and Delegation
- Approve Register of Compliance with Licence Conditions
- Approve Register of Compliance with Code of Governance
- Annual Review of the Effectiveness of Third-Party Processes and Relationships
- Board Reporting Governance Cycle
- Independence of Non-Executive Directors
- Annual Board Effectiveness Report

**Reading Room Materials**

Risk Register Report *(Agenda Item 6.2)*

**AGENDA – PART 2 PRIVATE MEETING**

**15:30 on Wednesday 25 January 2023**

| Time | Item | | Method | Purpose | Lead |
|---|---|---|---|---|---|
| **15:30** | **17** | Welcome, Introductions, Apologies & Quorum | **Verbal** | | **Chair** |
| | **18** | Declarations of Interest | **Verbal** | | **Chair** |
| **15:35** | **19** | **MINUTES AND ACTIONS** | | | |
| | **19.1** | For Accuracy and to Agree: Part 2 Minutes of meeting held on 30 November 2022 | **Paper** | **Approval** | **Chair** |
| | **19.2** | Matters Arising – Action List | **Paper** | **Review** | **Chair** |
| **15:40** | **20** | **EXECUTIVE UPDATES** | | | |
| | **20.1** | Chief Executive Officer's Update | **Verbal** | **Assurance** | **CEO** |
| | **20.2** | CQC Update | **Verbal** | **Information** | **CNO** |
| **15:55** | **21** | **STRATEGY AND TRANSFORMATION** | | | |
| | **21.1** | Implementing the Clinical Services Review | **Paper** | **Approval** | **CSTO** |
| **16:05** | **22** | **GOVERNANCE** | | | |
| | **22.1** | Winter Bed Capacity | **Paper** | **Approval** | **CFO** |
| | **22.2** | Demand and Capacity – Winter Emergency Capital Spend | **Paper** | **Approval** *(Ratification)* | **Chair** |
| | **22.3** | Delegation for Recommendation Reports | **Paper** | **Approval** | **CFO** |
| | **22.4** | Enabling Accountability Framework | **Paper** | **Review** | **COO** |
| **16:30** | **23** | **ITEMS FOR INFORMATION** | | | |
| | **23.1** | Serious Incident Report | **Paper** | **Information** | **ACMO** |
| | **24** | Escalations from Board Committees:<br>Audit Committee<br>Finance and Performance Committee<br>Quality Committee<br>Sustainability Committee | **Verbal** | **Discussion/ Review** | **Committee Chairs** |

| | | | | | |
|---|---|---|---|---|---|
| | | Transformation Committee<br>Workforce Strategy Committee | | | |
| | **25** | Any Other Business | **Verbal** | | **Chair** |
| | **26** | Reflections on the Board Meeting | **Verbal** | | **Chair** |
| | **27** | **Date and Time of Next Board of Directors Part 2 Meeting:**<br>Board of Directors Part 2 Meeting on Wednesday 22 February 2023 at 9:30. | | | |
| **17:00** | **28** | **Close** | **Verbal** | | **Chair** |

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

**Items for Next Board Part 2 Agenda**

Standing Reports

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

Annual Reports

- Draft Operational Plan

**Reading Room Materials**

**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

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

# UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

## BOARD OF DIRECTORS PART 1

Minutes of the Board of Directors Part 1 meeting held on Wednesday 30 November 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 |
| | Stephen Mount | Non-Executive Director |
| | 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 |
| | Ruth Williamson | Acting Chief Medical Officer |
| **In attendance:** | Mandi Barron | Appointed Governor |
| | Robert Bufton | Public Governor |
| | Sharon Collett | Lead Governor |
| | Yasmin Dossabhoy | Associate Director of Corporate Governance |
| | Paul Hilliard | Public Governor *(until 14:31)* |
| | Marjorie Houghton | Public Governor |
| | Frances Jones | Interim Director of Midwifery *(for item 6.7)* |
| | Sarah Locke | Deputy Company Secretary |
| | Keith Mitchell | Public Governor |
| | Louise Pennington | Lead Nurse for Cancer Services *(for item 3)* |
| | Diane Smelt | Public Governor |
| | Kani Trehorn | Staff Governor |
| | David Triplow | Public Governor |
| | Michele Whitehurst | Deputy Lead Governor |
| **Public attendees:** | 4 members of the public | |

| | |
|---|---|
| **BoD 272/22** | **Welcome, Introductions, Apologies & Quorum**<br>Rob Whiteman welcomed everyone to the meeting.<br>Apologies were received from:<br>• John Vinney, Associate Non-Executive Director<br>The meeting was declared quorate. |
| **BoD 273/22** | **Declarations of Interest**<br>No existing interests in matters to be considered were declared. In addition, no further interests were declared. |
| **BoD 274/22** | **Patient Story**<br>Louise Pennington introduced the patient story and shared a video of a 77-year-old female patient called Jan, who had been very fit and well, ex-military and an avid golfer. Jan presented with sepsis and multi-organ failure to Bournemouth Hospital. She had been transferred to the intensive care unit |

| | |
|---|---|
| | where sadly her condition continued to deteriorate, and she was subsequently admitted to the Macmillan Unit for end of life care. With the incredible support from the rehab team, palliative care team and the patient centred approach, her condition improved, and she was eventually discharged home where she continued to do well.<br>Paula Shobbrook added that the story demonstrated the impact of teams working alongside patients and the Trust values.<br>The Board NOTED and thanked Jan for the Patient Story. |
| **BoD 275/22** | **For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 28 September 2022**<br>The minutes of the Board of Directors meeting held on 28 September 2022 were APPROVED as an accurate record. |
| **BoD 276/22** | **Matters Arising – Action List**<br>**BoD 073/22 –** *Annual Board Effectiveness Report* – Rob Whiteman updated that this would be completed early in 2023. It had been considered preferable to complete the review after the changes to the Board Committee structures. Action remained OPEN. |
| **BoD 277/22** | **Trust Chair's Update**<br>Rob Whiteman provided the Trust Chair's Update highlighting:<br>• The national autumn statement: Although social care had been relatively protected, the demand and costs pressures would be greater than the envelope provided. Social care was very important to the Dorset system - some of the impact on the Trust of delayed discharges would be discussed later in the meeting. Social care was unlikely to receive as much funding as the government had originally announced. The government figures had assumed that councils would increase council tax by the maximum allowed under law, although it was doubtful that this would happen given the cost-of-living crisis. As a provider trust, the Trust's pressures were also likely to be greater than the financial envelope provided;<br>• His visits to the older people's wards and the orthopaedics ward;<br>• His meetings with the Chairs of Macmillan Caring Locally, Forest Holme and Lewis Manning to discuss the future of hospice and palliative care working, including re-provisioning of some of the premises in due course; and<br>• His meeting the Integrated Care Board (ICB) Chair to discuss the Dorset system and the role of the Trust within it.<br>Rob Whiteman acknowledged the considerable pressures that staff were under and extended thanks to the executive team, managers and all staff, for the considerable efforts and dedication given to the Trust.<br>The Board NOTED the Trust Chair's Update. |
| **BoD 278/22** | **Chief Executive Officer's Report**<br>Siobhan Harrington echoed her thanks to all staff, underlining also that it was incredibly busy across the Trust. She welcomed the patient story, which demonstrated staff were going above and beyond.<br>Presenting the Chief Executive Officer's Report, she highlighted in addition:<br>• As of that morning, there were 30 inpatients with Covid and approximately 50 members of staff off work with Covid. This was a plateaued position, demonstrating an expectation that those numbers may remain or indeed rise over the next few months. |

| | |
|---|---|
| | • Whilst acknowledging that time to be seen and patient flow were not optimum, work continued to improve the situation.<br>• Referencing recent visits and inspections, she had been incredibly proud about how welcoming and engaged staff had been with the CQC to share where the Trust had performed well, where there had been difficulties and challenges and where improvements were being made as well as plans to improve.<br>• In relation to the New Hospitals Programme, the Joint Investment Committee meeting went well. The formal report on the outcome of the Outline Business Case (OBC) was to be received.<br>• The Royal College of Nursing (RCN) had announced the first wave of trusts that would be part of the nursing strikes on 15 and 20 December 2022. It had been confirmed that the Trust would not be among the first wave.<br>Karen Allman added that if a second wave of strike action were announced, this would happen after the Christmas period. The Unison vote had indicated that the Trust had not passed the threshold for industrial action but there were various other ballots taking place. Work with staff side colleagues would continue to ensure that plans were in place and were communicated for any further industrial action.<br>The Board NOTED the Chief Executive Officer's Report. |
| **BoD 279/22** | **ICB Minutes – 1 September 2022**<br>Siobhan Harrington referenced the ICB's evolution, including the governance and infrastructure being established.<br>She welcomed that the ICB meetings started with a patient or staff story and that there had been a great degree of challenge at the meetings. There had been an emphasis on the acute sector, with discussion having taken place about this needing to evolve to a whole system approach, including primary care, social care and community services.<br>The Board NOTED the ICB Minutes. |
| **BoD 280/22** | **Integrated Quality, Performance, Workforce, Finance and Informatics Report (IPR)**<br>Mark Mould presented key messages from the IPR in relation to Performance, which had been reviewed at the Finance and Performance Committee earlier in the week.<br>• He highlighted three key areas: (i) urgent and emergency care linked with ambulance handovers, (ii) time in emergency department and (iii) patients with no criteria to reside (NCTR).<br>• The NCTR remained the greatest challenge across the Dorset system. Actions in place to retain the position and prevent further deterioration were: (i) implementing the professional standards as referenced in the Chief Executive's Report; (ii) transferring patients to wards earlier in the day, supporting the discharge lounge and discharging patients' home before the afternoon; (iii) same day emergency care and virtual wards; and (iv) continued conversations with local authorities about schemes to support those patients with NCTR to return home early.<br>• Good progress had been made on the elective recovery programme and waiting lists had reduced.<br>• Progress continued to improve in relation to the six-week standard for receipt of diagnostics; the Trust remained the best performing organisation in the region and one of the best nationally. |

| | |
|---|---|
| | In relation to the Quality aspects of the IPR, which had been reviewed at the Quality Committee on 29 November 2022, Paula Shobbrook presented the following highlights.<br>• Infection Prevention Control:<br>  ○ C. Difficile had increased across Dorset and the country – the Trust was below the national average.<br>  ○ For the two MRSA bacteraemia cases reported, no lapses of care had been identified. Further information would be presented through the Quality Committee.<br>• Fundamentals of care: A correlation had been noted between (i) the number of patients falls and (ii) the frailty of patients on admission as well as those with NCTR.<br>• Patient experience metrics: There had an increase in the number of complaints being received, which was being encouraged as part of the Trust being responsive to patients and members of the public. Increased levels of early resolution were also being seen. A significant amount of work was being undertaken with open complaints over 55 days relating to the Trust's urgent and emergency care pathway – additional resource had been deployed in this area.<br>Cliff Shearman invited Paula Shobbrook to comment further upon tissue viability, noting that if pressure areas become heightened, then patients could not be discharged as they would not have help in the community. He also understood that there was a shortfall in the service and enquired how the Trust would move forward from the current position. Paula Shobbrook replied that there was careful assessment upon patients being admitted; there had been an increase in numbers of patients admitted with existing pressure damage. Cases would be recorded as a serious incident where pressure damage had deteriorated to a severe pressure ulcer; from this, the link to admission with pressure damage had been noted. There had been an increase in referrals for more complex tissue damage to the tissue viability specialist nurses. However, she emphasised that pressure damage was a fundamental of nursing care. It was not an activity for specialist nurses to perform. There were skilled nurses across the organisation. The focus was upon staffing being available and providing the relevant care at the bedside.<br>Cliff Shearman added that if the Trust were going to have more complex cases, then this would be when the pressures upon the tissue viability team would be greatest.<br>Referencing discussions at Quality Committee about falls having increased in comparison to the same period in the previous year, Caroline Tapster raised further support being provided with partners to assist with prevention. Ruth Williamson added that falls prevention included ensuring that patients had:<br>• good bone health;<br>• responding when patients fell;<br>• reviewing medication, environment and the capabilities of patients.<br>The areas of risk were particularly the admission areas and the hospital at night. Paula Shobbrook added that a meeting had been held with some of the leaders of falls in the NHS England Quality Team in connection with the work at the Trust to differentiate when patients had NCTR, which was not available elsewhere. Conversations with system partners were also taking place.<br>Rob Whiteman asked whether any extra training or guidance was available with the increased numbers of patients staying beyond the date of discharge to which the Trust was accustomed. Paula Shobbrook responded that when patients were ready for discharge, the risk for those patients would increase. The challenge was caring for acutely unwell patients alongside patients with |

NCTR that may have other co-morbidities such as dementia. This had been discussed at the recent falls summit. Work was ongoing in relation to appropriate discharge and care once out of hospital. While remaining in hospital, a risk assessment would be carried out, which was being performed consistently.

Pankaj Davé asked if there was anything further that could be done to reduce the number of patients with NCTR and what best practices were being seen in other organisations. Siobhan Harrington emphasised the significant work happening across Dorset, with Bournemouth, Christchurch and Poole Council (BCP) and community services, in particular, to identify different ways to reduce pressure and ensure patients were in the right place in the system. Although it could not necessarily be resolved through money, new funding within the system would be allocated to support. It would be important to consider how the impact of those funds were measured. However, all systems were struggling with these issues. Mark Mould added that work was ongoing with BCP to support patients coming into the emergency department returning home and appropriately avoid the need for admission. Additional domiciliary care hours had been commissioned to support a further 20 patients outside of hospital, with the intent of building this capacity further. Ongoing dialogue continued with local authorities about schemes to unlock better care for patients and provide better support for staff to care for those with acute needs. In relation to the medium and long term, Rob Whiteman added that the Trust was looking at broader issues with the ICB including workforce sustainability.

Stephen Mount asked whether consideration was being given to the care hotel initiative again this winter. Mark Mould confirmed that every option would be considered but the care hotel required an external workforce not currently available. Capacity remained in the independent sector that could potentially be utilised to replicate a care hotel model which had been discussed with BCP. However, it was essential for the risk appetite to be managed across the Trust, BCP and community partners about where best patients were cared for.

In relation to Workforce, Karen Allman commented upon the extensive system working that took place and referred to the focus upon attracting staff. Additionally, she highlighted:

- The vacancy rate mirrored the national and cross-Dorset vacancy rate.
- Vocational scholarships were in place to aid recruitment and support the development of workers in the care sector;
- The learning from LERNs conference organised by the training and education team;
- Vaccination rates remained low this also being a national issue; staff were being encouraged to have both Covid and flu vaccinations.
- Internal recruitment was also being tracked which evidenced career progression within the Trust. Internal retention and mobility was important.

Key messages from the IPR in relation to Finance were presented by Pete Papworth including him reiterating the financial volatility.

- The premium pay, particularly for agency staff continued to increase. Should the trend since June 2022 continue, it would render it more difficult to deliver the break even forecast. Although there was a route to the break even forecast, it would mean delivering a surplus over the remaining months to offset the current deficit;
- The capital spend remained below budget and this largely reflected the phasing of the budget but it was expected to be accelerated and be on plan toward the end of the year;

| | |
|---|---|
| | • The Trust had secured £6.4m of additional capital funding to the Trust to support the replacement of the Electronic Patient Record (EPR). This was specifically to support a number of the enabling schemes.<br>Peter Gill presented key messages from the IPR in relation Informatics highlighting:<br>• The EPR outages and special monitoring in place;<br>• The increased usage of the Dorset care record with 85,000 hits in one month;<br>• The work being undertaken with BCP to support how social care records would link into the Dorset care records.<br>Caroline Tapster posed a question to Karen Allman about the timescale from interview to start date for new starters. Karen Allman replied that from shortlist to interview was seven days; interview to job offer was a further two days, conditional offer to ID check was five days and DBS check was three days; all of which were improved timescales. Further information would be collated and shared through the Workforce Strategy Committee. Compared to the national benchmarking through Getting It Right First Time (GIRFT), the Trust was generally in the upper quartile performance.<br>Rob Whiteman asked:<br>• Whether there were any concerns with achieving any milestones associated with the national funding for EPR; and<br>• What the next milestone would be for deployment of resources given.<br>Pete Papworth reported that following the OBC having been approved by the Trust, confirmation had been provided of the funding being received by the Trust. The next milestone would be approval of the OBC by the relevant national bodies, which would take approximately 12 weeks. This would be followed by a Full Business Case (FBC) process. Peter Gill added that the aim was to move to a new EPR by March 2025. This would involve moving millions of clinical data points, thousands of staff and hundreds of workflows or applications. It would take approximately 18 months from identifying a new EPR supplier to moving to the new system for clinical services. He highlighted that this was a Dorset wide programme with a single system between Dorset County Hospital and the Trust and to also improve links with primary care.<br>The Board NOTED the Integrated Performance Report. |
| **BoD 281/22** | **Mortality Report (Q2)**<br>Ruth Williamson presented the Mortality Report, highlighting in addition that the Quality Improvement project relating to the digital format for reviewing inpatient deaths would effect a standardised format across the Trust, allowing for amalgamated data and more effective learning from it.<br>The Board NOTED the Mortality Report. |
| **BoD 282/22** | **Annual Winter Plan**<br>Mark Mould presented the Annual Winter Plan, drawing attention to the four key elements set out within it. One of the risks related to the reduction of NCTR patients by 30%, with there being mitigating actions in place. He also drew attention to the workforce challenges.<br>In addition, he commented:<br>• Upon the plan having been co-designed with the Trust's staff including Ruth Williamson as part of the Winter Planning Group, Pete Papworth and the Business Intelligence (BI) team around modelling;<br>• That progress against the winter plan would be provided to the Board. |

| | |
|---|---|
| | John Lelliott questioned whether, even allowing for the risks and mitigations, the plan was realistic and achievable. Mark Mould replied that the plan was based on the best information available, with a series of mitigations in place. If the mitigations were not realised, reduction in elective work would need to be considered following discussions with Siobhan Harrington, the Dorset system and the region. There had been further developments since the plan had been developed including the £500m additional funding for social care and also a proposal for £2.7m of capital funding would be submitted that day.<br><br>Philip Green enquired whether any sensitivity analysis against the plan had been completed. Mark Mould outlined that as part of the modelling there were a number of factors that were 'assumed' such as 92% occupancy and assumed growth in emergency admissions, which were tracked. However, there was an opportunity for a best/worst case scenario to be developed.<br><br>**ACTION**: To complete a sensitivity analysis against the winter plan. **Mark Mould**<br><br>Cliff Shearman commended the detail in the plan, noting also his concern with the risks outside of the Trust's control and reduction in medically fit to discharge. He asked whether the funding for the virtual ward development had been achieved. Mark Mould responded that no impact of the virtual ward had been assumed, although the team were working on recruitment and areas where the virtual ward could have impact, such as respiratory and paediatrics. There was some funding to progress the virtual ward.<br><br>Stephen Mount suggested that given the plan was dependent upon other partners, that the Board received updates and that particularly if not successful, the root causes and cost impact be highlighted. Mark Mould updated the Board on the weekly Chief Operating Officer meeting to discuss the winter plan across the Dorset system. Across the system, a gap of 45 beds across the system existed; while the Trust had delivered upon its commitment in the plan, further conversations were needed about the remaining gap. This would be monitored at the Chief Operating Officer meetings.<br><br>**ACTION**: To provide progress reports against the winter plan to the Board on a regular basis, to include progress being made by partners. **Mark Mould**<br><br>Richard Renaut commended the comprehensiveness of the winter plan. He highlighted that the cost-of-living crisis was likely to mean that the profiles for emergency admissions may be different than previously. It would be important to track and feed back as strokes and heart attacks could change thresholds with people living in unheated homes. Secondly, he commented upon the need as part of its agile governance for the Board to be able to fast-track potential capital, with there being condensed timelines for submissions.<br><br>Siobhan Harrington also referenced the difference this year with the ICB and there being a control centre running from 8am-8pm, 7 days a week, which would monitor the performance across the Dorset system. Also, trusts had been encouraged through NHS England to do everything within their control - this is what the Trust would be doing, focusing on patient safety and maintaining a 'can do' approach.<br><br>The Board APPROVED the Annual Winter Plan. |
| **BoD 283/22** | **Risk Register Report**<br><br>Paula Shobbrook presented the Risk Register Report, highlighting in addition:<br><br>• The top 5 areas of risk related to emergency pathways, elective recovery, the reconfiguration work, workforce and delivery of the Cost Improvement Plan (CIP). |

| | |
|---|---|
| | • Risk 1378 had been accepted at the Quality Committee on 29 November 2022. Ruth Williamson added that the current Electronic Patient Record (EPR) was older generation and did not include closed loop acknowledgment of test results. There had been incidents related to timely visibility of results and therefore some mitigating actions had been agreed until the new EPR system was implemented.<br>Peter Gill added that a result look-up system could be implemented in the interim but that this would need to track back to the EPR to cross-reference the patient.<br>Cliff Shearman emphasised the importance of involving senior clinicians with the development of the interim measures and the new EPR system.<br>The Board APPROVED the Risk Register Report. |
| **BoD 284/22** | **CQC Inspection Update**<br>Paula Shobbrook presented slides for the CQC Inspection Update, noting that this was an update with the inspection phase still ongoing. She added that confirmation about whether the Trust would be rated for the Medical and Surgical Care inspections remained pending.<br>The Board thanked Paula Shobbrook for her contributions with the CQC inspections.<br>Siobhan Harrington commented that it was important to take the positives but also to recognise the learning and strengthen governance and risk management on a continuous basis.<br>Pankaj Davé invited Paula Shobbrook to outline the process for the CQC inspections. She summarised that six inspectors and two specialist advisors had attended on 28 September 2022 and three inspectors with no specialist advisors on 29 September 2022. For the maternity inspection there were three inspectors, a midwife and an anaesthetist. The inspectors and specialist advisors talked to staff and reviewed data, which was then triangulated with other evidence that the CQC would have to provide a full overview.<br>Caroline Tapster referenced that the CQC inspections had been discussed in depth at the Quality Committee on 29 November 2022. The clinical staff in attendance had said that they welcomed the inspection, felt it was important to be open and saw it as an opportunity for learning and improvement. The ongoing action plan would be monitored through the Quality Committee.<br>The Board NOTED the CQC Inspection Update. |
| **BoD 285/22** | **Kirkup (East Kent) Review**<br>Paula Shobbrook presented the Kirkup (East Kent) Review.<br>Rob Whiteman emphasised that the Board would welcome any concerns or issues that the Trust Management Group wanted to bring to its attention through the Chief Executive.<br>The Board NOTED the Kirkup (East Kent) Review. |
| **BoD 286/22** | **Ockenden Review**<br>Paula Shobbrook presented the Ockenden Review, referencing also Caroline Tapster's role as the Non-Executive Maternity Safety Champion and Frances Jones' role as the Interim Director of Midwifery. The report would be used to triangulate data between the Insight and CQC reports.<br>The Board expressed its thanks to the midwifery staff and to Frances Jones for her work and support.<br>The Board NOTED the Ockenden Report. |

| | |
|---|---|
| **BoD 287/22** | **Board Assurance Statement: Elective Care**<br>Mark Mould presented the Board Assurance Statement. He reminded the Board that delegation had been given to the Trust Chair and Chief Executive to sign off the statement at the 28 September 2022 Board meeting, which statement had been submitted to NHS England on 11 November 2022. He summarised the actions, two of which would be monitored at the Finance and Performance Committee and the third would be reviewed separately.<br>**ACTION:** To further discuss the designation of a Non-Executive Director to act as a sponsor for theatre productivity. **Mark Mould and Rob Whiteman**<br>The Trust had been visited by the regional team which had looked at the elective recovery programme; positive feedback had been received.<br>The Board RATIFIED the Board Assurance Statement: Elective Care. |
| **BoD 288/22** | **Board Assurance Framework (six-month review)**<br>Paula Shobbrook presented the Board Assurance Framework six-month review. She added that as part of the agile governance review, the format had been discussed through the Audit Committee. Going forward, an enhanced approach was intended to provide greater oversight of the ratings and progress against the strategic objectives.<br>The Board NOTED the Board Assurance Framework six-month review. |
| **BoD 289/22** | **Standing Financial Instructions – Annual Review**<br>Pete Papworth presented the Annual Review of the Standing Financial Instructions (SFIs), summarising the changes and noting that:<br>• A full update of document would be completed following the broader governance review that was in progress.<br>• The Audit Committee had recommended approval to the Board.<br>The Board APPROVED the revised Trust's Standing Financial Instructions. |
| **BoD 290/22** | **Amendment to the Trust's Constitution**<br>Rob Whiteman presented the proposed Amendment to the Trust's Constitution. He drew attention to the proposed changes having been discussed and recommended for approval at the Appointments and Remuneration Committee. Following recommendation by the Nominations, Remuneration and the Evaluation Committee, the changes had been approved by the Council of Governors.<br>The Board APPROVED the amendments to the Trust's Constitution. |
| **BoD 291/22** | **Board Schedules for 2023 and 2024**<br>Rob Whiteman presented the Board Schedules for 2023 and 2024. It was proposed to introduce a staggered approach between the meetings of the Committees and the Board taking place to reduce the number of duplicate items being considered by both. The change to reflect Committee meetings not taking place in the same week as Board meetings was reflected in the 2023 schedule. The 2023 schedule had been in circulation since August 2022 but had since been updated to take account of the proposed Committee changes.<br>However, those changes would give rise to some production challenges. Consequently, for 2024, the dates of Board meetings would be moved back.<br>The dates and times for the Population Health and System Committee meeting dates would be 15 March 2023, 14 June 2023, 13 September 2023 and 13 December 2023, each being held between 2pm-4pm.<br>The Board APPROVED the Board Schedules for 2023 and 2024. |

| | |
|---|---|
| **BoD 292/22** | **Questions from the Council of Governors and Public**<br>Diane Smelt, Public Governor, had submitted the following question to the Board in advance of the meeting:<br>*It is understood that the Trust was one of twenty three Trusts who were recently flagged for their perinatal mortality in the latest "Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries audit for maternity services". Trusts with mortality rates more than 5 per cent higher than an average of peer group providers were given a red rating and UHD was one of 6 rated red for both still births and neonatal mortality. The report, which was published last month, looked at data for 2020 and showed that average perinatal mortality rates have been falling across England since 2013, although it highlighted that there was a significant variation across England.*<br>*As a result of this Trusts with mortality rates in the red band have been asked to carry out detailed reviews to see if any of the deaths were avoidable or if there were any local factors that might explain the high mortality rates.*<br>*Can the Trust therefore give an assurance that this review will take place as one of urgency.*<br>Responding to this question, Ruth Williamson explained that the MBRRACE data looked at maternal deaths and neonatal deaths. The numbers were very low; however, this meant that there could be significant change in percentile standing between years. For 2019 and 2020, the Trust had the same number of deaths within a year of birth. In 2019, the Trust was rated green and within the best 5% organisations. In 2020, it was in the lower rating, this being an indication of statistical variation. Deaths of babies under the Trust's care were investigated. The majority related to babies born with non-survivable conditions. Although the Trust always endeavoured to capture the learning, there were no key themes identified about foetal and maternal care giving cause for concern. She confirmed that the deaths from 2019 and 2020 had already been investigated; if there were any learning, it had already been embedded. An annual review was conducted of how learning from incidents takes place, this having been made more robust for serious incidents with a post-event review. Consequently, these historic incidents had been closed and the learning captured.<br>Rob Whiteman responded to questions submitted by Philip Warn, member of the public to the Board in advance of the meeting relating to:<br>• whether all Board members visited wards regularly and spoke to patients and staff;<br>• whether all Board members took time to consider why all trusts across the country had "communication" as their top complaint and what was each Board member doing to address this; and<br>• whether the Board could do more for "poor old patients".<br>Rob Whiteman confirmed that Board members did visit wards, citing examples of his visits and Caroline Tapster having visited maternity services. He anticipated that more regular visits would be conducted post Covid.<br>In relation to communication, he referenced the Trust's work with its Council of Governors, particularly around engagement and patient experience, being very important to ensure that communication was effective.<br>Rob Whiteman acknowledged that more could be done for those suffering the cost-of-living crisis. He clarified that if the question were about care for the |

elderly, then there had been lengthy discussions about the focus and the importance of this, particularly with the demography of the area.

Siobhan Harrington responded to a question submitted by Mr Warn relating to how the complaints backlog had been reduced since she and Rob Whiteman had been in post. She outlined that in addition to the recovery from Covid, there were a number of planned changes that had reduced the complaints backlog. These included:

- changes in the management of the complaints team;
- recruitment following merger of the complaints team;
- investment into the care groups to support the complaints model;
- becoming an early adopter in embedding the early resolution of complaints as the Trust's preferred model of complaint handling;
- additional project funding from NHS England to employ an experienced nurse into the PALS team, which funding had continued;
- investment and experienced investigators to support the clinical teams;
- alignment of a single Trust PALS team; and
- improved monitoring and use of technology.

She also referred to the focus upon trying to resolve issues before they became formal complaints, including her speaking to complainants where possible.

Mr Warn had also raised a question in advance of the meeting relating to steps taken by the Trust to reduce the length of walk any patient coming in via the bus hub had to endure. In response to this, Richard Renaut referenced the large building being built on the Bournemouth site. There were excellent volunteer buggy services in place to transport people from the bus hub around the hospital site. When the building works at Bournemouth hospital were complete then the bus hub would be located directly outside the main entrance.

**ACTION**: To send a written response to Mr Warn to the questions he raised related to the complaints backlog and the steps taken by the Trust to alleviate the walk for patients arriving at the bus hub. **Siobhan Harrington**

Siobhan Harrington also referred to Mr Warn having commented upon missing signage for toilets and that he would like further clarity to distinguish staff food sources from patients and visitors, especially at Poole hospital. He had also recommended that the Trust think like a visitor or an outpatient in this context. Siobhan Harrington felt that it was a very good point for the Trust to further consider as signage continued to be improved, including how patients, governors and others were used to help with optimum signage.

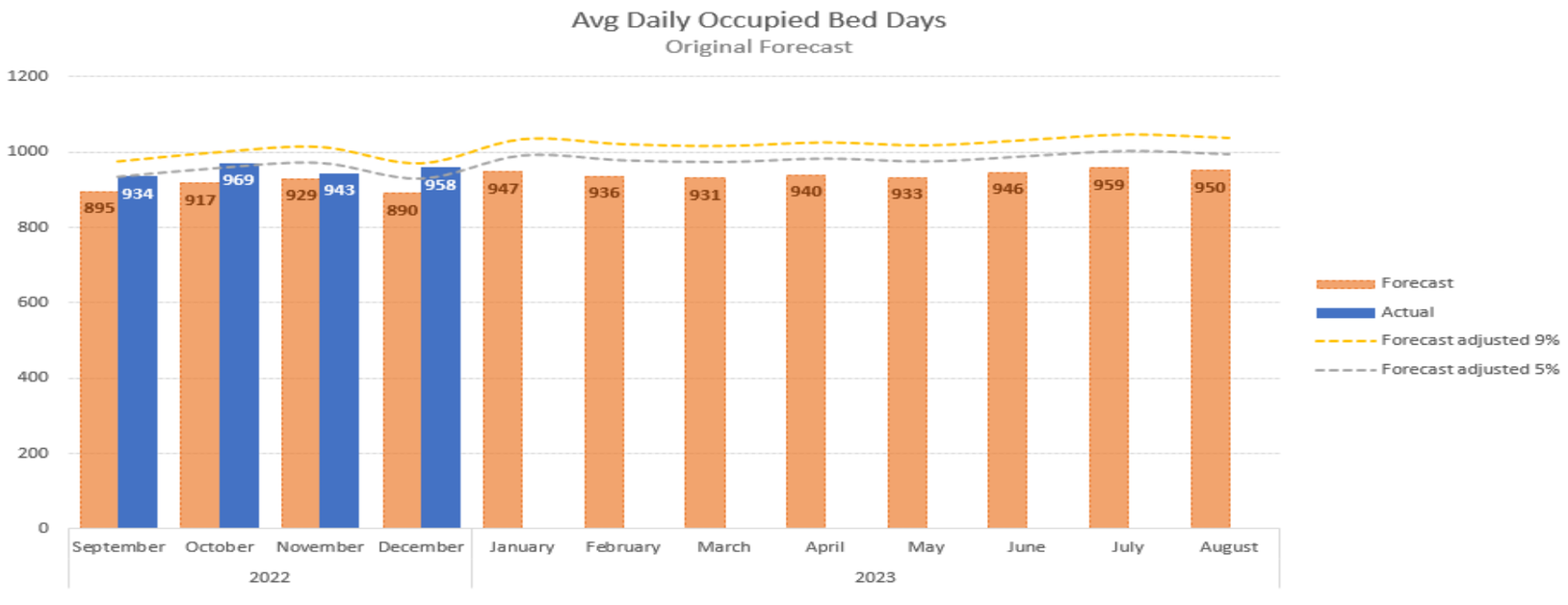
Kani Trehorn, Staff Governor, asked whether Paula Shobbrook could elaborate further upon the CQC expectations for the fractured neck of femur pathway and if there was an associated action plan. She replied that the focus was on the management of patients not being operated upon within thirty-six hours. This had been discussed at Quality Committee on 29 November 2022. There was a range of metrics reviewed, there being some patients where it was appropriate for them not to be operated upon in that timeframe. The ongoing work to mitigate any harm to those patients was being articulated to the CQC.

Malcolm Podier, member of the public, enquired whether the Trust had plans to recruit more staff. Responding to this question, Karen Allman referenced the recruitment initiatives outlined within the IPR; which included career fairs and international recruitment. A team was in place in resourcing including

| | |
|---|---|
| | medical workforce recruitment that supported clinical and non-clinical medical recruitment across the Trust. |
| **BoD 293/22** | **Any Other Business**<br>On behalf of the Board, Rob Whiteman expressed his thanks to those Governors that would be standing down at the end of the year.<br>No other business was discussed. |
| **BoD 294/22** | **Resolution Regarding Press, Public and Others**<br>The Board APPROVED, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board, 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 nature of the business to be transacted. |
| | **The date and time of the next Board of Directors Part 1 Meeting was announced as Wednesday 25 January 2023 at 13:15 via Microsoft Teams.** |

| Board Part 1 Action List - January 2023 | | | | | | |
|---|---|---|---|---|---|---|
| **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 effectiveness report would be scheduled for a future Board meeting following the completion of Board Committee reviews | SL | ~~September 2022~~<br>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 |
| 30/11/2022 | BoD 282/22 | **Annual Winter Plan:** To complete a sensitivity analysis against the winter plan | MM | January 2023 | **January 2023:** Due to the complexity of factors, sensitivity analysis has more simply focused on variation from forecast since September and projected forward, with regular review. Currently this indicated a variation of 5% from (worse than) forecast occupancy - 50 beds.<br><br>*Figure 1 (attached). Sept-Dec variation (forecast vs actual) and projected that forward.*<br><br>This is explained by:<br>•MRFDs 20-30 worse than same period 21/22 (though improved by 30 since system challenge baseline)<br>•Impact of IPC (flu, covid, RSV) bed closures and management of 'contacts' etc<br>•Bedded in SDEC areas<br>•Note: increased emergency demand has impacted on elective and increased cancellations<br>•It is expected that the range of strikes may increase LoS .<br><br>**Mitigations (in addition to winter plan) in place**:<br>•TIU/W8 opened for inpatients<br>•Ward 12 increased outliers/inpatients (bed shortfall is in non electives)<br>•Pacing of elective activity<br>•Bedded in SDECs<br>•Additional 38 system beds as part of the 50 additional LA commissioned beds | Complete |
| 30/11/2022 | BoD 282/22 | **Annual Winter Plan:** To provide progress reports against the winter plan to the Board on a regular basis, to include progress being made by partners | MM | January 2023 | Progress to date against our winter plan:<br>•Planned escalation beds opened (Trust)<br>•Increased activity in SDECs above previous year (despite 'bedding' overnight at peaks of pressure) (Trust)<br>•38 additional system beds (Partners/Trust)<br>•Virtual Ward - due to accommodate patients late January (Trust + partners)<br>•Discharge facilitators - 6 appointed - 2 started, 2 in Jan, 2 in Feb (Trust)<br>•Rapid discharge (Tiger) Team commenced (System funding)<br>•Departure lounges - consistently open but remains not fully utilised (Trust)<br>•TAD process identifies discharges earlier in the day (Trust)<br>•NHS Dorset discharge flow support visit in January (System)<br>•Reduced patients awaiting Social Worker assessment/at brokerage by 10% (Partners)<br>•Reduced delayed self funders by 55% (Trust/Partners) | Complete |
| 30/11/2022 | BoD 287/22 | **Board Assurance Statement - Elective Care:** To further discuss the designation of a Non-Executive Director to act as a sponsor for theatre productivity | MM/ RW | January 2023 | **January 2023:** Cliff Shearman will act as Non-Executive Director sponsor for theatre productivity. | Complete |
| 30/11/2022 | BoD 292/22 | **Questions from the Council of Governors and Public:** To send a written response to Mr Warn to the questions he raised related to the complaints backlog and the steps taken by the Trust to alleviate the walk for patients arriving at the bus hub | SH | December 2022 | **January 2023:** A letter was sent to Mr Warn following the meeting outlining the responses that were given at the Board meeting in November 2022. | Complete |

**Figure 1**



# CHIEF EXECUTIVE'S REPORT
# JANUARY 2023

The end of one year and the start of the next is often a time of reflection. This last year has been a unique experience of living and working through a pandemic within the NHS. This stage of recovery, during the winter, has led to continued pressures across the whole health and care system. Over the Christmas and New Year period many staff were redeployed or came in to help when due to be at home with their friends and families. Thank you to all our incredible staff; I continue to be inspired by their resilience and continued commitment to our patients throughout this period.

Whilst balancing the pressures we are all under, in December alone we saw 34,253 patients in our outpatients department and an additional 7,352 virtually. We carried out 1,137 day-case procedures, supported the birth of 348 babies, and attended 14,074 patients in ED. Given that this covers the Christmas period activity remained high despite the pressures.

## 1. NATIONAL UPDATES

### 2023/24 Priorities and Operational Planning Guidance

On 23 December 2022, NHS England (NHSE) released its 2023/24 priorities and operational planning guidance, outlining three priority areas for the service: to recover core productivity; progress the aspirations in the Long Term Plan; and transform the health and care system for the future.

There are fewer targets included in the guidance, with a greater emphasis on outcomes and less prescription on how to achieve them. It is also positive to see more flexible funding to deliver on local priorities and that the focus on productivity sits alongside continued investment.

The Trust is currently completing a 3 year operational plan with a detailed focus on Year 1 which will come to Trust Board in March.

### Adult Social Care Discharge Fund

The Rt. Hon. Steve Barclay wrote to health and social care leaders to share the details of the £500 million Adult Social Care Discharge Fund as part of the government's Plan for Patients. It was confirmed £200 million would be distributed to local authorities and £300 million to Integrated Care Boards. Discharge fund guidance has also been published in the last week.

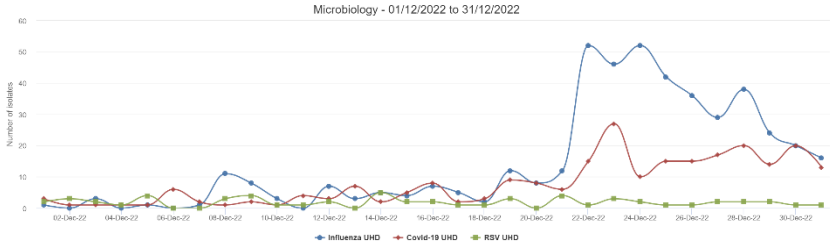
### Getting it Right First Time (GIRFT) Visit

On 5 December 2022, Professor Tim Briggs, the newly appointed National Director for Clinical Improvement and Elective Recovery and lead for "Getting it right first time" (GIRFT), visited the Dorset system. It was an opportunity to hear clinical teams outline the progress they have made at a specialty level and being clear about challenges and how they are dealing with them. We were able to showcase how the clinical teams across Dorset County Hospital and University Hospitals Dorset are working together with a shared purpose.

## 2. QUALITY AND SAFETY

### Covid

During December numbers of COVID-19 within our inpatient units remained static whilst cases of respiratory syncytial virus (RSV), Influenza and Group A strep rapidly rose.




UHD's experience is in line with other Trusts in terms of numbers of Hospital Onset cases and the % of these against overall numbers. At the time of writing we have 31 patients with Covid as in patients across our hospitals.

## 3. URGENT & EMERGENCY CARE AND FLOW

Staff have been working extremely hard to ensure our patients are kept safe during a very busy time over December and the festive period. Pressure on our emergency departments, the acuity of our patients, and the limited number of beds we have had available in our hospitals has meant that at several points the Trust has declared a critical incident. We have worked closely with the whole health and care system across Dorset, focussing on discharge and admission avoidance to alleviate the pressures within the emergency departments. We have cancelled some elective operations and have opened additional capacity across the trust.

We have had to flex our capacity and at times opened approximately 100 extra beds open across the trust. This helps us to admit more people who need our care but must be balanced with the need for them be staffed safely by colleagues with the right skills.

Extra care home beds were secured before Christmas to support discharge for appropriate patients whose hospital care has finished; they are almost in full use. This has enabled around 60 more patients to be discharged from our hospitals who otherwise would not have been.

Within December and up to 12 January 2023 (43 days) we have:

- been at OPEL 4 bedstate for 40 days across both sites;
- invoked our 'business continuity' plan on 30 days;
- escalated to 'critical incident' on four occasions.

When escalating to 'critical incident' as an organisation: this triggered additional short-term support from our partners in health and social care. Whilst we have stood down from critical incident the position is still seriously challenged. We continue to meet with our system partners at an executive level daily to work through the pressures being experienced.

We've also briefed our local stakeholders, including our MPs and local media, on the pressures the trust is facing.

## 4. ELECTIVE CARE

We have reduced planned elective activity in order to manage emergency demand: this is enabling us to refocus our resources on emergency care but has regrettably affected a number of our elective patients, including cancer and cardiology patients. This is not a measure we take lightly, and the patients' care will be prioritised as a matter of urgency.

Our elective improvement programme is running to support recovery, comprising 6 programmes: outpatient transformation, data and validation optimisation, cancer, diagnostics and theatres.

In December, we continued to see over 34,000 patients face to face in outpatients and a further 7,352 virtually. We also brought over 400 patients into theatres and completed over 1,100 daycases. We are also one of the top performing Trusts for diagnostic performance.

## 5. FINANCE

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 food and energy prices putting particular pressure on Trust budgets. Collectively, these pressures have resulted in a year-to-date deficit of £4.2 million.

The Trust recorded an adverse in-month variance of £0.2 million reflecting the further step-up in operational pressures over the festive period. Additional, unplanned bed capacity was opened to mitigate risks to patient's safety resulting in a further step up in premium agency expenditure. This has put even greater pressure on budgets and the forecast break-even position.

Our work to identify further savings opportunities continues in earnest and we have commenced our detailed planning for next year. We have procured some additional capacity to support this process and this will help with the identification of additional financial opportunities.

## 6. CARE QUALITY COMMISSION INSPECTIONS

### CQC Maternity Inpatient Survey Report 2022

The inspection report was published on 12 January 2023 and UHD results are one of seven trusts categorised as 'worse than expected'. A media statement has been issued outlining that the Trust recognises that this report does not represent our aspirations for maternity services, and we're working hard to make improvements.

The survey was undertaken in February 2022, during the Covid-19 pandemic, which was an extremely challenging time. Since then a range of improvements have been introduced, including increasing support for mums-to-be with mental health issues, employing more midwives and specialist staff, and increasing the availability and scope of breastfeeding information and expert advice.

We recognise there is still further to go and we're working with Dorset Maternity Voices Partnership to continually improve the quality of services. The maternity team is working incredibly hard to provide care that they can be proud of and that our mums and families deserve. We are joining the national programme for Maternity improvement to support our ongoing work.

**Update on CQC inspections in Maternity, Medical and Surgical services**

Following the CQC inspection of maternity, medical services and surgical services, we are reviewing the reports and responding to the CQC as part of their factual accuracy process.

We anticipate the CQC report on Maternity will be published in the near future. Our improvement actions have been discussed at the Quality Committee and the final report will be submitted to the Trust Board once received.

## 7. MP VISIT

Tobias Ellwood, one of our local MPs for Bournemouth asked to visit Royal Bournemouth Hospital to learn more about the pressures our trust is under and to speak with staff on their experiences. He focused on the impact of delayed discharges, as well as the importance of recruitment and retention, and judging by the comments he made to the BBC following his visit, he appreciated the opportunity. He commented that the staff he spoke to were "passionate about their work" and thanked them for their dedication and commitment.

## 8. PATIENT FIRST

Patient First is a process of continuous improvement that focuses on giving frontline staff the time and freedom to identify opportunities for positive, sustainable change and the skills to make it happen. It is a way of bringing us all together following the merger and the pandemic, to truly engage with our hardworking and dedicated staff and focus on the right things for patients. It is a structured model of support that will build upon UHD's strong foundations and what works well within the organisation, refreshing our culture of excellence and further developing 'the way we do things around here'. All of this will require a different way of working to unleash the passion and skills of our staff, create a sense of belonging and promote a more inclusive service and workplace so that our people will want to stay and positively contribute to the success of our organisation.

**Phase 1:** is on track to complete at the end of January 2023. The Readiness Assessment report will be shared on 27 January, following a number of board member interviews, briefing workshop and four focus groups involving over 100 staff.

**Phase 2:** Strategy Development will commence in February 2023, with a series of workshops involving executives and our senior leaders from the clinical care groups and corporate directorates. During this period we will be reviewing our Trust vision and objectives (True North) and developing our 'inch wide, mile deep' strategic initiatives for UHD based on the Patient First approach.

Aligned with this, we will be:

- reviewing our current QI and Leadership Development offers across UHD and preparing our roadmap for an integrated Patient First training programme. This will build our 'improvement muscle' capacity and capability amongst our managers and frontline staff and encourage new leadership behaviours to support the required culture change;
- increasing our communication and engagement activities with staff to encourage inclusive conversations about Patient First: What is it? Why do we need it? How will it affect me? How can I get involved?;
- Confirming our governance arrangements and organising site visits to exemplar organisations who have adopted a similar approach within the NHS.

## 9. TRANSFORMATION

We had a positive meeting with the national team on the New Hospitals Programme, regarding the £263m investment into UHD. Approval has been received on our enabling works. Looking ahead for 2023 we will see major changes including:

- updating our catering offer to patients, staff and visitors;
- opening the Dorset Pathology Hub with cutting edge facilities and digital systems;
- Poole theatres Phase 1 opening giving us new operating capacity, especially helping trauma patients.

It's been agreed for cardiology and stroke to progress to their next stage of integration in 2023 which will provide better patient pathways, reducing delays and improving clinical outcomes.

Our integration of services since merger continues. Examples include greater flexing of surgical emergency admissions, sharing critical care capacity and accommodating complex elective surgery. This will ensure we are better able to meet demand.

Our Green UHD sustainability actions continue, these include lift share, cycle and bus offers to support cost of living, cut congestion and support healthier lives for staff patients and visitors.

## 10. ELECTRONIC PATIENT RECORD

On 15 December 2022 the Dorset EPR leadership team met with the South West regional business case lead from which it was clear that there are a number of deficits in our current Outline Business Case which needed to be resolved before submission. The inward investment team of the Dorset ICB is coordinating the effort to remedy these gaps with an expectation that this will be resolved by end January 2023. This puts us one month behind our previously declared timetable, in the OBC. Whilst regrettable, this is not material to the overall programme but signals the complexity associated with navigating these large scale business cases. Meanwhile, the Chief Information Officers from all the provider organisations and the ICB have met to agree the principles by which organisations must remain aligned during this strategic programme, one of which for example, is to be completely open minded about the solution architecture and choice of vendor(s) and trust the procurement process, with full clinical leadership engagement, to generate the most optimal solution.

## 11. WORKFORCE

### Industrial Action in relation to the National Pay Dispute

As you will be aware the Royal College of Nursing (RCN) gave notice of intended strike action at UHD on 18 and 19 January 2023. Ambulance staff working for South Western Ambulance Service had taken part in strike action on 11 and a further date is expected on 23 January 2023.

Industrial action planning is being managed through the Trust's Emergency Planning Response Team and incident management framework.

The ballot for Junior Doctors who are BMA members opened on 9 January 2023.

## Resourcing

Significant focus has been on recruitment to Healthcare Support Worker roles, with the support of our in-house Digital Recruitment Marketing resource and funding from NHSI for an Indeed sponsored platform. We have 70 HCSWS in the onboarding process following our previous 2 events and aim to add a further 70 from the forthcoming one on 3 February 2023. We have been successful in bidding for funding from NHSI to support this event.

A multi-professional Career Fair has been arranged for 29 March 2023.

Following a Trainee Nurse Associate (TNA) recruitment drive with Indeed - 15 successful candidates are due to commence a TNA programme with Bournemouth and Poole College in March 2023.

In December we welcomed 59 new joiners to the trust; 53 Agenda for Change staff and 6 medical staff. In addition, 61 internal candidates took up new roles.

## Workforce Planning

Helping set the scene for strategic workforce planning (SWP) at the Operational Planning launch event, Ernst Young shared the challenges faced by NHS organisations when engaging in SWP, together with the benefits that can be released if we get this right.

Embedding a standardised approach to strategic workforce planning will allow the organisation to develop an understanding of where we are now, where we need to be and help determine the solutions and actions required to ensure we have the workforce required to meet the needs of the services and those who use them.

A workforce planning template has been developed, along with supporting guidance and BI workforce reports that will support senior leads to define, evaluate, understand, model and design their strategic workforce plans in the short, medium and long term.

## Chief Medical Officer Appointment Process

I'm pleased to share that we had a good response to the advertisement for the Chief Medical Officer role. Six candidates have been shortlisted and the carousel stakeholder event took place on 13 January 2023. Interviews took place on 20 January.

## UHD Staff Excellence Awards

We continue to receive nominations for the Staff Excellence Awards and the following staff have been identified as going above and beyond in their duties. December and January recipients are:

Dr. Aditya Deshpande, ED RBH

The Dermatology Team

The Eye Ward/ Eye Ward Day Team

April Dalley, Housekeeping Orthodontics

Annie Creasey, Pharmacy

Mr Alex Taylor, Midwifery

Carolina D’Andrade, Stroke Rehabilitation

## 12. DORSET INTEGRATED CARE BOARD (ICB)

I attended the ICB meeting which took place on 3 November 2022. The minutes of the meeting are appended to my report.

# NHS DORSET INTEGRATED CARE BOARD
# ICB BOARD
# THURSDAY 3 NOVEMBER 2022
# MINUTES

A meeting of the ICB Board was held at 10am on Thursday 3 November 2022 in the Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG

| | | |
|---|---|---|
| **Members Present:** | | |
| | Jenni Douglas-Todd (JDT) | ICB Chair |
| | John Beswick (JB) (virtual) | ICB Non-Executive Member |
| | Cecilia Bufton (CB) | ICB Non-Executive Member |
| | Jonathon Carr- Brown (JCB) (virtual) | ICB Non-Executive Member |
| | Dawn Dawson (DD) | Acting Chief Executive Dorset Healthcare NHS Foundation Trust and ICB NHS Provider Trust Partner Member |
| | Spencer Flower (SF) | Leader Dorset Council and ICB Local Authority Partner Member (West) |
| | Siobhan Harrington (SH) | Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member |
| | Paul Johnson (PJ) | ICB Chief Medical Officer |
| | Drew Mellor (DM) | Leader Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East) |
| | Patricia Miller (PM) | ICB Chief Executive |
| | Rob Morgan (RM) | ICB Chief Finance Officer |
| | Ben Sharland (BS) | Primary Care Partner Member |
| | Debbie Simmons (DSi) | ICB Chief Nursing Officer |
| | Kay Taylor (KT) | ICB Non-Executive Member |
| | Dan Worsley (DW) | ICB Non-Executive Member |
| | Simone Yule (SY) (Virtual) | Primary Care Partner Member |
| | | |
| **Invited Participants Present:** | | |
| | Neil Bacon (NB) | ICB Chief Strategy and Transformation Officer |
| | Louise Bate (LBa) (virtual) | Manager, Dorset Healthwatch |
| | Graham Farrant (GF) (virtual) | Chief Executive, Bournemouth, Christchurch and Poole Council |
| | David Freeman (DF) | ICB Chief Commissioning Officer |
| | Dawn Harvey (DH) | ICB Chief People Officer |
| | Leesa Harwood, (LH) | ICB Associate Non-Executive Member |
| | Nick Johnson (NJ) (virtual) | Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust |
| | Matt Prosser (MP) | Chief Executive, Dorset Council |
| | Stephen Slough (SS) | ICB Chief Digital Information Officer |
| | Dean Spencer (DSp) | ICB Chief Operating Officer |
| | | |
| **In attendance:** | | |
| | Liz Beardsall (LB) (minutes) | ICB Company Secretary |

| | | |
|---|---|---|
| | Sam Best (SB) (observing) | ICB Principal Lead for Children and Young People |
| | Tim Bossenger (TB) (virtual – item 6) | Head of Recruitment and Resourcing, Dorset HealthCare NHS Foundation Trust |
| | Gaurika Kapoor (GK) (observing) | Deputy General Manager for Cancer Care, University Hospitals Dorset |
| | Natalie Violet | Business Manager to the ICB Chief Executive |
| | | |
| **Public:** | | |
| | 10 members of the public via Livestream | |
| | | |
| **Apologies:** | | |
| | Sam Crowe (SC) | Director of Public Health Dorset |
| | Manish Tayal (MT) | ICB Interim Non-Executive Member |

**1. Apologies**

The Chair welcomed everyone present to the meeting, especially Liz Beardsall, Ben Sharland and Debbie Simmons who were attending for their first meeting of the ICB Board.

**2. Quorum**

It was agreed that the meeting was quorate and could proceed.

**3. Declarations of Interest**

There were no declarations of interest made in relation to items on the agenda.

**4. Minutes**

The Part 1 minutes of the meeting held on 1 September 2022 were approved as a true and accurate record subject to clarification by the ICB Chief Finance Officer (ICB-CFO) of minute 9.3.6 regarding adult and children social care funding, which would be provided outside the meeting.

**ACTION: RM**

**Resolved: the Board approved the minutes of the Part 1 meeting held on 1 September 2022 subject to inclusion of the clarification above.**

**5. Matters Arising**

It was noted that all actions were complete as detailed in the previously circulated report.

The Board requested that future actions were presented as an actions log, rather than a matters arising report.

**ACTION: LB**

**Resolved: The Board noted the report matters arising from the Part 1 minutes of the meeting held on 1 September 2022.**

**6. Patient Story – Nurses from Overseas**

The ICB Chief Nursing Officer (ICB-CNO) introduced the patient story video from some of the system partners' overseas recruits regarding their experiences.

The interviews highlighted the issues overseas recruits faced regarding administration, including visa and bank account applications for those who were recruited outside an international recruitment programme, as well as accommodation and transport issues in Dorset. The recent work undertaken by Dorset County Hospital (DCH) and Dorset HealthCare (DHC) was noted, including the dedicated pastoral support for recruits from overseas.

The Board discussed the issues raised in the story. It was noted that significant work had already been undertaken to improve the support available to overseas recruits and additional work was underway regarding some of the challenges raised including:

- a planned round-table discussion with local authority partners regarding housing
- listening events at University Hospitals Dorset (UHD) and a review of their race equality strategy.

Other aspects which needed to be addressed included:

- broader cultural aspects, including greater recognition of individual's skills and the value of overseas training, providing better progression opportunities and maximizing overseas recruits' experience to improve services and challenge how the NHS works
- reciprocal arrangements so that domestic recruits could experience and learn from other health services
- how the system could give back to home countries who were losing staff to the NHS
- an integrated support package for overseas recruits across Dorset, including all sectors not just NHS staff
- a common approach to induction
- the possibility of establishing the system as a Certificate of Eligibility for Specialist Registration (CESR) academy, which would increase the ICS's reputation internationally.

It was noted that the system workforce approach and priorities would form part of the system People Plan, although practical steps could be taken now to help improve the experience of overseas recruits. The Board asked the ICB Chief Executive (ICB-CEO) and Chief People Officer (ICB-CPO) to bring a programme of action to the Board, regarding both immediate actions that could be taken and longer-term plans.

**ACTION: DH/PM**

**Resolved: the Board noted the patient story.**

**7. Chief Executive Officer's Report**

The ICB-CEO introduced the previously circulated Chief Executive Officer's Report which was taken as read. It summarized the key strategic developments across the NHS and within Dorset, and reflections on how the system was performing and the key areas of focus. The key issues were:

- the appointments of a new Prime Minister and Secretary of State for Health and Social Care, since the report was written
- the commencement of the COVID Inquiry
- the publication of the National Audit Office report regarding the introduction of Integrated Care Systems
- the publication of the NHS England Operating Framework, and the resulting work on the system operating framework and priorities

- work which was underway on the Integrated Care Partnership strategy
- work that was underway with the Integrated Care Board (ICB) executive team and Pricewaterhouse Coopers (PwC) to develop Place, and the need for conversations between the ICB and local authority partners to ensure Place was ready for mobilisation in April
- winter pressures and the need to mobilise out of hospital models quickly.

The Board welcomed the updates from partners in the report and requested that future reports contained an update from primary care as well.

**ACTION: NV**

The Joint CEO and Joint Chair appointments between DHC and DCH were noted. The Board asked that background information and a summary on progress to date was circulated.

**ACTION: DD**

The Board discussed the operational pressures on the system and the need for prioritisation, the importance of the out-of-hospital work, and the need for an understanding of where capacity was available in the system.

Consideration was given to the need for a dynamic system risk assessment which linked to live data. The Board requested partners work with the ICB-CNO, in conjunction with the ICB Chief Operating Officer (ICB-COO), to agree what this would look like.

**ACTION: Partners, DSi, DSp**

Upcoming pilots for Provider Collaboratives and a National Care Leavers Covenant were noted. These would be considered further by the ICB executive team.

**ACTION: ICB Executives**

The Chair thanked the ICB-CEO for her report.

**Resolved: the Board noted the Chief Executive Officer's report.**

## 8. Items for Decision

### 8.1 Committee Terms of Reference and Work Plans

The Company Secretary introduced the revised committee Terms of Reference (ToRs) and work plans which were circulated in the meeting papers along with details of the review process.

The ToRs and work plans had been approved by the relevant committees in October, and both would be reviewed again as part of the year-end review, to reflect the strategic objectives and enabling plans. The Quality and Safety Committee and Risk and Audit Committee work plans were to follow.

The ToRs and workplans were approved, subject to the correction of Director of Nursing/Medical Director to Chief Nursing Officer/Chief Medical Officer in the Clinical Commissioning Committee ToRs.

**ACTION: LB**

**Resolved: the Board approved the committee Terms of Reference and Work Plans.**

## 9. Items for Noting

### 9.1 Quality Report

The ICB-CNO introduced the previously circulated Quality Report highlighting the key quality issues in the system. Key items included:

- ambulance handover delays and the resulting impact on patient safety
- delays to completion of Initial Health Assessments
- positive initial feedback from the Care Quality Commission's Section 117 inspection
- the publication of the 'Reading the Signals: Maternity and Neonatal Services Report' into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. Four areas for action were identified: monitoring, compassionate and kind care, teamwork and organisational behaviour. The Local Maternity and Neonatal System (LMNS) was reviewing the report and would provide an assurance report addressing these areas, alongside those arising from the Ockenden Report. NHS England were developing a combined national delivery plan on these action areas, and the ICB were looking to strengthen its leadership of maternity in the Dorset system.

The format of the Quality Report would be revised for future meetings, focusing on escalations and providing detail on the implications of the data and resulting actions. These proposed changes were welcomed by the Board.

**Resolved: the Board noted the Quality Report.**

### 9.2 Performance Report

The ICB-COO introduced the previously circulated Performance Report detailing operational performance in the Dorset health system. The report had been reduced in length from previous iterations and would be moving to a dashboard approach in future, which was welcomed by the Board. Key items included:

- for elective care: progress on reducing long waiters and the risk related to delivery of these plans due to winter and emergency care pressures
- for emergency care: increasing category two ambulance response times, continuing challenges relating to delayed ambulance handovers, and the upcoming Winter Improvement Collaborative
- for cancer services: treatment times were positive but there remained some delays in the diagnosis pathway. Work was ongoing to address this.

The Board requested that the ICB-COO worked with the ICB Chief Commissioning Officer (ICB-CCO) on the development of relevant and appropriate Key Performance Indicators (KPIs) for primary care, noting that increased standardisation in primary care would be required to make comparison of data possible.

**ACTION: DSp, DF**

The Board discussed the importance of harm reviews and noted the good work done regarding these by the South Western Ambulance Service and University Hospitals Dorset (UHD). Consideration was given to the need for a holistic approach to winter pressures encompassing prevention and admission avoidance in addition to discharge.

**Resolved: the Board noted the Performance Report.**

**9.3 Finance Report**

9.3.1 The ICB Chief Finance Officer (ICB-CFO) introduced the previously circulated Finance Report, which outlined the financial performance of the system as at August 2022 (month 5). The ICS was reporting a deficit of £14.0 million against a breakeven plan, with NHS Dorset and the two acute providers reporting deficits. Since the report was written, cost pressures had increased notably driven by agency spend, prescribing and Personal Health Commissioning. The system has committed to continuing to deliver a balanced plan and this would be reviewed again in month 7.

No questions were raised by the Board in relation to the report. The Finance and Performance Committee reported that in addition to the cost drivers above, it had also discussed the risks around Cost Improvement Programme (CIP) slippage.

**Resolved: the Board noted the Finance report.**

**9.4 Quality Assurance of Mental Health and Learning Disabilities Inpatient Services**

The ICB-CNO and ICB-CCO introduced the previously circulated Quality Assurance of Mental Health and Learning Disabilities Inpatient Services Report. The report was in response to the letter from the National Director for Mental Health to all mental health, learning disability and autism providers following a BBC Panorama report regarding patient abuse and organisational culture.

The Acting Chief Executive Dorset Healthcare NHS Foundation Trust provided an overview of the report. A root and branch review had been undertaken, providing good internal assurance, and a gap analysis was also underway. Measures in place included independent clinical reviews, regular unannounced Care Quality Commission (CQC) visits, independent mental health advocates, engagement with people with lived experience and the Freedom to Speak Up process.

It was suggested that non-executive directors were invited to attend the ICB's quality assurance visits, and that outcomes of the visits should be added to the Quality and Safety Committee workplan.

**ACTION: DSi, LB**

Consideration was given to the need for assurance on these issues beyond that which a narrative report could provide and the Board requested a possible deep dive was added to the forward plan.

**ACTION: LB**

**Resolved: the Board noted the Quality Assurance of Mental Health and Learning Disabilities Inpatient Services.**

**9.5 Reading the Signals: Maternity and Neonatal Services**

The ICB-CNO confirmed that this has been covered as a verbal update under the Quality Report (item 9.1) above.

**Resolved: the ICB Board noted the verbal update on maternity and neonatal services provided under item 9.1.**

**10. Items for Consent**

There were no items for consent.

**11. Public Questions**

The following question was received from a member of the public:

Payment Scheme

NHS England is currently running engagements on the new Payment Scheme and intends to begin consulting on the Scheme in October / November. According to the engagement session on 2023 finance and payment, NHS England "don't believe a variable payment linked to any acute non-elective activity would be appropriate, given the aims to reduce this demand where possible."

a) do the ICB agree that there should be no variable payment linked to any acute non-elective activity?

b) if so, how do the ICB propose to fund acute non-elective care for patients diagnosed with cancer, heart disease, stroke, or other life-threatening illness if the Fixed element for acute non-elective care is used up before the end of the financial year?

c) if not, do the ICB intend to object formally to any such proposal during the consultations on the Payment Scheme?

d) do the ICB agree that the inability of an NHS organisation to keep the cost of acute non-elective activity below a financial target in the Plan may indicate a problem with the target and/or the Plan and/or the forecasting model on which they are based?

The Chair provided the following response:

We are aware that the Payment Mechanisms for 2023/24 are being developed and we are keen to understand the proposals fully and engage with the consultation process when this is issued. Whilst we understand and agree with the rationale for the potential to move back to a tariff-based payment for elective activity and for not doing so for non-elective activity; we are keen to understand the wider payment structure given the risks inherent with this approach. Specifically, the impact that increases in non-elective activity, and the delays in safely discharging patients from acute hospitals has on a provider's ability to deliver elective activity. Only once we have understood and considered the impact of the whole package, will we be able to formulate our response.

**12. Any Other Business**

There was no further business.

**13. Date and Time of Next Meeting**

The next meeting of the ICB Board would be held on Thursday 5 January 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

**14. Exclusion of the Public**

The Board resolved 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.

The Chair introduced the HSJ nominees, who were joining the Board for lunch to celebrate their nominations. The Board welcomed the nominees for the Digitising Patient Care Award, Integrated Care System of the Year: Dorset ICS Medical Examiner Programme and Think Big; Performance Recovery Award: Think Big; and Using Data to Connect Services Award: Transforming COPD.

Signed by: 

Jenni Douglas-Todd, ICB Chair

Date: 05 January 2023

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 6.1**

| | |
|---|---|
| **Subject:** | Operational Performance |
| **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 |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☒<br>Be a great place to work ☒<br>Use resources efficiently ☒<br>Be a well led and effective partner ☒<br>Transform and improve ☒ |
| **BAF** | Trust Integrated Performance report December 2022 Appendix A |
| **Purpose of paper:** | Assurance |
| **Executive Summary**: | 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 maintained in the organisation. Impact on reduced hospital flow has the potential to impact on patient safety, experience, increased cancellations and industrial action days. Workforce availability to meet escalating capacity levels, that driving increased agency costs and staff wellbeing. Impact on hospital reputation and increased challenge to elective care recovery as a result of having to more capacity aside for emergency /urgent care response. The impact this may have on the fundamentals of care, in particular, deconditioning of patients. |
| **Background:** | The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums the ability, if needed, to deep dive into a particular area of interest for additional information and scrutiny. |

| | |
|---|---|
| ***Urgent & Emergency Care (2 Alerts)*** | **Strategic objective: To continually improve the quality of care**<br><br>***Alert (1) to Finance & Performance Committee (FPC): Significant levels of risk are being managed within the Trust's emergency departments on a daily basis. Over 14,000 attendances in December (circa 16% increase compared to December 2021). SDEC and elective care areas escalated to meet surge of emergency demand. Significant IPC challenges with increase in COVID-19 and Flu-A.***<br>***Alert (2) to FPC:*** **Ambulance handover delays in December were the highest recorded during 2022/23 with more than 6,600 hours lost, SWAST regionally experienced an increase of 100% in hours lost.**<br><br>UHD was stepped up to Critical Incident status a number of times in December due to ongoing pressures on flow impacting the Emergency Department (ED). Overall increase in meantime for attendances in ED and the number of patients waiting over 12 hours in ED after a decision to admit increased.<br><br>A significant increase in ambulance handover delays waiting longer than 60 minutes. In December SWAST/ UHD agreed to support cohorting of patients to release physical ambulances back on the road.<br>*(colours based on change from last month)*<br>Dec-22<br>Standard / Aim / Poole / RBCH / Combined<br>**Operational (Field testing standards)**<br>Mean time in the dept: 200 mins / 357 / 433 / 396<br>Time to Initial Assessment: 15 mins / 13 / 29 / 21<br>12 Hour ED Waits: 0 / 768 / 1232 / 2000<br>**Internal Care Standards**<br>Time to first clinician seen (*RBCH: to Dr seen*): 60 mins / 158 / 223 / 191<br>Mean Clinically Ready To Proceed to Leave Dept: 60 mins / 340 / 250 / 298<br>Weekly ED rapid decompression meetings continue chaired by the COO. |
| ***Occupancy, Flow & Discharge***<br><br>***(1 Alert)*** | **Strategic objective: To continually improve the quality of care**<br><br>***Alert FPC: Daily average of medically ready for discharge (MRFD) patients consistently above 220.***<br><br>Both sites continued to maintain escalation beds open in December. Occupancy has increased to an average of 93.3% across UHD, however has often exceeded 100% on a single site, with OPEL 4 being declared across the system. This includes planned winter escalation but does not account for additional surge beds opened in extremis.<br><br>There was an average of 221 patients MRFD occupying beds across both sites in December (27% of overall beds). This is an improvement on the November position by 3%. 60 additional care home beds were made available mid-December which supported this reduction.<br><br>Hospital bed occupancy also increased to just above 93% (+0.6%) |

| | |
|---|---|
| ***Surge, Escalation and Ops Planning*** | **Strategic objective: To continually improve the quality of care**<br><br>At the time of writing, UHD has 48 confirmed Covid inpatients with an increase in influenza presentations which has resulted in further cohorting of patients to manage transmission.<br><br>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. |
| ***Referral to Treatment (RTT)***<br><br>***(1 Advise)*** | **Strategic objective: To ensure that all resources are used efficiently to establish financially and environmentally sustainable services**<br><br>***Advised FPC: Reduction in elective long waiters is on track at end of December 2022. 25 patients waiting more than 104 weeks were reported and waits over a year and a have are ahead of plan.*** |

| Planning requirement | Nov 22 | December 22 | |
|---|---|---|---|
| Referral to treatment 18-week performance | 56.1% | 55.06% ▼ | National Target 92% |
| Eliminate > 104 week waits | 37 | 25 ▼ | Plan Trajectory 0 by January 23 |
| Reduce >78 week waits to zero | 487 | 4[illegible]3 ▼ | Trajectory 774 by December 22 |
| Hold or reduce >52+ weeks | 3,634 | 3,472 ▼ | Trajectory 3,158 by December 22 |
| Stabilise Waiting List size | 71,161 | 70,259 ▼ | Decrease of 902 v Nov 2022 |

**Other**

- Capped theatre utilisation was 73% in December against a planning trajectory of 82%. Sustained improvement in early and late starts continues to be seen in periods outside of ED/hospital escalation.
- There was a small reduction in month in the attainment of targets for fractured neck of femur (# NoF) patients with 43% achieving surgery within 36 hours of admission and 73% within 36 hours of being fit for surgery. However, the improvement on September performance has been maintained.

Weekly oversight of long waiters is in place by the Director of Operational Performance and Oversight and Chief Operating Officer.

| | |
|---|---|
| ***Cancer Standards***<br><br>***(1 Alert & 1 Advise)*** | **Strategic objective: To ensure that all resources are used efficiently to establish financially and environmentally sustainable services** |

**Alerted FPC:** *Achievement of improvement in Cancer faster diagnosis standard and 62 day standard is off track.*

**Advised FPC:** *Cancer: Numbers of patients waiting 63 days or more for treatment after referral for suspected cancer is reducing. 232 at 18-Dec compared to 332 in September 22. Expected rise at end of December as a result of reduced validation over Christmas/New year period but plan to address early January.*

| Measure | Target | Q1 22/23 FINAL | Q2 22/23 FINAL | Oct 22 FINAL | Nov 22 FINAL |
|---|---|---|---|---|---|
| Cancer Plan 62 Day Standard (Tumour) | 85% | 71.4% | 68.5% | 69.4% | 64.3% |
| 62 Day Screening Standard (Tumour) | 90% | 82.4% | 94.0% | 80.4% | 82.6% |
| 31 Day First Treatment (Tumour) | 96% | 97.4% | 97.4% | 98.4% | 97.1% |
| Subsequent Treatment - Surgery | 94% | 91.5% | 92.2% | 87.7% | 76.9% |
| Subsequent Treatment - Radiotherapy | 94% | 98.6% | 99.3% | 94.7% | 98.3% |
| Subsequent Treatment - Anti Cancer Drugs | 98% | 99.5% | 98.8% | 100.0% | 99.1% |
| Faster Diagnosis | 75% | 70.2% | 63.7% | 63.1% | 59.6% |
| Over 104 days (treated in month) | N/A | 53 | 52 | 18 | 24.5 |
| PTL over 62 days (average) | N/A | 213 | 288 | 306 | 293 |

- 28-day FDS performance decreased in November to 59.6% (threshold 75%). Seven tumour sites continue to achieve the standard. First outpatient capacity to meet demand in colorectal, gynaecology and skin are areas of particular challenge.
- 31-day standard – achieved.
- The 62-day performance in November reduced to 64.3% (threshold 85%) but continues to be above the current national average of 60.2%.

***DM01 (Diagnostics report)***

***(1 Advise)***

**Strategic objective: To ensure that all resources are used efficiently to establish financially and environmentally sustainable services**

**Advised FPC:** ***UHD has achieved the best performance in the SW in December (18-Dec) for diagnostics (DM01) – Number of patients are waiting 6 weeks or more for a diagnostic test.***

The DM01 standard has achieved 86.4% of all patients being seen within 6 weeks of referral, 13.6% of diagnostic patients seen >6weeks.

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

| December | Total Waiting List | < 6weeks | > 6 weeks | Performance |
|---|---|---|---|---|
| UHD | 11,771 | 10,176 | 1,595 | **13.6%** |

***Stroke Performance***

The Stroke (SSNAP) quarterly clinical and organisational audit indicator score for quarter 2 was B; an improvement from quarter 1 C score. Q3 internal reporting to date demonstrates continued achievement at level B.

| | |
|---|---|
| ***Elective Recovery Actions*** | ***Five Trust-wide improvement programmes are providing a foundation for improvements in elective care recovery:***<br>• **A Theatre improvement programme -** to optimise theatre efficiency and utilisation and improve staff and patient experience of theatres.<br>• **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.<br>• **Diagnostics recovery:** Endoscopy, Echocardiology and imaging.<br>• **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.<br>• **Data and validation optimisation:** Ensuring access to the best quality data for elective care delivery and planning. |
| ***Health Inequalities*** | **Strategic objective: To transform and improve our services in line with the Dorset ICS Long Term Plan**<br><br>The Dorset Intelligence & Insight Service (DiiS) Health Inequalities dashboard enables analysis waiting times disaggregated by ethnicity and deprivation (Dorset Patients only).<br><br><u>Waiting list by Index of Multiple Deprivation (IMD)</u><br>A reduction in the variation in length of wait for patients on an RTT waiting list according to their index of multiple deprivation has been maintained in Q3.<br><br><u>Waiting list by ethnicity</u><br>Where ethnicity is recorded, 10.9% of patients on UHD waiting lists are within community minority ethnic populations (increase 0.1% since November). Patients from community minority ethnic groups had a higher (1.5%) average week wait compared to patients recorded as White British in Q3. The variance has increased in Q3 compared to Q2.<br><br>A health inequalities improvement programme is supporting action on health inequalities in the Trust. |
| ***Infection Prevention and Control:*** | **Quality, Safety, & Patient Experience Key Points**<br><br>Hospital Associated cases trend |

| | 2021/2022 | | | | | | | | | | | | 2022/2023 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Organism | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
| Cdiff | 4 | 8 | 8 | 8 | 5 | 8 | 6 | 6 | 4 | 2 | 8 | 3 | 9 | 10 | 9 | 9 | 11 | 9 | 2 | 4 | 5 |
| eColi | 4 | 4 | 9 | 9 | 10 | 7 | 8 | 7 | 9 | 7 | 2 | 4 | 6 | 1 | 7 | 4 | 7 | 9 | 6 | 7 | 5 |
| MRSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 |
| MSSA | 3 | 2 | 4 | 4 | 5 | 5 | 1 | 4 | 4 | 3 | 7 | 5 | 4 | 4 | 2 | 3 | 3 | 3 | 7 | 2 | 3 |

- Work continues the follow up of COVID-19 outbreaks with post infection review for cases from Q3 2021 to Q1/Q2 2022. This was due to be completed in December 2022 but with large numbers of acute respiratory infection and high sickness in the IPC Team this is delayed.
- Community and hospital associated cases of COVID-19 in Dorset continue to decline but this month saw a rapid rise in Influenza and RSV cases impacting greatly on the hospital to function at its best.
- Cases of Clostridioides Difficile have increased over the past 2 years. The frequency of patients relapsing, and the severity of cases has also increased. We are now over our 22/33 trajectory with 71 cases reported against a trajectory of 59. An indepth review of case findings and changes in epidemiology will be presented to IPG in January 23.
- Group A Strep cases continued to be identified in young patients with a number of those creating admissions to general wards and intensive care.

The IPC Team supported rapid changes to guidance for admissions with Influenza and COVID-19 to enable safe flow into and out of the Trust.

***Clinical Practice Team***

**Moving & Handling**

Our band 3 moving & handling trainer is leaving us in January, this post was kindly funded by Education & Training dept. The M&H team now consists of 2.0 WTE a registered practitioner and an associate practitioner.

**Core Induction**

Level 2 Moving & Handling training is an essential component in the trust induction programme (day 2) for clinical staff

- These sessions have been protected (as much as possible) in order to support the safe onboarding of staff, however this has required a small number of ECS level 2 sessions to be cancelled
- The M&H trainers have been supporting the Education & training team to deliver the level 2 training for the HCSW

**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, consisting of face to face and eLearning.<br>• Videos will be recorded during January 2023.<br><br>**Falls prevention & management**<br>• One of the falls team has taken the opportunity to complete a 3 month secondment (Nov-Feb) as Matron for Medical Specialties, this leaves the falls team consisting of 2.0 WTE a registered nurse and an Associate Practitioner.<br>• A total of five severe events were reported in month. All five patients sustained #nofs, four of the incidents were unwitnessed and one of the incidents witnessed.<br>• The relevant scoping and investigations are being undertaken with support from the falls team.<br><br>**Tissue Viability**<br>The ability of the service to meet the increased demand has been distilled into a risk register entry 1821 and rated as 8 (moderate).<br>The number of complex patients being referred to the service remains high.<br>• The number of referrals to the service are now consistently above 200 per month.<br>• The number of complex patients who are remaining on the caseload during admission are also on the increase.<br>A total of nine category 3 pressure ulcers have been reported in this month, six are combination damage which includes both pressure and moisture factors. The remaining three incidents relate to pressure ulceration due to medical devices, two due to tracheostomy sites and one found on removal of a lower limb cast. |
| ***Patient Experience:*** | **Friends & Family Test**<br>FFT Positive responses have seen a decline at 87.8% compared with 90.2% in November. The response rate for FFT also has reduced.<br>**PALS and Complaints**<br>In December there were 355 PALS concerns raised, 41 new formal complaints and 33 Early Resolution complaints (ERC) processed.<br>**Complaint response times**<br>The number of complaints that were responded to and closed in December were 74. Regular meetings with the care groups continue to focus on closing of complaints.<br><br>There were 216 outstanding open complaints including ERC, 82 of which have been open 55 working days or longer.<br>The last half of December saw an increase in complaints breaching 55 days, where a steady decline |

| | |
|---|---|
| | in these breaches has been seen since May.<br><br>Key themes from PALS and complaints<br>• Communication – Absent or incorrect<br>• Organisation process – Bureaucracy, waiting times, accessing care<br>• Quality – Clinical Standards<br>**Mixed Sex Accommodation Breaches**<br>There were no MSA incidents in December 2022. |
| ***Workforce Performance:*** | **Please note the YTD (12 month rolling data) Indicators to December 2022 can be found on the Workforce Integrated Performance Report Page**<br><br>**<u>December (in month) Indicators:</u>**<br><br>**Turnover** — Actual this month: 14.8% — Variance on last month: 0.1%<br>**Vacancy** — 6.3% — -1.3%<br>**Sickness Rate** — 6.4% — 1.1%<br>**Appraisals** — Values based: 56.2% (1.0%); Medical & Dental: 63.8% (-0.7%)<br>**Statutory and Mandatory Training** — 85.9% — 0.1%<br><br>**UHD turnover** has increased by 0.1% in month, overall YTD remains at 14.6%.<br><br>**Vacancy rate** is being reported at 6.3% in month, a decrease of 1.3% compared to November.<br><br>**Sickness absence** in-month for December 2022 is 6.4%, an increase of 1.1% compared to November. Latest rolling 12 month is 5.9%, an increase of 0.2% since last month.<br><br>**Statutory and Mandatory training:** Overall UHD Trust compliance is standing at 85.9%, an increase of 0.1% on October. Our aim is to reach 90% across all sites. Face to face course are still proving difficult |
| ***CPO Headlines:*** | **Industrial Action in relation to the National Pay Dispute:**<br>The Royal College of Nursing (RCN) have given notice of intended strike action at UHD on 18 and 19 January 2023. The industrial action shall commence at the beginning of the day shift and will last until commencement of the night shift on both the 18 & 19 January 2023 within 24 hours services. For services that are not 24 hours the industrial action shall commence at 08:00am on both the 18 & 19 January 2023 and will last for 12 hours.<br><br>Ambulance staff working for South Western Ambulance Service will be taking strike action on 11 and 23 January 2023. Industrial action planning is being managed through the Trust's Emergency Planning Response |

| | |
|---|---|
| | Team and incident management framework. The ballot for Junior Doctors who are BMA members opened on 9 January 2023 and will run until 20th February. They are proposing a full withdrawal of labour for 72 hours. |
| ***Occupational Health and Enhanced Wellbeing Service*** | In December 2021 OH received 139 management referrals, the average wait from point of referral to appointment is 6 working days. 195 preplacements were received in December and processed.<br><br>**The MSK staff physiotherapy service** has an average wait for an appointment of 4 weeks, the service remains very busy and has high levels of positive feedback<br><br>**The Psychological Support & Counselling Service (PSC)** continues to develop its offer to promote staff wellbeing and reduce sickness absence due to stress and mental health. The PSC service received a high number of referrals in December 2022 following central communications by the Trust. |
| ***Blended Education & Training*** | All 'Induction' webpages (e.g. Volunteers, Nonclinical staff working offsite) are all up to date and the Governors page is being updated this week.<br>The team are currently focusing on Non-Exec directors (NEDs), their BEAT VLE accounts and are being offered volunteers days to do their mandatory training in that face to face format.<br><br>Due to the high number of transformation changes with cost centers being created has meant the team are needing to focus efforts to ensure staff have the right safety training on their BEAT VLE. OLM leads are working on this with the Workforce team. This has added this to the Risk Register. |
| ***Resourcing*** | **Medical Recruitment**: During December we advertised 20 medical posts, and made 22 job offers, with 6 new Medical staff joining the Trust in month. Posts advertised in October and December have received record numbers of applications, between 400 and 700, which appears to align with PLAB 1 and 2 exam dates, which International Qualified Doctors are required to pass prior to obtaining GMC registration. Recruiting Managers have responded very positively to managing their medical recruitment via TRAC, and the portal is saving the resourcing team a great deal of time in the longlisting process.<br><br>**General Recruitment:** During the month of December, Applications received, Job Adverts placed and Offers made remained at consistent levels, whilst the number of starters was lower at 112, 50% of which were internal moves. An Indeed funded and marketed Recruitment Day for Healthcare Support Workers held on the Poole site, resulted in over 40 offers, 31 of whom are completing recruitment checks. A further event is |

| | |
|---|---|
| | planned for 4 February, using funds successfully bid for via NHSI. |
| ***Workforce Systems*** | **Changes:** The total amount of changes processed by the team in December 2022 was 3560, an increase of 973 on the previous month.<br>The main reason for the increase is due to over 1000 positions which were generated or amendments to positions were carried out, mainly subjective code changes.<br>The ESR establishment work continues but the team are hoping to see the data stabilize in the next couple of months.<br><br>**Medical Staffing Systems Project:** The interface between Health Rota and ESR is now live, the outbound and inbound interfaces have been tested and are working, testing will continue with absence data and time and attendance, this is a large step forward for the project. |
| ***Temporary Workforce*** | **Medical Bank:** 1,949 shifts were requested in December 2022 (the highest number since the launch of Locum's Nest usage across UHD). 69% of shifts were filled via Locum's Nest, leaving 31% unfilled. The top three users for December were: Emergency Medicine (686 shifts, 58% filled), Medicine (638 shifts, 73% filled) and Orthopaedics (274 shifts, 85% filled). Over 4% of all shifts were filled by doctors from the Digital Collaborative Bank. We are seeing high numbers of activity with requests for locums to be affiliated with UHD (117 in review).<br><br>**Bank Recruitment:** Activity remains high with approx. 25 active adverts and 191 candidates in progress on TRAC. The status of all candidates is currently under review, along with an expedited process review for candidates in the 'starting' category, to support the organisational needs outlined within the tactical meetings.<br><br>**Recruitment to Temporary Staffing Team:** The majority of positions within the structure have now been filled, with new starters currently going through induction and extensive training in their areas of responsibilities.<br><br>**Registered Nursing and Midwifery:** 55,421 hours were requested in December 2022 (up 8% from November 2022). 75% of requested hours were filled - 49% by bank and 26% by agency. Of the hours filled by agency, 48% were off-framework (Thornbury).<br><br>"**Our Dorset" Collaborative - Off- Framework Reduction Strategy:** To support our strategy to eradicate off-framework usage, as a collaborative we have implemented revised single charge rates to be applied to all RN placements across our organizations |

| | |
|---|---|
| | to those frameworks agencies within an SLA. UHD commenced these rates on 9 January and will be trialing for a period of three months where we will continue to monitor fill performance and off-framework reduction.<br><br>**UHD Temporary Staffing Policy:** Work continues on this new draft policy, with ratification expected in Q4 2022/23. |
| ***Organisational Development*** | **Leadership & Talent** - Initial mock-up and e-form request for the appraisal form to be automated has been submitted. Awaiting response from Change Advisory Board.<br>Leadership in Action programmes dates for 2023 advertised and open for applications and Leadership Fundamentals cohort 3 places filled. Starting to report on personal protected characteristics, with the first 3 cohorts of Leadership Fundamentals reporting 32%, 29% and 36% of non-White British delegates attending respectively.<br>**Team Development** - Working with transformation colleagues to further align support and identify priority teams. Increasing access to training modules on leading teams through integration and change.<br>**Culture & Engagement** - Staff Awards Committee created with OD & Comms engagement. Reviewing high level Staff Survey results and action plans being drafted. Additional Managers module being drafted for line managers to better understand and use their results.<br>**EDI -** UHD Staff networks recognised as best practice by NHS England and will feature in new national toolkit. EDIG task and finish group has established 4 priorities - Race, Career Progression, Staff Networks, Governance.<br>**Health & wellbeing** - The "Winter boosts" (such as discounted meals, catering vouchers and Love2Shop cards) have all been distributed and Manager's guide to accessing support during Winter published. We have offered the position to a new Wellbeing Lead OD practitioner who will hopefully start in the team in February.<br><br>**FTSU** - The FTSU team remain a well-used route for our staff to raise concerns. 213 referrals were made from April to end of December with elements of behaviours in 41% of these. Observations of intractable engagement and relationships noted and escalated. Speaking up strategy presented to WSC for 2023-26 which will go to Board at the end of the month. |
| ***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 food and energy prices putting particular pressure on Trust budgets. |

| | |
|---|---|
| | Collectively, these pressures have resulted in a year to date deficit of £4.2 million.<br><br>Despite the favourable forecast for December, the Trust recorded an adverse in-month variance of £192,000 reflecting the further step-up in operational pressures over the festive period. Additional, unplanned bed capacity was opened to mitigate risks to patient's safety resulting in a further step up in premium agency expenditure. This has put even greater pressure on budgets increasing the year to date adverse variance to £4.6 million.<br><br>Whilst the Trust is currently holding to a forecast full year break-even position, this is now reliant upon additional income from NHS Dorset ICB which has yet to be formally agreed. Even with this assumption, there remains considerable risk within this forecast linked to further seasonal demand and capacity pressures, anticipated investment following the recent CQC inspections, and the potential financial impact of the planned industrial action.<br><br>The year to date capital position represents an under spend of £5.2 million, largely driven by under spends in IT and the One Dorset Pathology Hub schemes. A CDEL underspend of £538,000 is now forecast reflecting some anticipated programme slippage and as a contribution to the improvement in the Dorset ICS CDEL position.<br><br>The Trust ended December with a consolidated cash balance of £82.5 million, all of which remains fully committed against the medium term capital programme. The phasing of the capital plan is the main driver for this increased cash holding against plan.<br>The Trusts payment performance recovered in December; however, the previous impact of the national cyber-attack continues to impact the year to date achievement which currently stands at 91.4%. Further improvement is expected in the remaining months of the year. |
| **Key Recommendations**: | Members are asked to:<br>• Note the content of the report<br>• Note and consider the areas of Board focus |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality and Diversity ☒<br>Financial ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒ |

| | | |
|---|---|---|
| | System | ☒ |
| **CQC Reference:** | Safe<br>Effective<br>Caring<br>Responsive<br>Well Led<br>Use of Resources | ☒<br>☒<br>☒<br>☒<br>☒<br>☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Trust Management Group | Jan 2023 | |
| Quality Committee (Quality) | Jan 2023 | |
| Finance & Performance Committee (Operational / Finance Performance) | Jan 2023 | |

| | | |
|---|---|---|
| **Reason for submission to the Board in Private Only (where relevant)** | Commercial confidentiality<br>Patient confidentiality<br>Staff confidentiality<br>Other exceptional reason | ☐<br>☐<br>☐<br>☐ |

University Hospitals Dorset
NHS Foundation Trust



# Integrated Performance Report

Reporting month: December 2022
Meeting Month: January 2023

**Performance at a Glance - Key Performance Indicator Matrix**

| | | | standard | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | ytd | ytd var | trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SAFE** | | | | | | | | | | | | | | | | | | | |
| Quality | Presure Ulcers (Cat 3 & 4) | | | 6 | 13 | 14 | 5 | 4 | 5 | 2 | 1 | 3 | 5 | 4 | 6 | 9 | 39 | -51 | |
| | Inpatient Falls (Moderate +) | | | 1 | 7 | 8 | 3 | 3 | 5 | 1 | 6 | 7 | 7 | 3 | 2 | 5 | 39 | 8 | |
| | Medication Incidents (Moderate +) | | | 2 | 3 | 2 | 2 | 3 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 7 | -15 | |
| | Patient Safety Incidents (NRLS only) | | | 967 | 1106 | 932 | 916 | 936 | 935 | 947 | 1070 | 1026 | 944 | 1095 | 1041 | 1038 | 9032 | -1022 | |
| | Hospital Acquired Infections | MRSA | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 2 | 1 | |
| | | MSSA | | 4 | 3 | 7 | 5 | 4 | 4 | 2 | 3 | 3 | 3 | 7 | 2 | 3 | 31 | -2 | |
| | | C Diff | | 4 | 2 | 8 | 3 | 9 | 10 | 9 | 9 | 11 | 9 | 2 | 4 | 5 | 68 | 11 | |
| | | E. coli | | 9 | 7 | 2 | 4 | 6 | 1 | 7 | 4 | 7 | 9 | 6 | 7 | 5 | 52 | -14 | |
| **EFFECTIVE** | | | | | | | | | | | | | | | | | | | |
| Mortality | SMR Latest Jan 21 | (source Dr Foster) | | 86.03 | 110.90 | 96.78 | 97.09 | 101.18 | 92.68 | 115.74 | 107.50 | 118.90 | | | | | 118.90 | | |
| | Patient Deaths | YTD | | 247 | 270 | 203 | 241 | 227 | 211 | 236 | 234 | 226 | 225 | 256 | 256 | 294 | 2165 | 281 | |
| | Death Reviews | Number | | 172 | 176 | 134 | 139 | 168 | 143 | 194 | 143 | 137 | 99 | 100 | 82 | | 1066 | | |
| | Deaths within 36hrs of Admission | | | 36 | 48 | 34 | 29 | 41 | 31 | 37 | 30 | 29 | 29 | 41 | 37 | 50 | 325 | 15 | |
| | Deaths within readmission spell | | | 12 | 21 | 15 | 22 | 13 | 18 | 35 | 21 | 22 | 21 | 21 | 17 | 24 | 192 | 54 | |
| **CARING** | | | | | | | | | | | | | | | | | | | |
| | Complaints Received | | | 27 | 48 | 38 | 65 | 55 | 63 | 80 | 78 | 83 | 90 | 98 | 100 | 75 | 722 | 263 | |
| | Complaint Response in month | | | 58 | 37 | 37 | 51 | 37 | 47 | 47 | 56 | 58 | 74 | 91 | 99 | 70 | 579 | 149 | |
| | Section 42's | | | 13 | 0 | 0 | 13 | 0 | 0 | 7 | 0 | 0 | 8 | 0 | 0 | | 15 | -34 | |
| | Friends & Family Test | | | 91% | 90% | 89% | 88% | 88% | 90% | 88% | 86% | 90% | 90% | 90% | 90% | 88% | 89% | 1% | |
| **WELL LEAD** | | | | | | | | | | | | | | | | | | | |
| Safe | Risks 12 and above on Register | | | 44 | 42 | 41 | 39 | 36 | 35 | 35 | 33 | 38 | 36 | 35 | 34 | 36 | 34 | -8 | |
| | Red Flags Raised* | | | 161 | 180 | 148 | 130 | 159 | 41 | 45 | 86 | 128 | 142 | 107 | 74 | 84 | 866 | -108 | |
| People | Turnover | | | 12.81% | 12.10% | 13.50% | 14.00% | 14.50% | 12.80% | 14.80% | 14.50% | 14.50% | 14.70% | 14.60% | 14.70% | 14.80% | 14.6% | 2.6% | |
| | Vacancy Rate *(only up to Oct 2020)* | | | - | - | - | - | 6.0% | 6.4% | 6.3% | 6.4% | 7.2% | 6.8% | 7.5% | 7.1% | 7.1% | 6.7% | 1.4% | |
| | Sickness Rate | | | 5.3% | 5.1% | 5.2% | 5.4% | 5.6% | 5.2% | 5.7% | 5.8% | 5.8% | 5.8% | 5.8% | 5.7% | 5.9% | 5.7% | 0.7% | |
| | Appraisals | Values Based | | 58.4% | 55.3% | 59.1% | 59.1% | 5.1% | 7.0% | 13.0% | 19.9% | 28.9% | 42.1% | 50.2% | 55.3% | 56.2% | 29.7% | -4.8% | |
| | | Medical & Dental | | 54.1% | 44.1% | 38.8% | 56.6% | 55.5% | 54.7% | 59.4% | 59.0% | 59.1% | 51.0% | 66.4% | 64.5% | 63.8% | 59.2% | 1.9% | |
| | Statutory and Mandatory Training | | | 86.18% | 85.72% | 85.60% | 84.79% | 84.50% | 83.41% | 83.70% | 85.50% | 87.10% | 86.75% | 85.32% | 85.80% | 85.91% | 85.4% | -1.9% | |

## Performance at a Glance - Key Performance Indicator Matrix

| | | | standard | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | ytd | ytd var | trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RESPONSIVE** | | | | | | | | | | | | | | | | | | | |
| Quality | Patient with 3+ Ward Moves (Non-Clinically Justified Only) | | | 18 | 24 | 12 | 4 | 14 | 22 | 14 | 11 | 10 | 11 | 7 | 5 | 1 | 95 | -3 | |
| | Patient Moves Out of Hours (Non-Clinically Justified Only) | | | 53 | 57 | 64 | 77 | 87 | 75 | 76 | 89 | 59 | 77 | 62 | 48 | 70 | 643 | -12 | |
| | ENA Risk Assessment | Falls | | 53% | 51% | 58% | 56% | 55% | | | | | | | | | 55% | -2.7% | |
| | **infection eNA assessment* | Infection* | | 58% | 54% | 61% | 60% | 58% | | | | | | | | | 58% | -4.0% | |
| | *went live at RBCH* | MUST | | 58% | 55% | 62% | 60% | 58% | | | | | | | | | 58% | -3.7% | |
| | *during April 20* | Waterlow | | 53% | 51% | 58% | 57% | 56% | | | | | | | | | 56% | -2.2% | |
| RTT | 18 week performance % | | 92% | 61.6% | 60.9% | 60.4% | 61.0% | 56.1% | 59.2% | 58.2% | 58.3% | 57.1% | 54.9% | 55.5% | 56.1% | 55.1% | | | |
| | Waiting list size | | 44,508 | 52,972 | 53,168 | 54,602 | 56,038 | 61,278 | 72,568 | 73,932 | 75,502 | 75,065 | 72,860 | 70,918 | 71,161 | 70,259 | RAG cf trajectory 22/23 | | |
| | Waiting List size variance compared to Sep 2021 (cf Mar 19 up to Mar 21, cf Jan 20 up to oct 21) | | 0% | 2.9% | 3.3% | 6.0% | 8.8% | 19.0% | 40.9% | 43.6% | 46.6% | 45.8% | 41.5% | 37.7% | 38.2% | 36.4% | | | |
| | No. patients waiting 26+ weeks | | | 12,904 | 13,561 | 13,829 | 13,765 | 17,433 | 19,913 | 20,428 | 20,244 | 21,326 | 21,172 | 20,227 | 20,765 | 21,024 | | | |
| | No. patients waiting 40+ weeks | | | 5,374 | 5,391 | 5,764 | 5,650 | 7,370 | 8,521 | 9,395 | 9,075 | 9,446 | 8,920 | 8,231 | 8,657 | 8,696 | | | |
| | No. patients waiting 52+ weeks | | 0 | 2,968 | 2,777 | 2,680 | 2,655 | 2,798 | 3,325 | 4,493 | 4,170 | 4,010 | 3,559 | 3,468 | 3,634 | 3,472 | RAG cf trajectory 22/23 | | |
| | No. patients waiting 78+ weeks | | | 952 | 870 | 864 | 758 | 759 | 550 | 520 | 492 | 502 | 504 | 513 | 487 | 473 | RAG cf trajectory 22/23 | | |
| | No. patients waiting 104+ weeks | | | 273 | 295 | 408 | 280 | 238 | 194 | 118 | 100 | 95 | 76 | 63 | 37 | 25 | RAG cf trajectory 22/23 | | |
| | Average Wait weeks | | 8.5 | 19.5 | 18.5 | 20.1 | 19.5 | 19.5 | 19.5 | 19.5 | 19.5 | 19.5 | 19.5 | 19.5 | 19.5 | 19.5 | | | |
| Theatre | Theatre utilisation (capped) - main | | 98% | 70% | 71% | 75% | 71% | 71% | 76% | 78% | 74% | 75% | 75% | 69% | 75% | 73% | | | |
| | Theatre utilisation (capped) - DC | | 91% | 61% | 62% | 64% | 63% | 62% | 69% | 73% | 69% | 69% | 70% | 74% | 74% | 69% | | | |
| | NOFs (Within 36hrs of admission - NHFD) | | 85% | 4% | 9% | 32% | 24% | 24% | 3% | 2% | 12% | 18% | 8% | 40% | 52% | 43% | | | |
| Outpatients | **Referral Rates** | | | | | | | | | | | | | | | | | | |
| | GP Referral Rate year on year +/- | *(prev yr baseline)* | -0.5% | 34.3% | 33.5% | 32.4% | 29.3% | -19.7% | 0.4% | -0.6% | -0.8% | -0.9% | -5.0% | -6.5% | -7.8% | -17.3% | | | |
| | | *(19/20 baseline)* | -0.5% | -10.2% | -10.8% | -10.7% | -7.0% | | | | | | | | | | | | |
| | Total Referrals Rate year on year +/- | *(prev yr baseline)* | -0.5% | 31.2% | 27.1% | 26.4% | 24.0% | -24.3% | -0.6% | -3.4% | -4.5% | -4.6% | -8.1% | -8.8% | -10.1% | -19.2% | | | |
| | | *(19/20 baseline)* | -0.5% | -4.6% | -5.0% | -4.8% | -1.4% | | | | | | | | | | | | |
| | **Outpatient metrics** | | | | | | | | | | | | | | | | | | |
| | Overdue Follow up Appts | | | 16,393 | 16,523 | 16,649 | 16,503 | 46,566 | 36,798 | 25,671 | 32,621 | 33,268 | 33,840 | 32,999 | 32,757 | 33,369 | | | |
| | % DNA Rate | | 5% | 7.1% | 7.1% | 6.7% | 6.4% | 6.7% | 6.9% | 8.3% | 8.3% | 8.0% | 7.4% | 6.8% | 6.5% | 7.5% | | | |
| | Patient cancellation rate | | | 14.0% | 12.9% | 12.9% | 13.2% | 12.7% | 10.5% | 10.7% | 11.2% | 10.5% | 11.4% | 11.0% | 10.5% | 12.3% | | | |
| | % non face to face (telemedicine) attendances | | 25% | 27.8% | 26.5% | 25.7% | 25.8% | 24.0% | 22.6% | 22.9% | 22.5% | 21.8% | 21.1% | 20.4% | 20.0% | 16.1% | | | |
| DM 01 | **Diagnostic Performance (DM01)** | | | | | | | | | | | | | | | | | | |
| | % of >6 week performance | | 1% | 14.3% | 18.3% | 13.1% | 15.9% | 19.9% | 18.6% | 19.5% | 20.2% | 22.6% | 20.0% | 16.4% | 11.0% | 13.6% | | | |
| Cancer | 2 week wait (RBH not being monitored) | | | - | - | - | - | | | | | | | | | | | | |
| | 62 day standard | | 85% | 70.0% | 71.6% | 65.5% | 71.3% | 71.5% | 69.6% | 73.4% | 66.2% | 65.9% | 71.2% | 69.4% | 64.3% | | *latest position nov22* | | |
| | 28 day faster diagnosis standard | | 75% | 65.4% | 60.4% | 72.3% | 73.3% | 71.9% | 71.8% | 66.9% | 63.6% | 62.9% | 64.7% | 63.1% | 59.6% | | *latest position nov22* | | |
| Emergency Dept | Arrival time to initial assessment | | 15 | 4.0 | 4.0 | 6.0 | 7.0 | 7.0 | 9.0 | 18.0 | 21.6 | 30.0 | 15.0 | 16.0 | 15.0 | 20.5 | | | |
| | Clinician seen <60 mins % | | | 30.6% | 31.6% | 23.7% | 21.6% | 26.9% | 24.4% | 20.0% | 20.9% | 26.6% | 26.0% | 25.5% | 24.3% | 21.8% | | | |
| | PHT Mean time in ED | | 200 | 298 | 297 | 285 | 300 | 307 | 296 | 317 | 297 | 295 | 303 | 325 | 307 | 357 | | | |
| | RBCH Mean Time in ED | | 200 | 304 | 294 | 321 | 374 | 314 | 302 | 300 | 329 | 355 | 406 | 355 | 347 | 433 | | | |
| | Patients >12hrs from DTA to admission | | 0 | 34 | 73 | 60 | 89 | 188 | 88 | 105 | 97 | 103 | 129 | 295 | 157 | 343 | | | |
| | Patients >12hrs in dept | | | 418 | 517 | 548 | 879 | 758 | 626 | 769 | 879 | 779 | 886 | 1292 | 1074 | 2000 | | | |
| | ED attendance Growth (YTD) | *vs prev yr* | | 31.5% | 30.2% | 31.2% | 30.5% | -3.0% | -0.3% | -0.2% | -2.2% | -6.4% | -7.5% | -1.7% | 2.3% | -0.2% | | | |
| | | *vs 19/20* | | 2.8% | 0.7% | 0.5% | 2.9% | 64.3% | 29.4% | 37.2% | 20.5% | 5.4% | 6.6% | 20.0% | 31.0% | 29.3% | | | |
| SWAST SCAST | Ambulance handover growth (YTD) | *vs prev yr* | | 2.7% | -1.3% | -2.0% | -3.3% | 7.8% | 9.9% | -13.6% | -19.9% | -8.2% | -3.6% | -3.7% | 2.6% | -10.8% | | | |
| | | *vs 19/20* | | -0.4% | -5.9% | -7.2% | -7.6% | 43.0% | 29.4% | -16.4% | -15.7% | -14.9% | -14.8% | -18.5% | -8.4% | -11.5% | | | |
| | Ambulance handover 30-60mins breaches | | | 281 | 362 | 349 | 280 | 315 | 469 | 462 | 449 | 490 | 371 | 401 | 496 | 765 | | | |
| | Ambulance handover >60mins breaches | | | 164 | 510 | 655 | 727 | 557 | 606 | 629 | 642 | 445 | 547 | 666 | 583 | 1568 | | | |
| Patient Flow | Emergency admissions growth (YTD) | *vs prev yr* | | 14.4% | 11.5% | 10.9% | -7.2% | 0.0% | -1.7% | -9.7% | -11.8% | -11.9% | -8.4% | -11.7% | -0.6% | -8.4% | | | |
| | | *vs 19/20* | | -4.1% | -8.0% | -8.6% | 9.5% | 66.1% | 30.2% | 3.6% | -3.5% | -10.2% | -9.3% | -10.7% | 3.3% | 2.1% | | | |
| | Bed Occupancy (capcity incl escalation) | | 85% | 91.3% | 94.9% | 94.4% | 93.7% | 94.7% | 94.3% | 93.4% | 93.6% | 93.4% | 92.8% | 94.2% | 92.7% | 93.3% | | | |
| | Stranded patients: | | | | | | | | | | | | | | | | | | |
| | Length of stay 7 days | | | 500 | 553 | 544 | 530 | 549 | 539 | 539 | 543 | 577 | 567 | 605 | 550 | 522 | | | |
| | Length of stay 14 days | | | 318 | 360 | 359 | 339 | 361 | 355 | 360 | 357 | 400 | 397 | 421 | 375 | 332 | | | |
| | Length of stay 21 days | | 108 | 224 | 260 | 253 | 238 | 247 | 254 | 256 | 255 | 295 | 303 | 315 | 281 | 228 | | | |
| | Non-elective admissions | | | 5621 | 5823 | 5301 | 5899 | 5485 | 6401 | 5802 | 5778 | 5367 | 5472 | 5535 | 5817 | 5956 | | | |
| | > 1 day non-elective admissions | | | 3575 | 3817 | 3339 | 3747 | 3488 | 4081 | 3633 | 3652 | 3396 | 3475 | 3578 | 3676 | 3905 | | | |
| | Same Day Emergency Care (SDEC) | | | 2044 | 2004 | 1961 | 2149 | 1994 | 2317 | 2168 | 2126 | 1971 | 1996 | 1956 | 2141 | 2050 | | | |
| | Conversion rate (admitted from ED) | | 30% | 32.70% | 31.40% | 28.20% | 28.70% | 29.20% | 28.40% | 26.90% | 26.50% | 26.30% | 27.60% | 25.80% | 29.10% | 28.30% | | | |

# Quality - SAFE

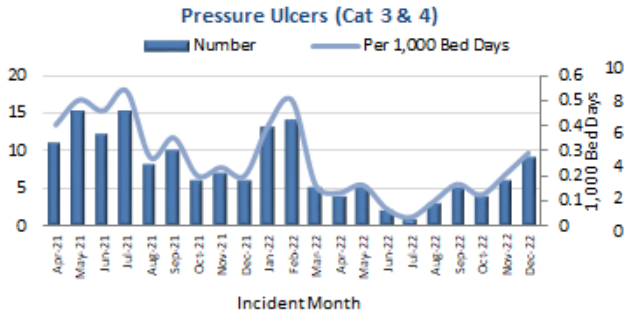
## Commentary on high level board position

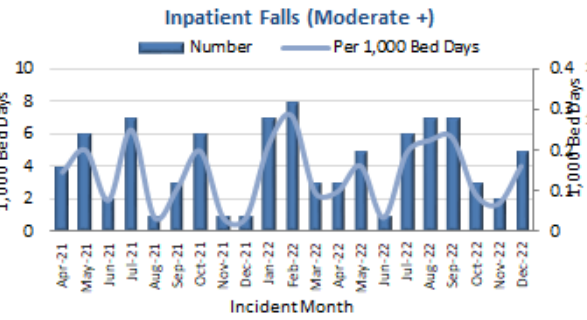
- Nine category 3 pressure ulcers reported in month, six of these are related to combination ulcers (moisture + pressure) and three are related to medical devices (2 tracheostomy sites and 1 seen on cast removal)
- There were five falls incidents in month, four were unwitnessed events with all patients sustaining #nof (severe)
- Five (5) externally reported incidents reported in month (December 22). YTD figures are lower than same period 21/22.
- No Never events reported in month (Dec 22).
- Patient Safety Incident (LERN) reporting remains consistent across the Trust.
- Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

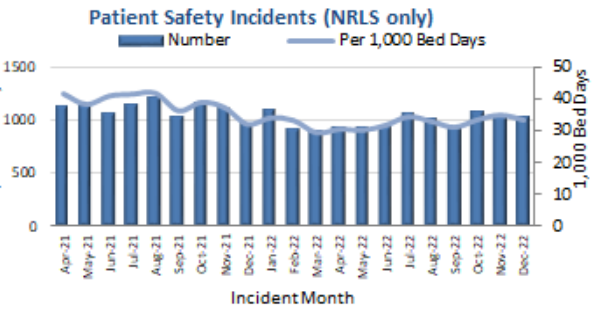
## High level Board Performance Indicators

| | | 22/23 YTD | 21/22 YTD | Variance |
|---|---|---|---|---|
| Presure Ulcers (Cat 3 & 4) | Number | 39 | 90 | -51 |
| | Per 1,000 Bed Days | 0.14 | 0.35 | -0.21 |
| Inpatient Falls (Moderate +) | Number | 39 | 31 | 8 |
| | Per 1,000 Bed Days | 0.14 | 0.12 | 0.02 |
| Medication Incidents (Moderate +) | Number | 7 | 22 | -15 |
| | Per 1,000 Bed Days | 0.03 | 0.08 | -0.06 |
| Patient Safety Incidents (NRLS only) | Number | 9,032 | 10,054 | -1022 |
| | Per 1,000 Bed Days | 32.65 | 38.80 | -6.16 |
| Hospital Associated Infections | MRSA | 2 | 1 | 1 |
| | MSSA | 31 | 33 | -2 |
| | C Diff | 68 | 57 | 11 |
| | E. coli | 52 | 66 | -14 |

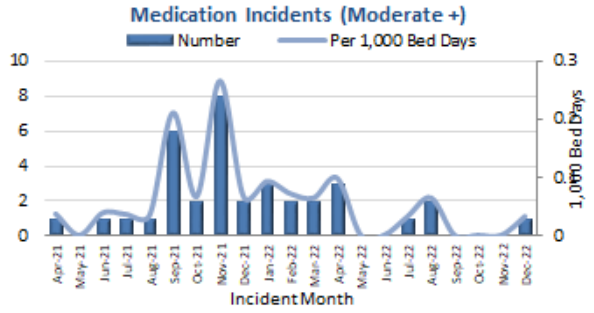
## High Level Trust Performance

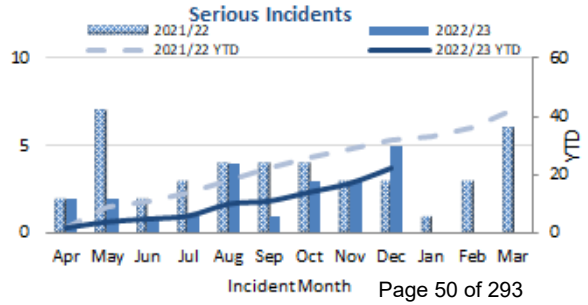


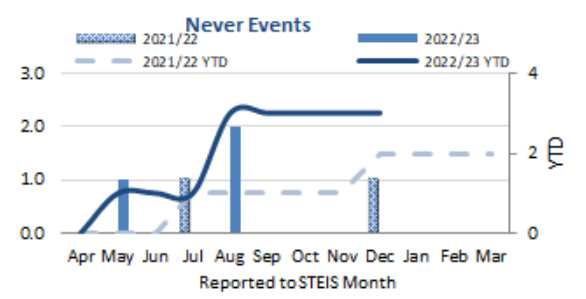




| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2 (Nov) | HAI: MSSA | 3 (Dec) | 0 (Nov) | HAI: MRSA | 0 (Dec) | 7 (Nov) | HAI: E. coli | 5 (Dec) | 4 (Nov) | HAI: C Diff (HOHA & COHA) | 5 (Dec) |



# Quality - RESPONSIVE

## Commentary on high level board position

- The eNA compliance data is not available. The eNA compliance logic remains different between sites, agreement reached and standardised logic will be applied when the two versions are merged towards the end of January 2023
- There were no instances of Mixed Sex Accomodation in December 2022.

## High level Board Performance Indicators

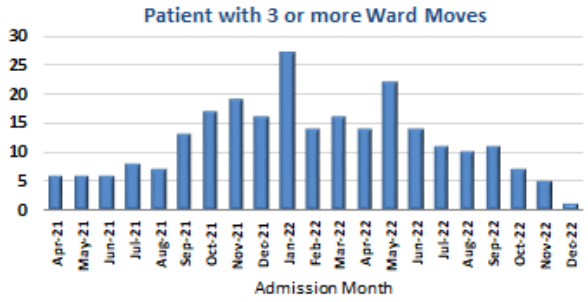
| | 22/23 YTD | 21/22 YTD | Variance |
|---|---|---|---|
| Patient with 3+ Ward Moves (Non-Clinically Justified Only) | 95 | 98 | -3 |
| Patient Moves Out of Hours (Non-Clinically Justified Only) | 643 | 655 | -12 |
| Mixed Sex Acc. Breaches Suspended Apr20 - Sep21 | 71 | 8 | 63 |

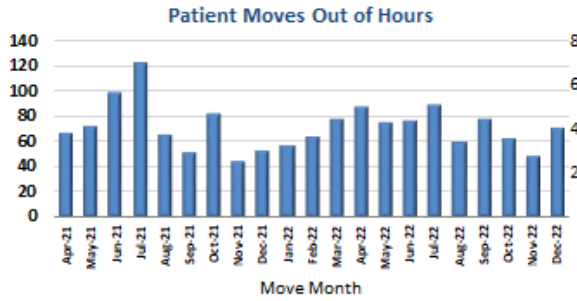
ENA Risk Assessment

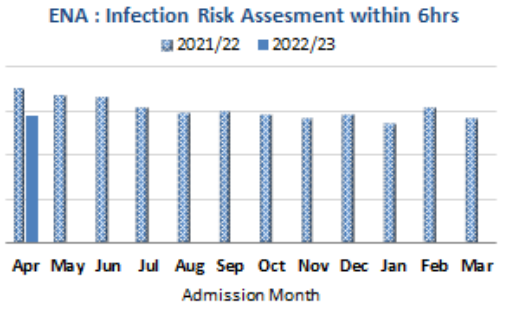
*Up to Apr 2022 only*

| | | | |
|---|---|---|---|
| Falls | 54.7% | 57.4% | -2.7% |
| Infection | 57.5% | 61.5% | -4.0% |
| MUST | 58.0% | 61.7% | -3.7% |
| Waterlow | 55.6% | 57.8% | -2.2% |

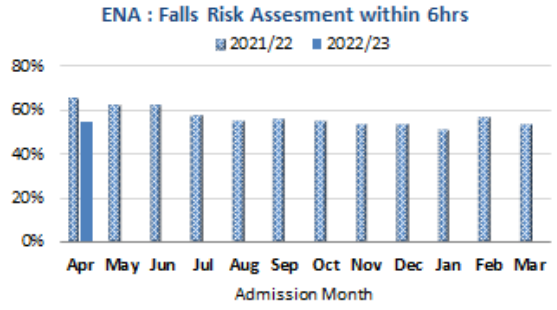
## High Level Trust Performance

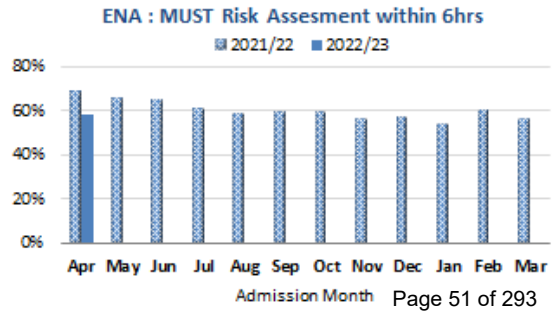


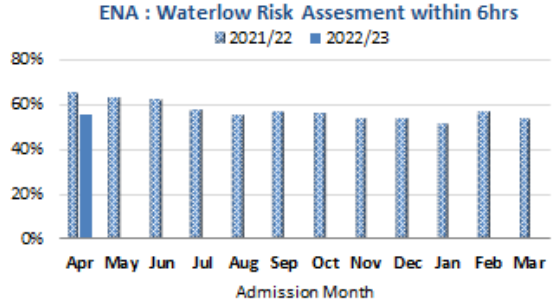




| 54.7% (Apr) | Falls | N/A | 57.5% (Apr) | Infection | N/A | 58.0% (Apr) | MUST | N/A | 55.6% (Apr) | Waterlow | N/A |
|---|---|---|---|---|---|---|---|---|---|---|---|



# Quality - EFFECTIVE AND MORTALITY

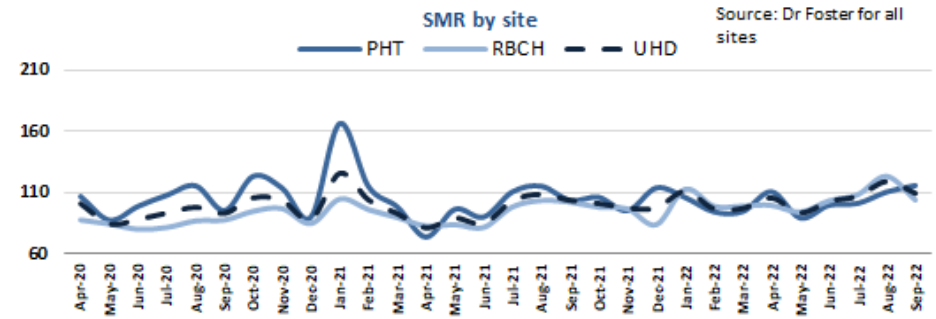
**Commentary on high level board position**

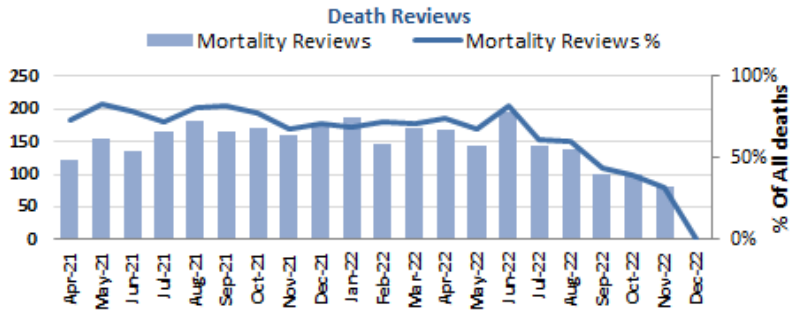
- The Mortality Surveillance Group meets monthly and reviews mortality reports from speciality M&M meetings.
- Work progresses on embedding the new UHD eLearning from Deaths process which was rolled out to remaining areas early December 2022.

**High level Board Performance Indicators**

| | | 22/23 YTD | 21/22 YTD | Variance |
|---|---|---|---|---|
| SMR (Source: Dr Foster for all sites) | Latest (Sep-22 - UHD) | 109.4 | 103.6 | |
| Patient Deaths | YTD | 2165 | 1884 | 281 |
| Death Reviews<br>Note: 3 month review turnaround target | Number | 1066 | 1427 | N/A |
| | Percentage | 49% | 76% | |
| Deaths within 36hrs of Admission | | 325 | 310 | 15 |
| Deaths within readmission spell<br>Patient readmitted within 5 days | | 192 | 138 | 54 |

**High Level Trust Performance**

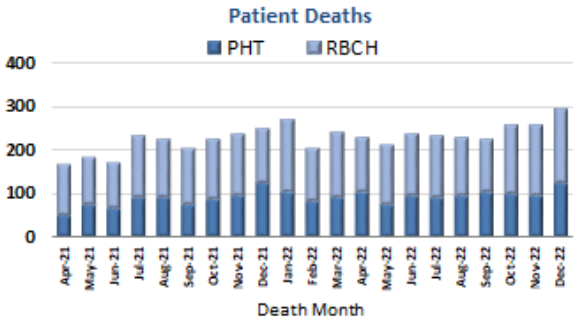


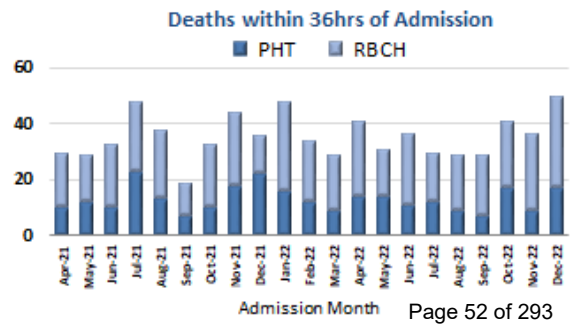



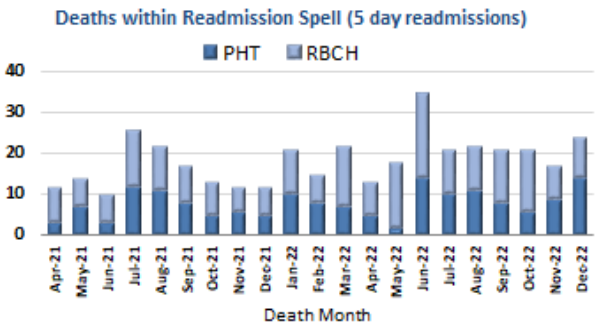

| 107.1 (Jul) | SMR | 118.9 (Aug) |
|---|---|---|

| 256 (Oct) | Patient Deaths | 256 (Nov) |
|---|---|---|

| 61.1% (Jul) | Deaths Reviewed | 60.6% (Aug) |
|---|---|---|



# Quality - CARING

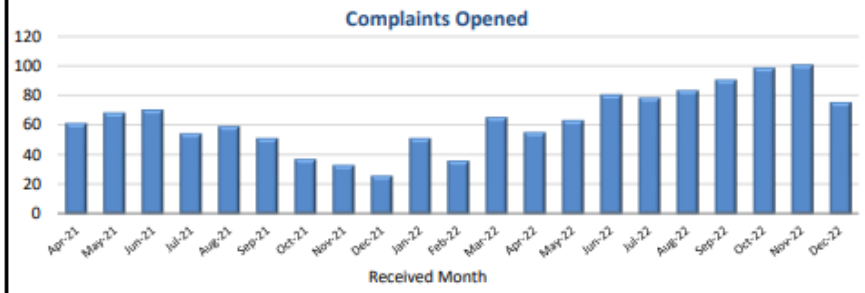
**Commentary on high level board position**

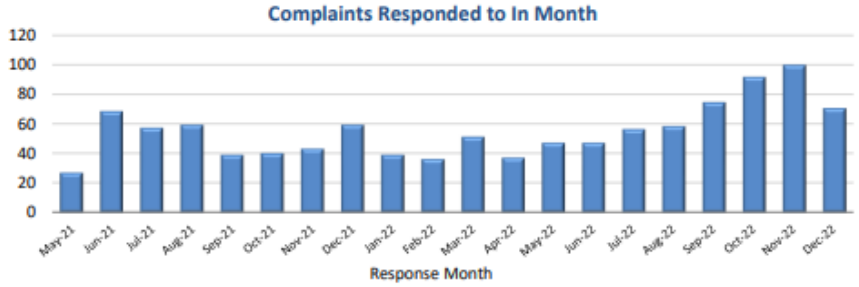
- FFT Positive responses have seen a decline at 87.8% compared with 90.2% in November. The response rate for FFT also has reduced.
- In December there were 355 PALS concerns raised, 41 new formal complaints and 33 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in December were 74. Regular meetings with the care groups continue to focus on closing of complaints.
- There were 216 outstanding open complaints including ERC, 82 of which have been open 55 working days or longer.
- The last half of December saw an increase in complaints breaching 55 days, where a steady decline in these breaches has been seen since May.
- Key themes from PALS and complaints:
  Communication – Absent or incorrect
  Organisation process – Bureaucracy, waiting times, accessing care
  Quality – Clinical Standard

**High level Board Performance Indicators**

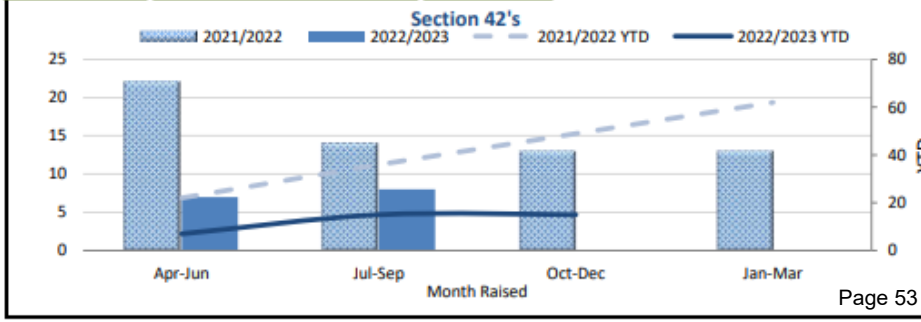
| | 22/23 YTD | 21/22 YTD | Variance |
|---|---|---|---|
| Complaints Opened | 722 | 459 | 263 |
| Complaint Response Compliance | TBC | | |
| Complaint Response in month | 579 | 430 | 149 |
| Section 42's | 15 | 49 | -34 |
| *Reported quarterly* | | | |
| Friends & Family Test | 89% | 88% | 1% |
| *New guidelines from June 2020* | | | |

**High Level Trust Performance**




| 99 (Nov) | Complaint Responses | 70 (Dec) | 100 (Nov) | Complaints Opened | 75 (Dec) | 90.2% (Nov) | FFT % V.Good/Good | 87.8% (Dec) |
|---|---|---|---|---|---|---|---|---|




# Quality - WELL LED

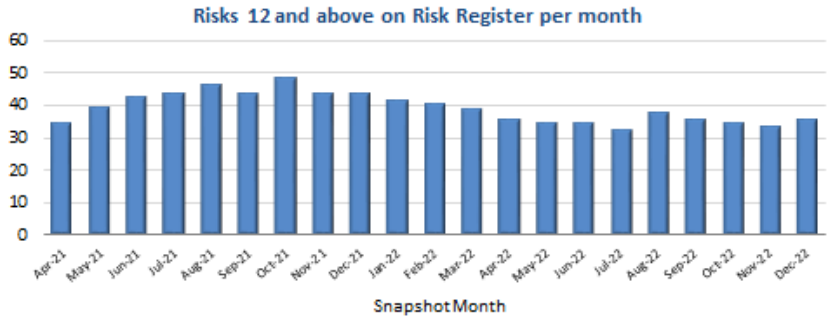
**Commentary on high level board position**

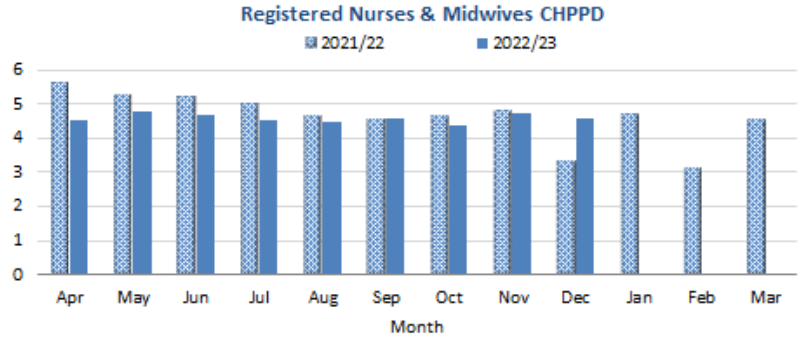
- Risk register update provided in Quality Committee, TMB, and Board report
- Heat map risk reports provided to Finance and Performance Committee, Workforce Committee and Operations and Performance Group .
- No outstanding Patient Safety Alerts

**High level Board Performance Indicators**

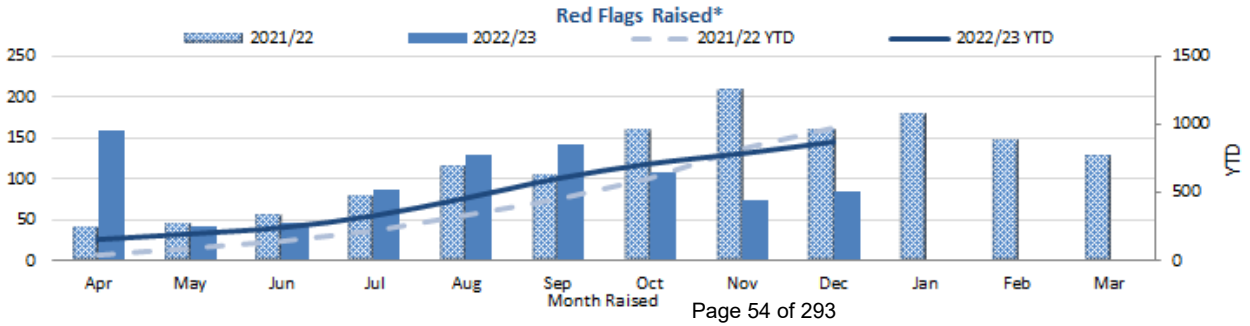
| | 22/23 YTD | 21/22 YTD | Variance |
|---|---|---|---|
| Risks 12 and above on Register | 36 | 44 | -8 |
| Red Flags Raised* | 866 | 974 | -108 |
| *Source: SafeCare from Dec21. Criteria aligned. | | | |
| Registered Nurses & Midwives CHPPD | 4.6 | 4.8 | -0.2 |
| Patient Safety Alerts Outstanding | 0 | 0 | 0 |

**High Level Trust Performance**




| 34 (Nov) | Risks 12+ | 36 (Dec) | 4.7 (Nov) | RN & RM CHPPD | 4.6 (Dec) | 74 (Nov) | Red Flags Raised | 84 (Dec) |
|---|---|---|---|---|---|---|---|---|



# Workforce

## Commentary on high level board position

**UHD turnover** has increased by 0.1% in month, overall YTD remains at 14.6%.

**Vacancy rate** is being reported at 6.3% in month, a decrease of 1.3% compared to November.

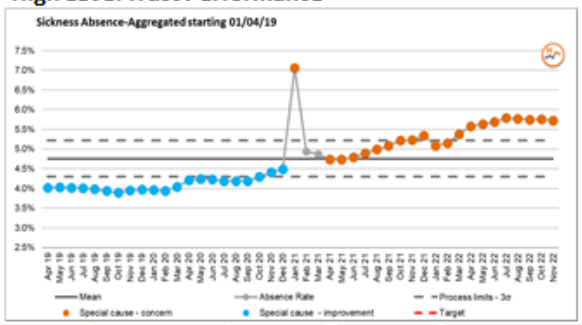
**Sickness absence** in-month for December 2022 is 6.4%, an increase of 1.1% compared to November. Latest rolling 12 month is 5.9%, an increase of 0.2% since last month.

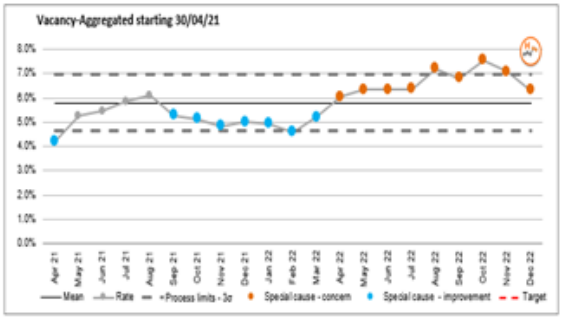
**Statutory and Mandatory training**: Overall UHD Trust compliance is standing at 85.9%, an increase of 0.1% on October. Our aim is to reach 90% across all sites. Face to face course are still proving difficult

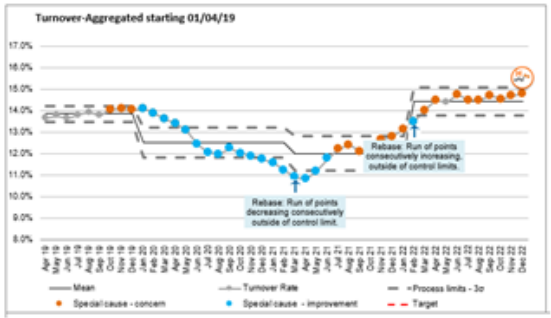
## High level Board Performance Indicators

| | | 22/23 YTD | 21/22 YTD | Variance |
|---|---|---|---|---|
| Turnover (12 month rolling) | | 14.6% | 12.0% | 2.6% |
| Vacancy | | 6.7% | 5.2% | 1.4% |
| Sickness Rate (12 month rolling) | | 5.7% | 5.0% | 0.7% |
| Appraisals | Values Based | 29.7% | 34.5% | -4.8% |
| | Medical & Dental | 59.2% | 57.3% | 1.9% |
| Statutory and Mandatory Training | | 85.4% | 87.3% | -1.9% |

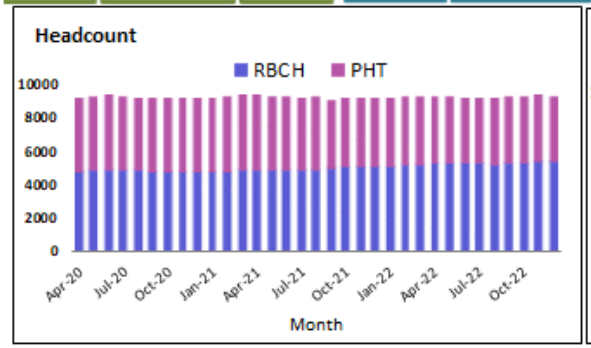
## High Level Trust Performance

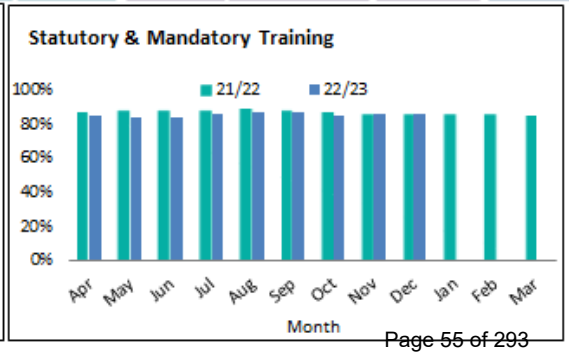


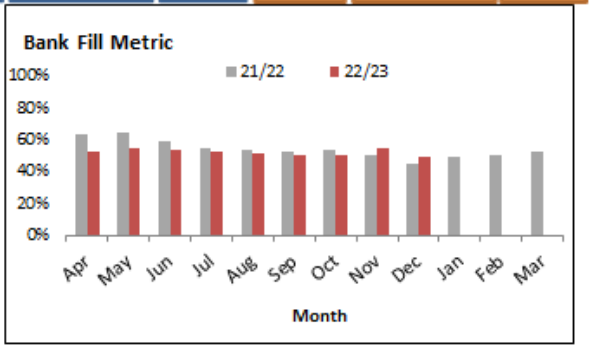



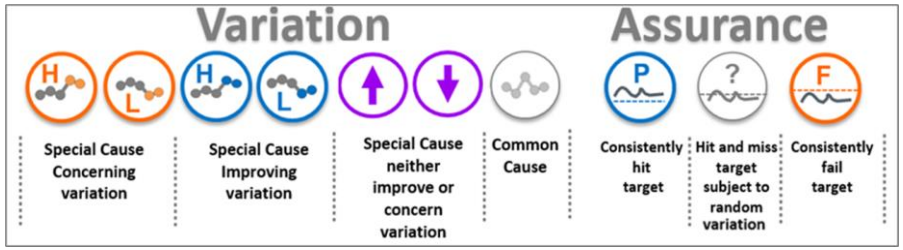

| 64.5% (Nov) | Appraisals (Medical) | 63.8% (Dec) | 55.3% (Nov) | Appraisals (Values) | 56.2% (Dec) | 14.7% (Nov) | Turnover | 14.8% (Dec) | 5.7% (Nov) | Sickness Absence | 5.9% (Dec) | 7.1% (Nov) | Vacancy | 6.3% (Dec) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|



# Statistical Process Control (SPC) – Explanation of Rankings

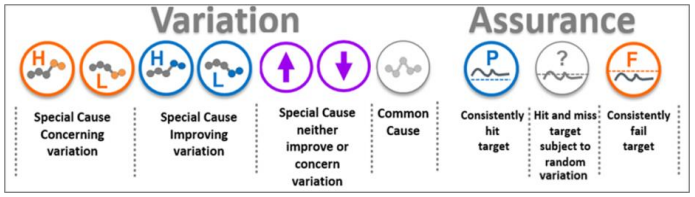



| Variation/Performance | Assurance: P | Assurance: ? | Assurance: F | Assurance: none |
|---|---|---|---|---|
| H | **Excellent** — **Celebrate and Learn**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• You are consistently achieving the target because the current range of performance is above the target. | **Good** — **Celebrate and Understand**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning** — **Celebrate but Take Action**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change. | **Excellent** — **Celebrate**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• There is currently no target set for this metric. |
| L | **Excellent** — **Celebrate and Learn**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• You are consistently achieving the target because the current range of performance is below the target. | **Good** — **Celebrate and Understand**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning** — **Celebrate but Take Action**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change. | **Excellent** — **Celebrate**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• There is currently no target set for this metric. |
| none | **Good** — **Celebrate and Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• HOWEVER you are consistently achieving the target because the current range of performance exceeds the target. | **Average** — **Investigate and Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning** — **Investigate and Take Action**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• HOWEVER your target lies outside the current process limits and the target will not be achieved without change. | **Average** — **Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• There is currently no target set for this metric. |
| H | **Concerning** — **Investigate and Understand**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• HOWEVER you are consistently achieving the target because the current range of performance is below the target. | **Concerning** — **Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• Your target lies within the process limits so we know that the target may or may not be missed. | **Very Concerning** — **Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• Your target lies below the current process limits so we know that the target will not be achieved without change | **Concerning** — **Investigate**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• There is currently no target set for this metric. |
| L | **Concerning** — **Investigate and Understand**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• HOWEVER you are consistently achieving the target because the current range of performance is above the target. | **Concerning** — **Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• Your target lies within the process limits so we know that the target may or may not be missed. | **Very Concerning** — **Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• Your target lies above the current process limits so we know that the target will not be achieved without change | **Concerning** — **Investigate**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• There is currently no target set for this metric. |
| none | | | | **Unknown** — **Watch and Learn**<br>• There is insufficient data to create a SPC chart.<br>• At the moment we cannot determine either special or common cause.<br>• There is currently no target set for this metric |

# Performance at a glance – Key Performance Indicator Matrix

## UHD Elective care

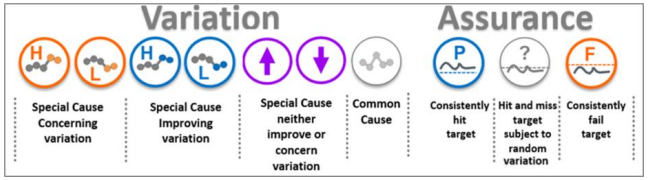
| KPI | Latest month | Actual | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| UHD - Total Waiting List Size | Dec 22 | 70259 | 51491 | | | 58279 | 53856 | 62703 |
| UHD - Patients waiting >104 wks actuals | Dec 22 | 25 | 0 | | | 134 | 42 | 225 |
| UHD - Patients waiting >78 wks actuals | Dec 22 | 478 | 0 | | | 898 | 588 | 1208 |
| UHD - Patients waiting >52 wks actuals | Dec 22 | 3472 | 0 | | | 3707 | 2827 | 4587 |
| UHD - Patients waiting >40 weeks | Dec 22 | 8696 | - | | | 7034 | 6027 | 8040 |
| UHD - Patients waiting >26 weeks | Dec 22 | 21024 | - | | | 15241 | 13351 | 17131 |
| UHD - RTT Performance against 18 week standard | Dec 22 | 55.1% | 92.0% | | | 60.3% | 56.3% | 64.2% |
| UHD - Total Diagnostic Waiting List | Dec 22 | 11771 | - | | | 10405 | 8408 | 12402 |
| UHD - % waiting over 6 weeks | Dec 22 | 14% | 1% | | | 11% | 5% | 18% |
| | | | | | | | | |
| Cancer 2ww Referrals | Dec 22 | 2231 | | | | 2980 | 1560 | 4399 |
| UHD - Faster Diagnosis Standard (FDS) 28 days | Nov 22 | 60% | 75% | | | 71% | 62% | 79% |
| UHD 62 day standard | Nov 22 | 64% | 85% | | | 73% | 63% | 82% |
| | | | | | | | | |
| UHD - Total Outpatient - Virtual (%) | Dec 22 | 20.0% | 25.0% | | | 28.7% | 24.3% | 33.0% |
| UHD Outpatient DNA rate | Dec 22 | 8% | 5% | | | 7% | 6% | 8% |
| Theatre utilisation (capped) - main | Dec 22 | 73% | 0% | | | 73% | 66% | 79% |
| Theatre utilisation (capped) - DC | Dec 22 | 69% | 91% | | | 65% | 57% | 73% |
| UHD Theatre case opportunity | Dec 22 | 23% | 15% | | | 28% | 15% | 41% |
| % of NOF patients operated on within 36 hrs of admission | Dec 22 | 43% | 85% | | | 26% | -17% | 69% |



# Performance at a glance – Key Performance Indicator Matrix

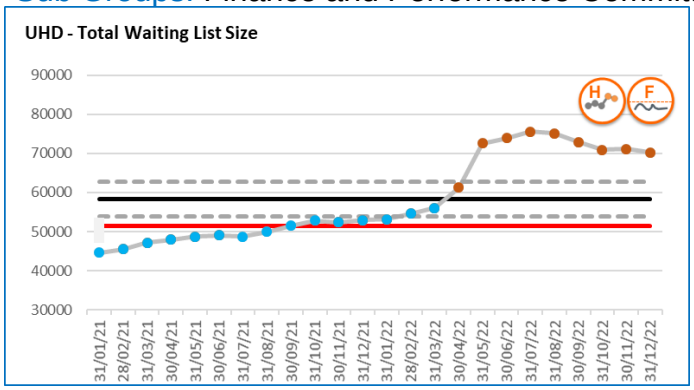
## UHD Emergency Care and Patient Flow

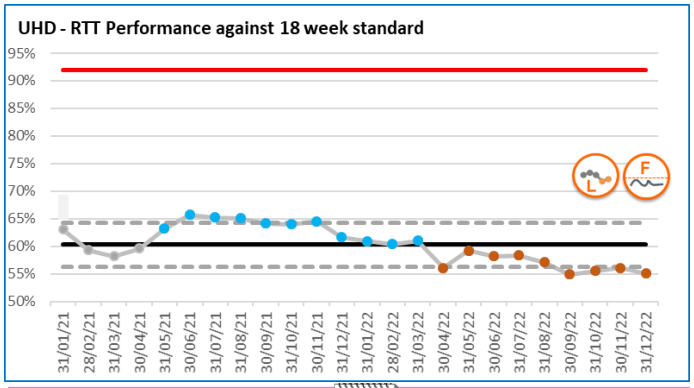
| KPI | Latest month | Actual | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Mean time in ED RBH type 1 | Dec 22 | 433 | 200 | | | 302 | 238 | 365 |
| Mean time in ED Poole type 1 | Dec 22 | 357 | 200 | | | 280 | 238 | 322 |
| Arrival time to initial assessment | Dec 22 | 21 | 15 | | | 11 | 3 | 19 |
| Clinician seen <60 mins % | Dec 22 | 22% | - | | | 27% | 17% | 37% |
| Patients >12hrs from DTA to admission | Dec 22 | 343 | 0 | | | 75 | -25 | 175 |
| Patients >12hrs in dept | Dec 22 | 2000 | - | | | 526 | 118 | 934 |
| | | | | | | | | |
| Ambulance handovers | Dec 22 | 3693 | - | | | 3976 | 3487 | 4465 |
| Ambulance handover 30-60mins breaches | Dec 22 | 765 | - | | | 352 | 161 | 542 |
| Ambulance handover >60mins breaches | Dec 22 | 1568 | 0 | | | 404 | 71 | 737 |
| | | | | | | | | |
| Bed Occupancy (capcity incl escalation) | Dec 22 | 93% | 85% | | | 91% | 88% | 95% |
| Stranded patients: Length of stay 7 days | Dec 22 | 522 | - | | | 486 | 408 | 564 |
| Stranded patients: Length of stay 14 days | Dec 22 | 332 | - | | | 306 | 243 | 369 |
| Stranded patients: Length of stay 21 days | Dec 22 | 228 | 108 | | | 211 | 162 | 260 |
| UHD NCTR % - all delays | Dec 22 | 48.0% | - | | | 50.3% | 42.0% | 58.5% |
| | | | | | | | | |
| Non-elective admissions | Dec 22 | 5956 | - | | | 5898 | 5062 | 6734 |
| > 1 day non-elective admissions | Dec 22 | 3905 | - | | | 3735 | 3143 | 4327 |
| Same Day Emergency Care (SDEC) | Dec 22 | 2050 | - | | | 2161 | 1820 | 2501 |
| Conversion rate (admitted from ED) | Dec 22 | 28.3% | 30.0% | | | 30.4% | 26.4% | 34.4% |

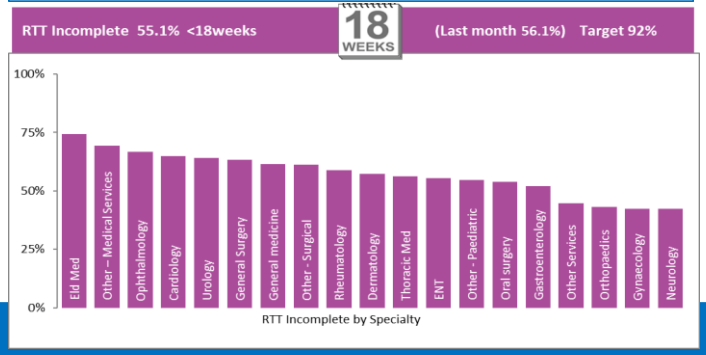


# RTT

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)
Sub Groups: Finance and Performance Committee




**Background/target description**
92% of all patients should be seen and treated within 18 weeks of referral.

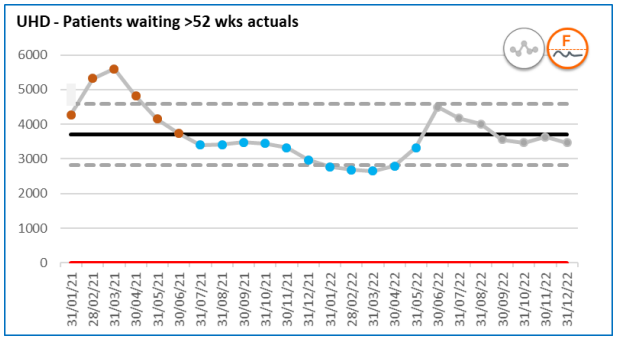
**Performance:**
55.06% of all patients were seen and treated within 18 weeks, a decrease of 0.4% on last month.
The total waiting list was 70,259 which is 659 less than last month and 5.6% above the December 2022 operational plan waiting list trajectory of 66,551.

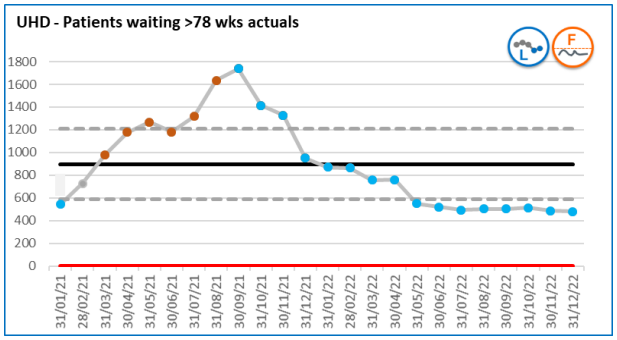
**Underlying issues:**
- Non-elective pressures, acuity, high bed occupancy and numbers of no criteria to reside patients in the hospital continued to impact elective bed base in December.
- Bank holidays in month and industrial action further reduced planned elective activity (outpatient, day case and inpatient).
- Outpatient activity and theatre utilisation levels have increased year to date but have not consistently reached the levels delivered in 2019/20.
- Increased urgent suspected cancer referrals year to date compared to previous years has impacted on first outpatient appointment capacity and prioritisation of cancer cases for surgery limits theatre capacity for non-cancer electives.

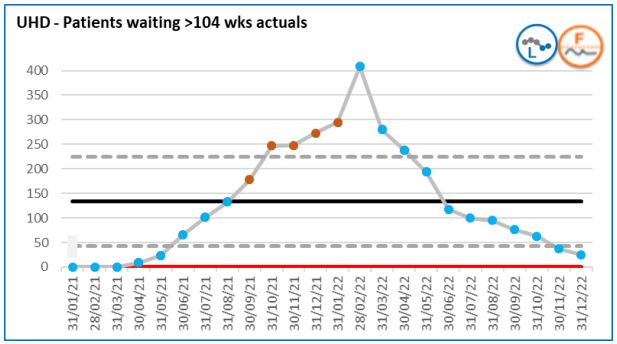
**Actions:**
- All cancelled patients are being prioritized for next available capacity but this will reduce elective capacity for P4 long waiters in January.
- Five Trust-wide improvement programmes are providing a foundation for improvements in elective care recovery: theatres, outpatients, diagnostics, cancer and data and validation optimisation.
- Additional external RTT validation resources secured via NHSE to commence in Quarter 4.
- Targeted internal validation of RTT waits <52 weeks in response to a growth in this group last month.

# RTT – Long waiters

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)
Sub Groups: Finance and Performance Committee




**Background/target description**
No waits over 104 weeks by June 2022 and no 78 week breaches by March 2023.

**Performance:**

Reduced Long waiters in all categories during December and consistent improvement evidenced for 78/104 week waits. Of the total waiting list 4.9% of patients are waiting over 52 weeks and 0.7% over 78 weeks; both are below the south west regional average.

| | Standard | Merged Trust | % of pathways with a DTA |
|---|---|---|---|
| **Referral To Treatment** | | | |
| 18 week performance % | 92% | 55.1% | |
| Waiting list size | 51,491 | 70,259 | 18% |
| Waiting List size variance compared to Sep 2021 % | 0% | 36.4% | |
| No. patients waiting 26+ weeks | | 21,024 | 22% |
| No. patients waiting 40+ weeks | | 8,696 | 28% |
| No. patients waiting 52+ weeks (and % of waiting lis | 4.9% | 3,472 | 39% |
| No. patients waiting 78+ weeks | | 473 | 63% |
| No. patients waiting 104+ weeks | | 25 | 48% |
| % of Admitted pathways with a P code | | 99.71% | |

**Underlying issues:**

- Surgical prioritisation of urgent (including cancer) patients impacts on capacity for lower clinical priority long waiting patients in some specialities such as Colorectal, breast, oral surgery and gynaecology. Elective cancellations in month reduced capacity further.
- Orthodontic waits are reducing following appointment of consultant in November. Regional mutual aid request enacted for colorectal surgery. Additional capacity outside the Trust to support reducing waits in our most challenged specialities due to workforce gaps or capacity is limited.
- Patient complexity and patient choice continue to impact breaches. New national patient choice reporting guidance has been implemented.

**Actions:**

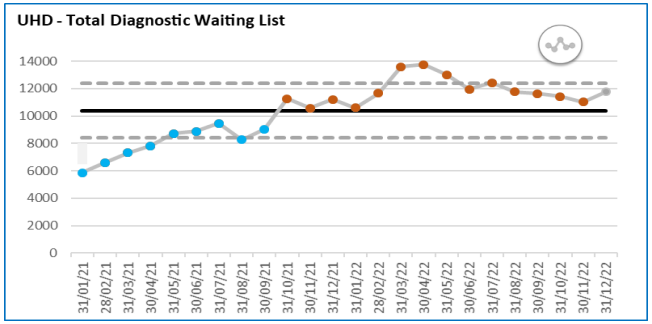
- Demand and capacity reviews are taking place in Gastroenterology, Gynaecology, Colorectal and Radiology.
- Validation hubs have taken place in ENT, Colorectal and Gastroenterology, with OMF and Paediatrics to adopt this approach in January 23.
- Use of additional insourcing or waiting list initiatives in gynaecology, OMF, community paediatrics and gastroenterology.
- Use of sub-contract arrangements to support treatment of long waiting patients in the independent sector.

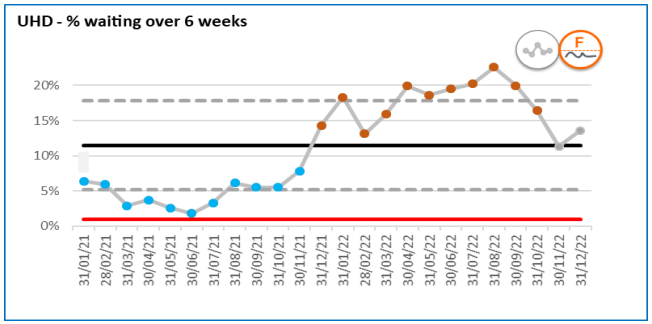
# Diagnostic Waits

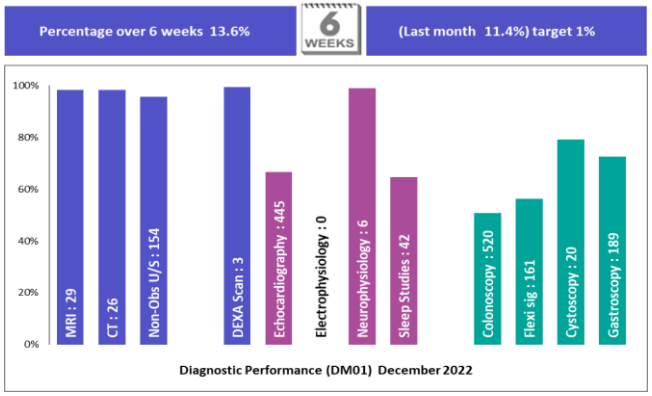
Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)
Sub Groups: Finance and Performance Committee

**Diagnostic Performance (DM01)**

| | | | | |
|---|---|---|---|---|
| % of >6 week performance | *(6+ Weeks / Total)* | 1% | 1595/11771 | 13.6% |




**Background/target description :**
Less than 1% of patients should wait 6 weeks or more for a diagnostics test

**Performance:**
Decrease against November position from 88.8% to 86.4% of all patients being seen within 6 weeks of referral.

- Endoscopy position has decreased from 60.6% in November to 59.8% in December.
- Echocardiography has decreased from 70.0% in November to 66.6% in December
- Neurophysiology has decreased from 99.3% in November to 99.1% in December
- Radiology has decreased from 99.7% in November to 97.2% in December

**Underlying issues:**

- Endoscopy experiencing continued reliance on insourcing to manage backlog
- Echocardiology – insourcing supporting high staff vacancies, traction on reducing backlog evident with early indications that trajectory will deliver recovery in year but remains fragile to variation and external influences, some COVID sickness in December set back recovery approx. 2 weeks
- Imaging position deteriorated predominately due to capacity in Ultrasound (reduced AECC and WLI's due to Christmas / New Year and COVID absences) and a reduction in cardiologist CT / MRI sessions.

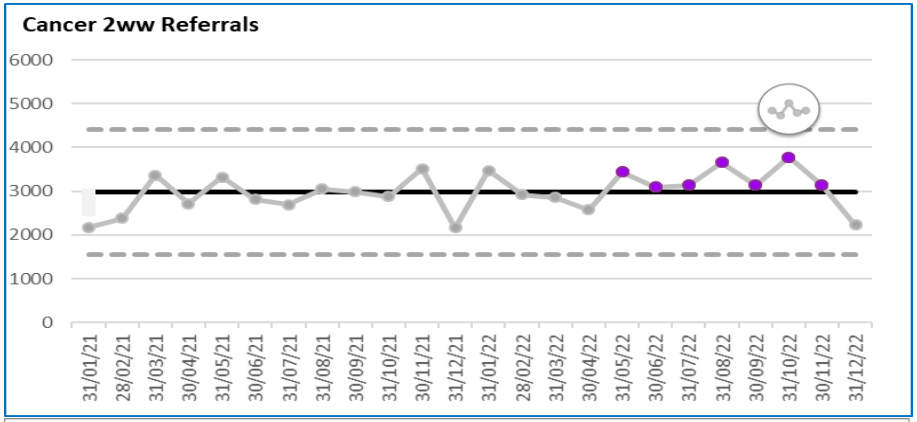
**Actions:**

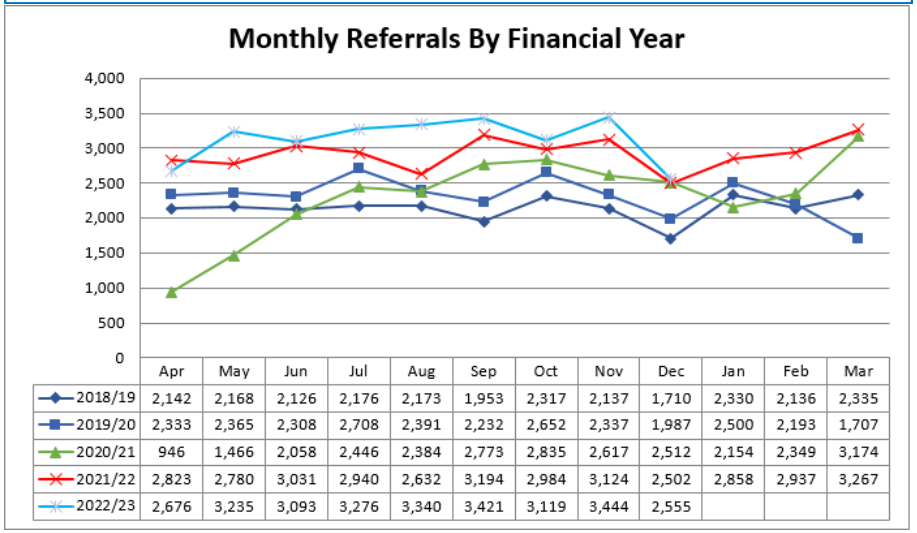
- Endoscopy – Running 3 rooms per day at weekends commencing January. Business cases submitted as part of Community Diagnostic Centre (CDC) bid and NHSE capital and revenue for sustainable services, outcome awaited.
- Require assistance from Cardiology for cardiac CT and MR; currently being covered predominately by specialist radiologists.
- Further assistance from AECC in January and February to increase ultrasound capacity further.

# Cancer Referrals

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)
Sub Groups: Finance and Performance Committee

## Urgent Suspected Cancer Referrals




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2018/19 | 2,142 | 2,168 | 2,126 | 2,176 | 2,173 | 1,953 | 2,317 | 2,137 | 1,710 | 2,330 | 2,136 | 2,335 |
| 2019/20 | 2,333 | 2,365 | 2,308 | 2,708 | 2,391 | 2,232 | 2,652 | 2,337 | 1,987 | 2,500 | 2,193 | 1,707 |
| 2020/21 | 946 | 1,466 | 2,058 | 2,446 | 2,384 | 2,773 | 2,835 | 2,617 | 2,512 | 2,154 | 2,349 | 3,174 |
| 2021/22 | 2,823 | 2,780 | 3,031 | 2,940 | 2,632 | 3,194 | 2,984 | 3,124 | 2,502 | 2,858 | 2,937 | 3,267 |
| 2022/23 | 2,676 | 3,235 | 3,093 | 3,276 | 3,340 | 3,421 | 3,119 | 3,444 | 2,555 | | | |

## High Level Performance Indicators

| Cancer Standards | Standard | UHD Nov-22 | Predicted Dec-22 |
|---|---|---|---|
| 31 day standard | 96% | 97.1% | 96.4% |
| 62 day standard | 85% | 64.3% | 60.2% |
| 28 day faster diagnosis standard | 75% | 59.6% | 67.8% |

**Background/target description**
Number urgent suspected cancer referral

**Performance:**
Continued increase in 2ww referrals year to date compared to previous years. December saw an increase of 22% compared with December 2019. The sites seeing the biggest increase in December are colorectal (+46%), gynae (+35%) and Head & Neck (+29%).

The total number on the UHD PTL reduced in December to just below 3600. This represents the 14th highest PTL when compared nationally.

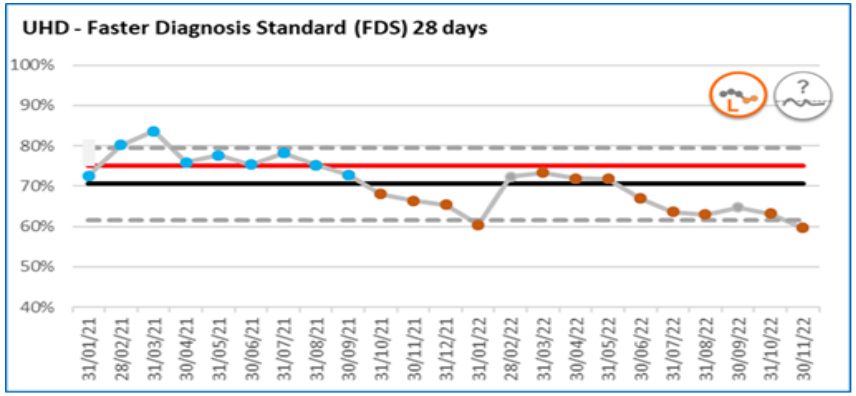
**Underlying issues:**
- Higher rates of 2ww referrals than expected resulting in increase in numbers requiring treatment and tracking.
- Largest volume of backlogs in gynaecology, colorectal and urology.

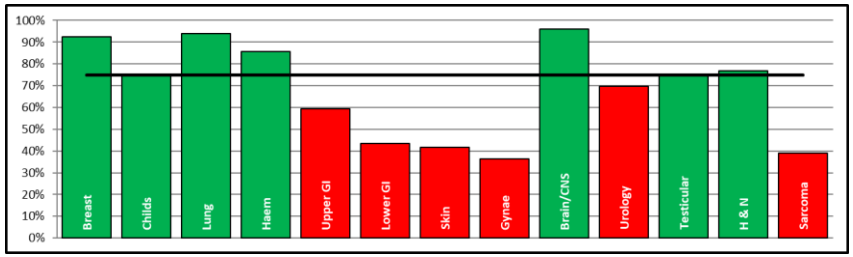
**Actions:**
- New FIT <10 pathway launched in January 23, expecting to impact on reducing GP colorectal referrals.
- Cancer improvement programme in place.

# Cancer FDS and 31 Day

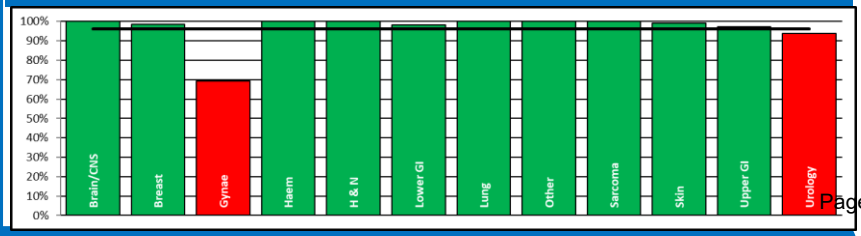
Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)
Sub Groups: Finance and Performance Committee

**28 Day Faster Diagnosis Standard (Target 75%)**
November Performance by Tumour Site (59.6%)




**31 Day Standard (Target 96%)**
November Performance by Tumour Site (97.1%)




**Background/target description:**

- Patient informed of diagnosis within 28 days from referral
- 96% of patients receive their 1st treatment within 31 days
- 94% of patients receive their subsequent surgery within 31 days
- 85% of patients receive their 1st treatment for cancer within 62 days
- The number of 62-day patients waiting 63 days or more in their pathway

**Performance:**

**28 Day:** Performance in November was not achieved (59.6%), 7 tumour sites achieved the 75% threshold with 1 further site performing 70%. December performance is currently showing an improvement (67.8%) with 7 tumour sites achieving the threshold and a further 3 performing over 60%.

**31 Day:** Performance continues to be above the 96% threshold and is predicted to achieve in December. Gynaecology and urology did not achieve the standard in December mainly due to surgical capacity.

**62 Day:** Performance in November was below the 85% threshold (64.3%), however remains above the current national average of 61.3%. Performance in December is currently at 60.2% however this is expected to increase as treatments are reported.

**PTL > 62 Days:** The average number of patients over 62 days on the PTL reduced to 293 in November, compared to 306 in October. This equates to 7.6% of the total PTL with a plan to reduce this to 6.4% to align with national requirement by March 2023. December saw the backlog further reduce to 241.

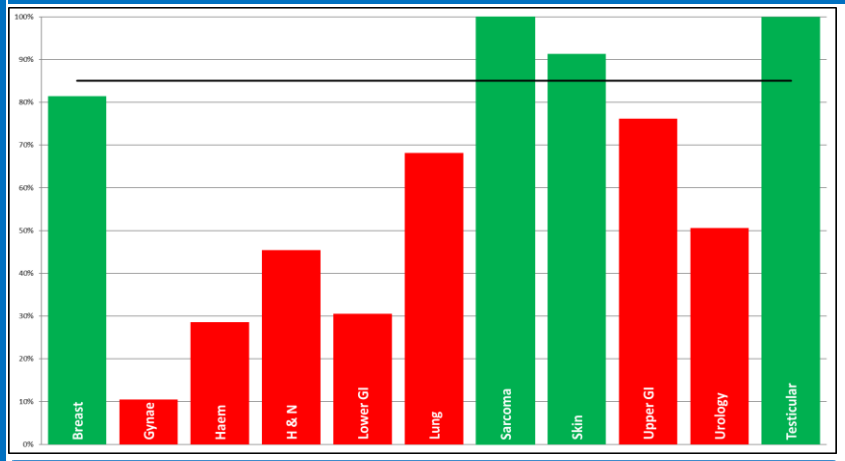
**Underlying issues:**

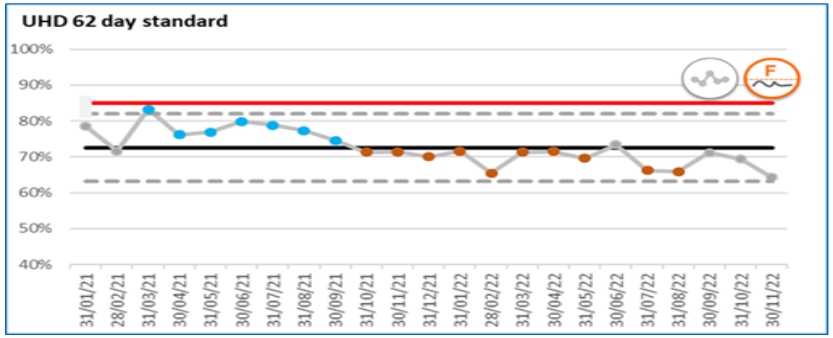
- Unmitigated theatre staffing shortfalls and bed occupancy impacting on surgical and bed capacity.
- Impact of demand on first OPA capacity, pathology reporting turn-around times, hysteroscopy and LA template biopsy capacity, waits for 1st oncology OPA's.

# Cancer 62d and PTL > 62 Days

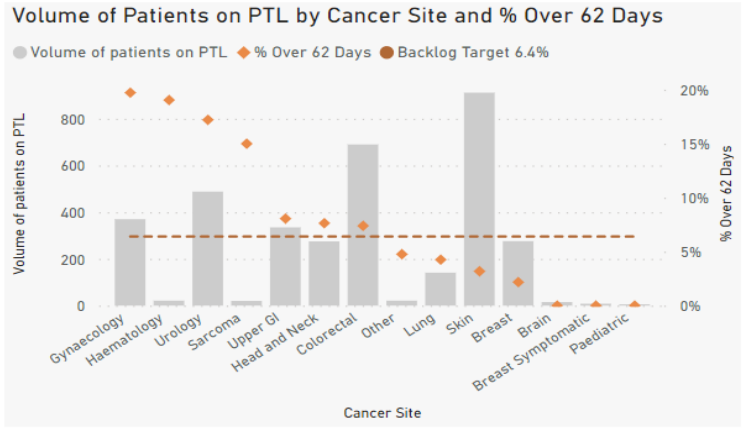
Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)
Sub Groups: Finance and Performance Committee

**62 Day Standard (Target 85%)**
November Performance by Tumour Site (64.3%)




| | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|
| Plan | 175 | 165 | 175 | 175 | 160 | 159 |
| Revised Plan | 315 | 305 | 286 | 265 | 240 | 209 |
| Current | 306 | 293 | 241 | | | |

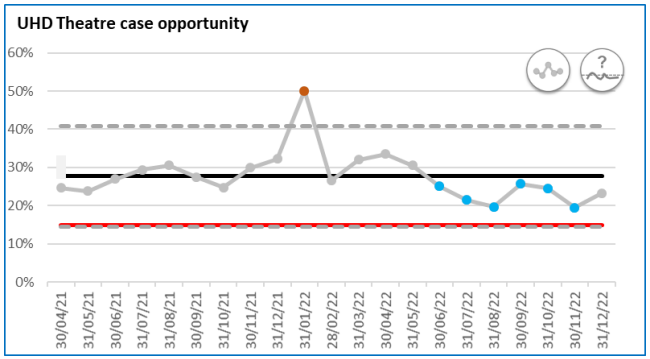


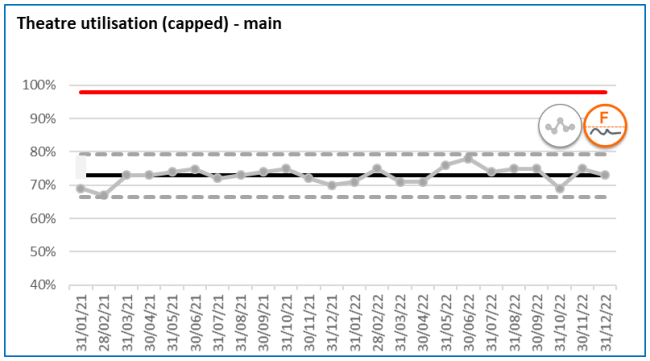

**Actions:**

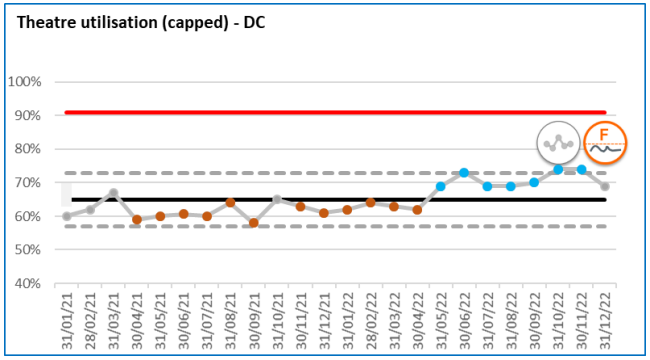
- Directorate escalation process embedded weekly to focus on patients >62 days.
- Directorates have confirmed additional 1st OPA capacity plans between Jan – March 23. Priority sites are skin, colorectal, gynae and urology. Additional funding to support recovery secured from Wessex Cancer Alliance (WCA).
- Pathway Navigators for colorectal and gynaecology in post with new posts commencing in January (will cover pathology, prostate, IDA & skin).
- Additional LA template biopsy sessions planned following sonographer training.
- Iron Deficiency Anaemia (IDA) pathway across both sites is being streamlined.
- New reporting guidance which impacts on the reporting of skin treatments was implemented in December, which will reduce the PTL size.
- Additional waiting list initiative sessions in colorectal, gynaecology and skin planned.
- Targeted validation of colorectal, skin, gynaecology and urology PTL

# Theatre Utilisation

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Abigail daughters (GDO)
Sub Groups: Finance and Performance Committee




**Background/target description**

Trust pursuing a capped utilisation of 85% which takes into consideration downtime between patients. Capped utilisation <65% will trigger external intervention/support. Intended utilisation is the utilisation booked into lists and excludes any on the day / 1-day prior cancellations. Theatre utilisation as reflected below includes emergency trauma lists which will be lower than capped utilisation (left) due to the unpredictable nature of emergency lists vs planned lists

**Performance:**

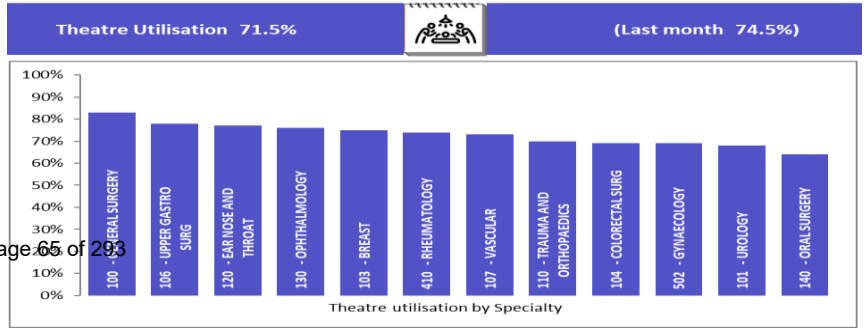
- December 2022 intended utilisation at 82% but actual utilisation of 73%.
- All efficiency markers down due to cancellations.
- Period prior to extremis saw continued and sustained improvement in early finishes, late starts, utilisation and number of lists run vs template.
- Number of lists run continues to be below template but noting an increase as compared to Oct 22.
- Staff turnover improved as compared to preceding months.

**Underlying issues:**

- Cancellation of routine activity has impacted across all efficiency markers.
- Ongoing staffing shortages across theatres.

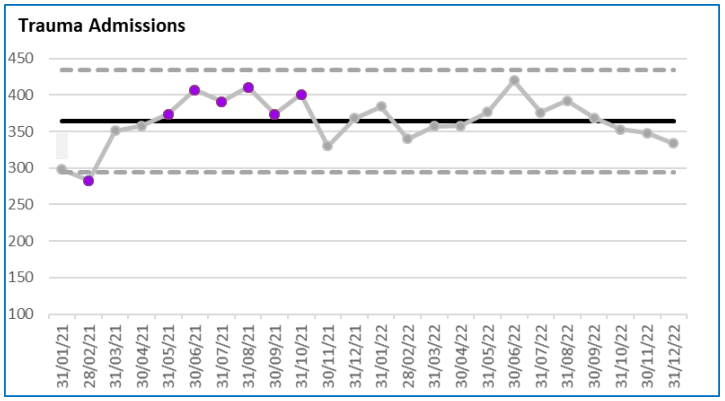
**Actions:**

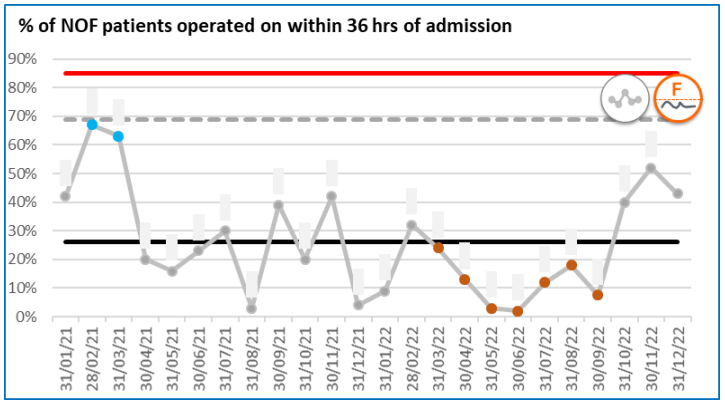
Ongoing improvement work focussing on theatre staffing, scheduling, digital solutions and pre-op assessment. Improvement plans for 2023 being drafted.



# Trauma Orthopaedics

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Abigail daughters (GDO)
Sub Groups: Finance and Performance Committee




**Background/target description**

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

**Quality Target:** 95% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission and being clinically appropriate for surgery, increasing to 95% by March 2019 (internal target remains at 95% on a monthly basis).

**Performance:**

December has seen sustained improvement in the attainment of targets for fractured neck of femur (# NoF) patients compared to September with 43% achieving surgery within 36 hours of admission and 73% within 36 hours of being fit for surgery.

The number of trauma admissions in month were within the normal variation range though there was an increase in the number of fractured NoF's admitted (99 compared with 85 in November).

No overall change in average daily NOF admissions, remains 3.25 per day.

**Underlying issues:**

Patients who breached 36 hours due to other priorities predominantly occurred mid-month where the service had 33 NoF's admitted in a 7-day period (with 13 in 2 days). Of the 99 NoF's admitted 31 were not fit to be listed on admission.

**Actions:**

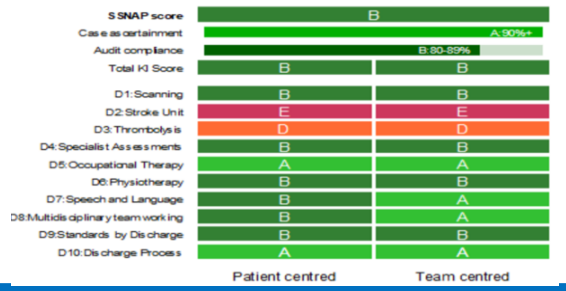
- Monthly Trauma Improvement group in place to review opportunity and blocks to safety, productivity and efficiency. Remedial action plan created and action log in place.
- Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate.
- Virtual fracture clinic capacity increased to provide same day access.
- Bed base, established bed place now in place across 4 ward areas allowing admission pathways for general trauma, lower limb fragility and COTRA pilot.
- Daily trauma escalation operational huddle in place.
- Trauma Ambulatory Care Unit (TOACU) opened at the end of July 21 80% admission avoidance rate improving to 90%. Service impacted at times of capacity issues as used for inpatient capacity. Service now had consistent ringfencing resulting in up to 40 patients/wk. with admissions avoidance >80%.
- High level of MRFD patients across trauma (45%), liaison and linking with Trust operational flow project ongoing (TAD).
- Business case for Orthogeriatrician service presented to care groups and trust management group.

# Stroke

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Alex Lister (GDO)
Sub Groups: Finance and Performance Committee

| DOMAIN | UHD SSNAP Q1 (April-June) | UHD SSNAP Q2 (July-Sept) |
|---|---|---|
| 1 Scanning | B | B |
| 2 Stroke Unit | E | E |
| 3 Thrombolysis | C | D |
| 4 Specialist Assessments | B | B |
| 5 Occupational Therapy | B | A |
| 6 Physiotherapy | C | B |
| 7 Speech and Language Therapy | C | A |
| 8 MDT Working | A | A |
| 9 Standards by discharge | B | B |
| 10 Discharge Processes | A | A |
| Audit compliance | B | B |
| Case ascertainment | A | A |
| SSNAP Level | C | B |
| SSNAP Score | 68.4 | 74.1 |

SSNAP Q2 Validated Data




**Background/target description:**
To measure the quality of care provided to stroke patients (clinical audit) and the structure of stroke services (organisational audit).
Domain levels are combined into separate patient-centred and team-centred total key indicator scores. A combined total key indicator score is derived from the average of these two scores. This combined score is adjusted for case ascertainment and audit compliance.

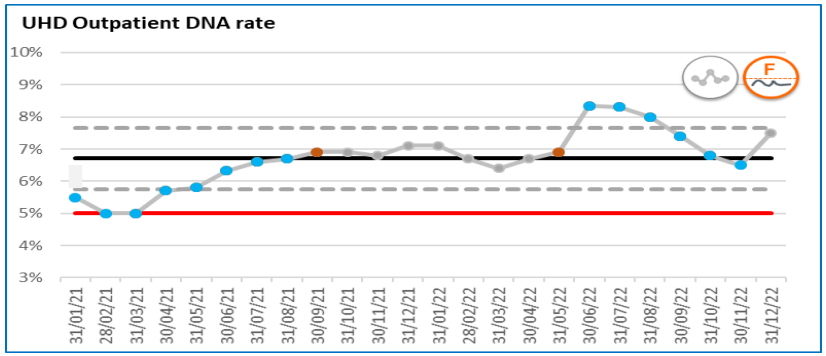
**Performance:**
- Q2 SSNAP B (improvement from Q1 C Score)
- Q3 internal reporting to date SSNAP B.

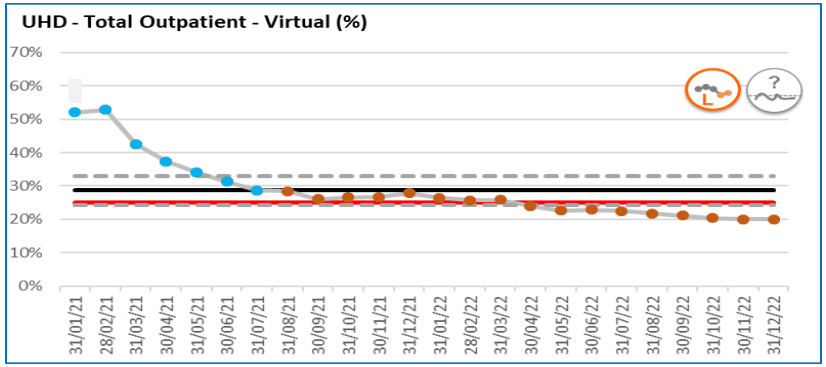
**Underlying issues:**
- Challenges with access and capacity on the stroke unit remain.
- Process mapping identified need for ambulance pre alert prior to attendance at ED.
- Timely request and access to scans in and out of hours.
- Over management of stroke mimics leading to reduced capacity in outreach team.

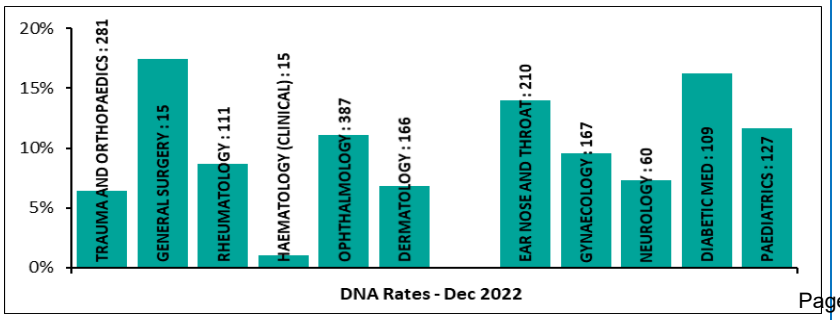
**Actions:**
- Formal consultation of reconfiguration stage 2 for stroke taking place currently. Efficiencies in workforce to optimise ambulatory and front door input and decision making.
- 1st April move to single site across two wards.
- Estates work starting on new stroke unit Summer 2023.
- Development of stroke ANP role to facilitate timely access including clerking and thrombolysis on the unit.
- Development and collaboration with SWAST re: pre alert.
- Collaborative working with radiology to improve access times to scanning.
- Reviewing SOP and developing criteria for referral to manage mimics.

# Outpatient Measures

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Sarah Macklin (GDO)
Sub Groups: Finance and Performance Committee




**Background/target description**
Reduction in DNA rate
25% of all attendances delivered virtually

**Performance:**

| | | Standard | Last Year | This Year | Trust Perf |
|---|---|---|---|---|---|
| **Referral Rates (acute only)** | | | | | |
| GP Referral Rate year on year | | -0.5% | 104159 | 86167 | -17.3% |
| Total Referrals Rate year on year | | -0.5% | 165710 | 133859 | -19.2% |
| **Outpatient metrics (acute only)** | | | | | |
| Overdue Follow Up Appointments | | | | | 33369 |
| New Appointments | | | | | 14740 |
| Follow-Up Appointments | | | | | 18060 |
| % DNA Rate | *(Total DNAs / New & Flup Atts)* | 5% | | 2652 / 32800 | 7.5% |
| Hospital cancellation rate | *Hospital Canx / Total Booked Appts)* | | | 7958 / 49498 | 16.1% |
| Patient cancellation rate | *(Patient Canx / Total Booked Appts)* | | | 6088 / 49498 | 12.3% |
| **Reduction in face to face attendances (acute only)** | | | | | |
| % telemed/video attendances | *(Total Non F-F / Total Atts)* | 25% | | 6620 / 32800 | 20.2% |

**Underlying issues:**

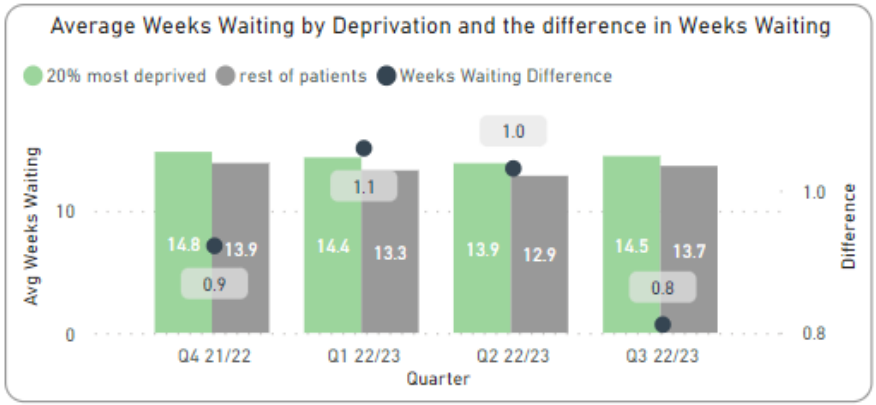
- Sustained reduction in DNA rate stalled in December due to a combination of patients not receiving letters in time due to Royal Mail industrial action, some patient confusion over clinics running due to industrial action and the holiday period.
- Continued drop-off in virtual appointments (now at 20% versus national target of 25%)
- High vacancy rates persist amongst outpatient administrative team, lower numbers of applicants for posts than previously.

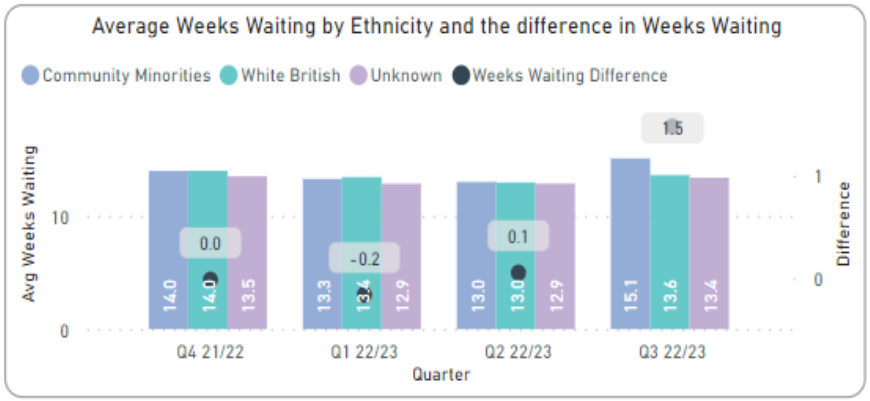
**Actions:**

- DrDoctor scheduled to launch January 2023. Soft launch undertaken of 'Quick Question' and Broadcast messaging'; to supporting fast track and short notice clinic management
- Conclusion of outpatient administration consultation.
- Planning an outpatient recruitment day plus stands at various centres and exploration of vocational scholarships.

# Health Inequalities

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)
Sub Groups: Finance and Performance Committee




**Background/target description**
Reduce inequalities in access to and outcomes of care

**Performance:**
**Waiting list by Index of Multiple Deprivation (IMD)** 8.2% of the Trust's waiting list are patients living within the 20% most deprived areas of Dorset by Index of Multiple Deprivation (IMD) (decrease of 0.2% compared to November). Analysing RTT activity, the average weeks waiting at the point of treatment among the 20% most deprived is 14.5 weeks compared to 13.7 weeks in the rest of the population treated. This variance has reduced from 1.0 weeks in Q2 to 0.8 weeks in Q3.

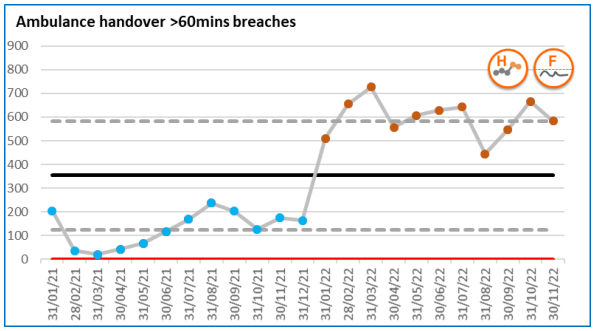
**Waiting list by ethnicity**
Where ethnicity is recorded, 10.9% of patients on UHD waiting lists are within community minority ethnic populations (increase 0.1% since November). Patients from community minority ethnic groups had a higher (1.5%) average week wait compared to patients recorded as White British in Q3. The variance has increased compared to Q2.

**Actions:**
2022/23 priority actions agreed via Trust Management Group are being delivered, including:

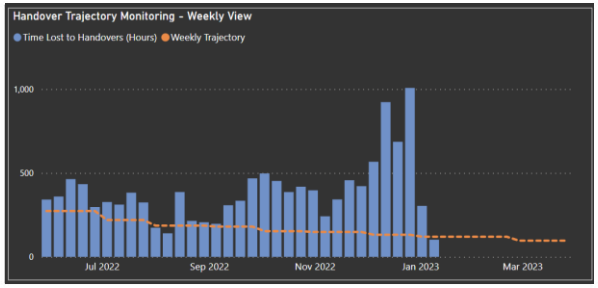
- A deep dive strategic review of DNAs and variation according to IMD and ethnicity.
- Prioritisation of people with learning disabilities and enhancing their access to care ensuring they have access to a first OPA within 18 weeks of referral.
- Development of approaches to address health inequalities through proactively targeting specific groups who do not engage e.g. access to screening programmes
- An assessment of the Trust against the CORE20PLUS5 approach.
- Publicising health inequalities training opportunities for staff.

# Ambulance Handovers

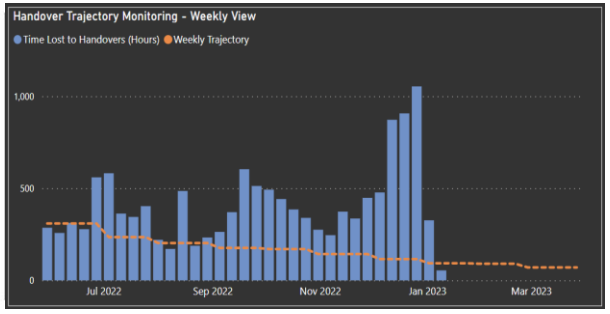
Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Alex Lister (GDO)
Sub Groups: Finance and Performance Committee




Poole – Position against Trajectory




Royal Bournemouth – Position against Trajectory




**Background/target description**
15 minutes is the target for an Ambulance to handover to a receiving ED from arrival. There is a site level recovery trajectory for lost ambulance hours per day. There should be no ambulances waiting over 60 minutes.

**Performance:**

- There was a small decrease in ambulance conveyances in December (n= 220), with RBH seeing the largest decrease of over 5 per day compared to November.
- 1,568 Ambulances waited longer than 60 minutes in December, a significant increase compared to November. Both sites deteriorated equally.
- In total there were 6,664 hours reported as lost at UHD sites in December.
- In mid December SWAST agreed to support cohorting of patients in corridors to release physical Ambulances, based on UHD data c.3500 hours of reported Ambulance delays were in cohort environments, meaning the physical Ambulances had been released back to front line work. In total SWAST saw an increase in handover delays to over 61,000 hours in December regionally .

**Underlying issues:**

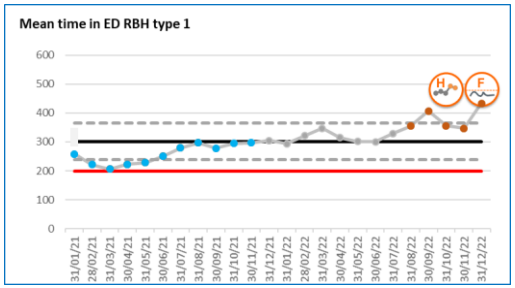
- Ambulance delays are primarily a barometer of crowding and delays in the Emergency Departments due to delays in transfers of patients that are clinically ready to proceed to an inpatient wards.
- 3rd Party Corridor support shifts are not being filled – in total 14 days at RBH and 5 at Poole were filled

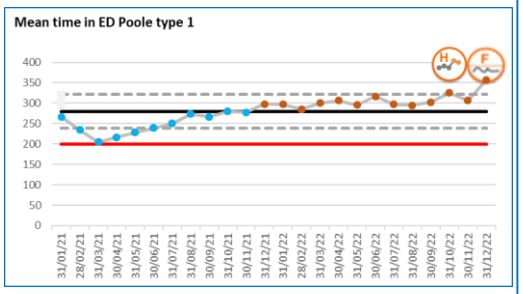
**Ongoing Actions:**

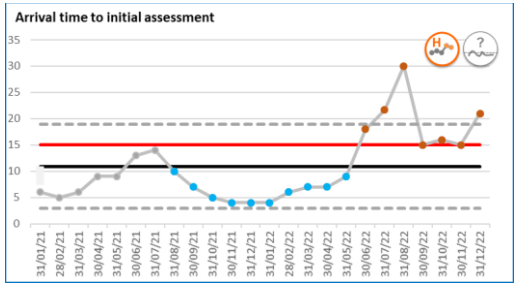
Weekly ED rapid decompression meetings continue chaired by the COO.
UHD was stepped up to Critical Incident Status a number of times in December due to ongoing pressures on flow impacting the Emergency Department

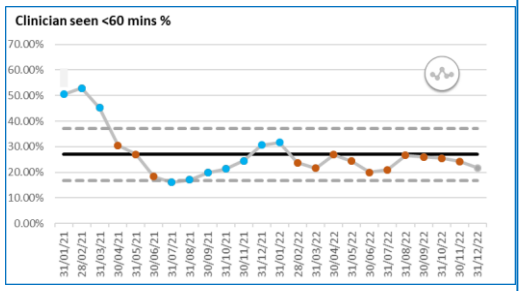
# Emergency Care Standards

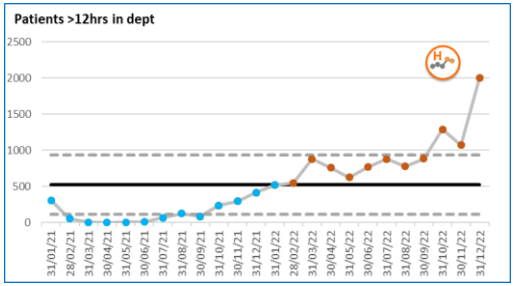
Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Alex Lister (GDO)
Sub Groups: Finance and Performance Committee

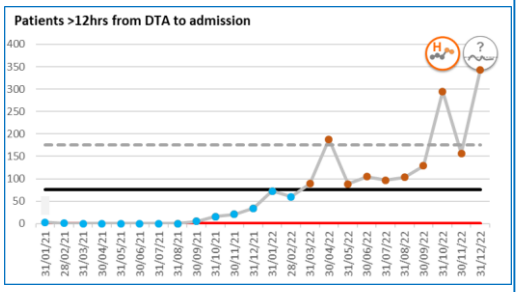



**Background/target description**

UHD continue to report against the pilot UEC standards. We are now aware that there will be a requirement to return to the 4 hour ED standard in 23/24.

**Performance:**

Overall attendances were higher than in November,+5% The average meantime for attendances increased by 68 minutes to 396 minutes (target 200 minutes) and an increase in the number of patients spending more than 12 hours in our EDs. The number of patients waiting for more than 12 hours after a decision to admit also increased by 118% to 343 (target – Zero). 2000 patients spent more that 12 hours in one of our Emergency Departments

**Underlying issues:**

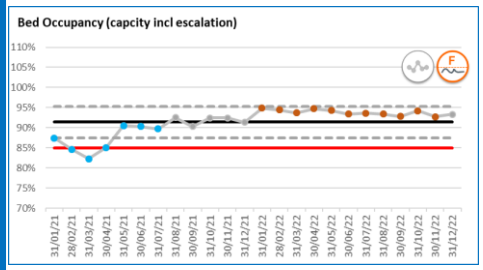
The mean time for admitted patients has increased to over 10 hours from arrival to leaving the department. This results in congestion and challenges to internal flow in the department and also drives up the overall time in the department.

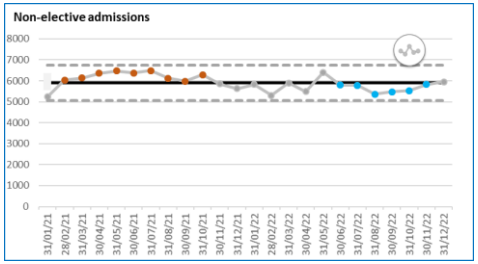
**Actions:**

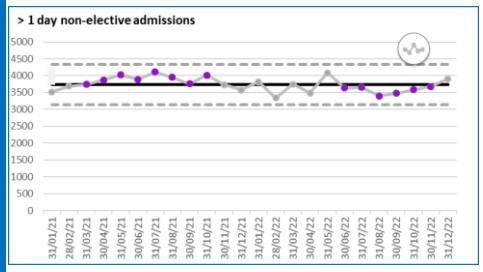
There remains an ongoing action plan for focusing on ED processes and quality, along with wider front door and Urgent Care processes, however progress and successes are hidden by factors outside the control of the ED's. There are ongoing actions regarding discharge and overall flow.

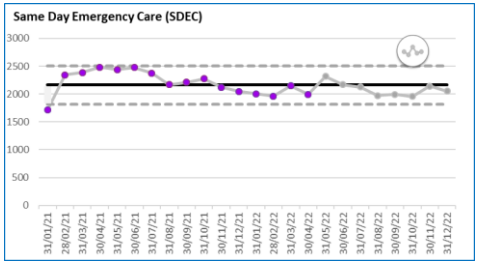
# Patient Flow

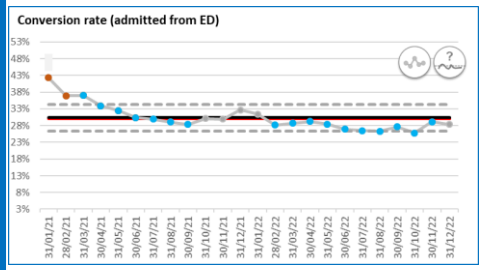
Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Alex Lister (GDO)
Sub Groups: Finance and Performance Committee




**Background/target description**
85% bed occupancy would support flow and delivery of rapid progression from the Emergency Department within an hour of being clinically ready to proceed

**Performance:**
Bed occupancy **has increased** to just over 93%, at 93.3% (+0.6%), this includes planned winter escalation but does not account for additional surge beds opened in extremis. Additional capacity has been required to support the pressures of Covid/Flu occupancy, maintaining elective activity and emergency care demand.

December saw **more patients discharged** than admitted (net improvement of 24 patients), which is expected during the Christmas period. However this did not provide the opportunity to consistently close surge capacity due to high occupancy and high MFRD levels.

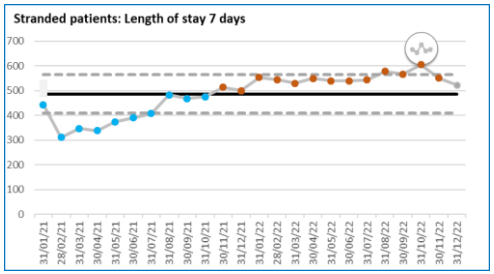
**Underlying issues:**
The ED conversion rate has **reduced to** 28.3% (-0.8%), in part driven by SDEC areas being used to support inpatient emergency flow.

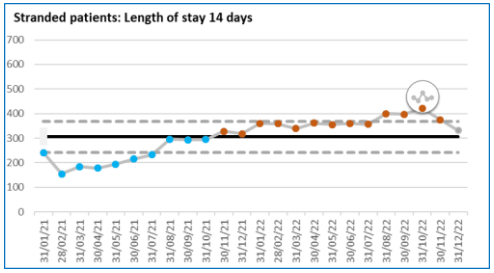
**The Actions:**
The Timely Admission and Discharge (TAD) programme gained momentum in December and continues to embed with increasing benefits. A review is expected in January.

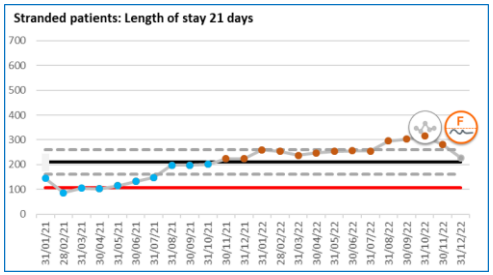
In December, the daily bed management process is being changed to a centralised model, with expected improvements in timeliness and coordination.

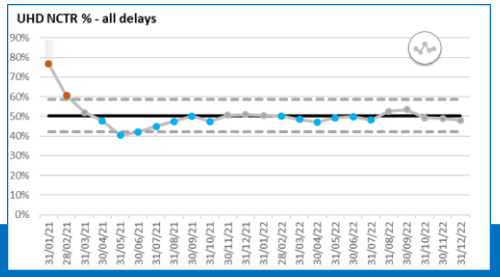
# Length of Stay and Discharges

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Alex Lister (GDO)
Sub Groups: Finance and Performance Committee




**Background/target description**
To reduce patient with no criteria to reside by 50%

**Performance:**
The average number of patients who are ready to leave/have no criteria to reside was 221 in December, **an improvement** of 37 patients per day.

- The overall delayed discharge position continues to challenge hospital flow. The overall proportion of MRTL patients is 27%, **an improvement** of 3% compared to November.
- The number of internal delays also reported **an improvement** of 2% (18% of delays were due to internal processes)

The number of patients with a length of stay over 21 days **fell in month** to 228, however remains significantly higher than pre-pandemic levels.

**Underlying issues:**
Delays in accessing community health and social care driven by capacity and funding are the significant factors impacting length of stay and numbers of patients waiting discharge.

Internal delays are reviewed and challenged daily, relative static number but with turnover.

**Actions:**
- Daily partner meetings focusing on MRFD
- Increase in Care Home capacity to support rapid decant of patients
- System site visit to take place in January to review complex patients and offer partner support
- Focus for organisation via Hospital Flow Programme Workstream 4, with an aim of improving pipeline of patients to utilise additional system capacity in quarter 4.
- Interim Director of Operations focussing on support of Discharge Services and reviewing internal and external processes.

# SCREENING PROGRAMMES

## Breast Screening

- The level of screening has been reduced through December from the significant levels processed In November in order to cope with the workload across the Christmas period where we have reduced clinic cover and the additional bank holidays.
- The round length this month has dipped to 77% which is expected due to the reduced screening numbers leading up to Christmas.
- The date first offered assessment target has not been met this month due to Radiology sickness (delayed film reading, loss of assessment clinic cover).
- The 90% round length recovery target is expected to be demonstrated in January as the screening numbers will once again be significantly increased after Christmas. A full recovery of the service is recorded when 90% round length has been reached for 3 months.
- There have been no equipment issues in December.
- Staffing numbers have remained consistent although no applicants have been received for the recent Radiologist job advert.

High Level Board Performance Indicators
**DECEMBER 2022** position :

| Breast Screening | Standard | ACHIEVED |
|---|---|---|
| Screening to Normal Results within 14 days | 95.00% | 97% |
| Screening to first offered assessment appointment within 3 weeks | 95.00% | 84% |
| Round Length within 36 months | 90.00% | 77% |
| Longest Wait Time (Months) | 36 | 37 |

## Bowel Screening

- The first two phases of age extension have been delivered and the programme is now planning for 54 year old roll out in 2023/24. The team is awaiting confirmation from the national team regarding Lynch syndrome launch which is currently scheduled for April 2023.
- The average uptake rate was 74% through 2021 (acceptable performance = >52%; achievable performance = >60%). Uptake in 2022 is averaging 72%. Age extension cohort uptake is 65%.
- The clinic wait standard continues to be maintained at 100% via virtual clinics (acceptable performance = 95%; achievable performance = 98%). Face to face clinics have now restarted at all three acute sites.
- The diagnostic wait standard has been achieved at 99%.
- The programme continues to see fluctuations in numbers of FIT positive subjects coming into clinics, which is making it challenging to plan colonoscopy capacity.
- The programme needs to develop an accredited screener development and succession plan and this is now on the risk register.

High Level Board Performance Indicators
**DECEMBER 22** position :

| Bowel Screening | Standard | ACHIEVED |
|---|---|---|
| "SSP Clinic Wait Standard (14 days) " | 95.00% | 100% |
| Diagnostic Wait Standard (14 days) | 95.00% | 100% |

# MATERNITY

| | OVERALL | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED |
|---|---|---|---|---|---|---|
| CQC Maternity Ratings Poole NHS FT last assessed Oct/~~Nov 2019~~ | GOOD | REQUIRES IMPROVEMENT | GOOD | GOOD | GOOD | GOOD |

| | |
|---|---|
| Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually) | 73.2% |
| Proportion of ~~speciality~~ trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually) | 89.3% |

NHS
University Hospitals Dorset
NHS Foundation Trust

## National position & overview

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

| Findings of review of all perinatal deaths using the national monitoring tool | Matters for Board information and awareness | Progress in achievement of NHSR/MIS Yr 4 |
|---|---|---|
| No perinatal death reviews this month<br><br>1 serious incident – antenatal patient admitted to Intensive care ( details in Safety Champions report)<br><br>No HSIB reportable cases.<br><br>POST dashboard – Apgars < 7 at 5 minutes still out of expected range both nationally and locally. Discussed potential causes to review in January MDT maternity/neonatal risk meeting for continuous audit.<br>These results are unexpected given good performance on other neonatal safety measures including low rates of perinatal deaths and low rates of reported Hypoxic Ischaemic Encephalopathy ( indicators of safe practices) as well as high standards in care bundle ATAIN - prevention of term admissions to Neonatal Unit. | • Factual accuracy submissions in process for draft CQC report of maternity services received Dec2022.<br><br>• Daily controls and monitoring of call bell systems during installation of new system ( CQC identified risk as system being upgraded during inspection visit)<br><br>• Consultation process underway for midwifery staffing of Triage unit 24/7 – currently operational 7am -1am.<br><br>• Obstetric staffing under review to improve timeliness of triage assessments for women requiring a medical review. | Safety actions assessed as compliant<br>1- Use of national perinatal mortality review tool<br>2 – Maternity services data set<br>3 – minimizing separation of mothers and babies<br>4 – effective maternity workforce planning<br>5 – effective midwifery workforce planning<br>7 – service user feedback and partnership<br>10 – reporting to NHS early notification scheme and healthcare safety investigations (HSIB)<br><br>Gaps identified for ongoing review by care group leads and maternity/neonatal safety champions in preparation for care group board and final submissions to trust board.<br>6 - saving babies lives<br>8 - training plans and compliance<br>9 - neonatal and maternity safety and quality reporting |

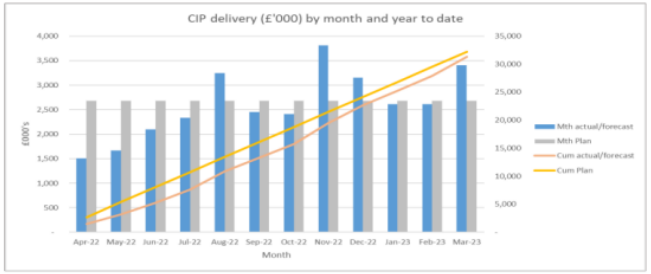
# Maternity Perinatal Quality Surveillance

| | Perinatal Quality Surveillance scorecard | Alert (national standard/average where available) | Running total/average | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|
| Perinatal | Red flags: 1:1 care in labour not provided | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 3rd/4th degree tear overall rate | > 3.5% | 1.79% | 3.2% | 1.2% | 1.4% | 1.1% | 2.6% | 2.5% | 4.1% |
| | Obstetric haemorrhage >1.5L | Actual | 74 | 10 | 9 | 13 | 6 | 14 | 7 | 12 |
| | Obstetric haemorrhage >1.5L | > 2.6% | 3.15% | 2.9% | 2.7% | 3.7% | 1.7% | 4.0% | 2.1% | 3.7% |
| | Term admissions to NNU | Actual | 0 | 17 | 15 | 14 | 8 | 14 | 18 | 19 |
| | Apgar < 7 at 5 minutes | > 1.2% | 2.3% | 2.3% | 1.5% | 3.2% | 1.9% | 3.9% | 1.5% | 2.5% |
| | Stillbirth number | Actual | 5 | 0 | 0 | 0 | 3 | 0 | 1 | 0 |
| | Stillbirth number/rate (per 1,000) | > 4.4/1000 | 2.13 | 0 | 0 | 0 | 3 | 0 | 1 | 1 |
| Workforce | Rostered consultant cover on Delivery Suite - hours pw | < 60 | 72.0 | 72 | 72 | 72 | 72 | 72 | 72 | 72 |
| | Dedicated anaesthetic cover on Delivery suite - per we | < 10 | 58.0 | 58 | 58 | 58 | 58 | 58 | 58 | 58 |
| | Midwife/band 3 to birth ratio (establishment) | 1:28 | 1:21 | | 1:21 | 1:21 | 1:21 | 1:21 | 1:21 | 1:21 |
| | Midwife/band 3 to birth ratio (in post) | 1:28 | 1:23 | | 1:23 | 1:23 | 1:23 | 1:23 | 1:23 | 1:23 |
| | Acute Maternity unfilled prospective RM shifts (pcm) | 160 pcm | | | | Not Available | | | Inaccurate | Inaccurate |
| | Maternity Ward 1-4 staff members short | Actual | | | | Not Available | | | Inaccurate | Inaccurate |
| Feedback | Number of compliments (Smiles via Badgernet) | | 306 | 92 | 44 | 31 | 73 | 65 | 66 | not available |
| | Number of concerns (PALS) | | 8 | 1 | 0 | 1 | 2 | 3 | 1 | 0 |
| | Complaints | | 26 | 5 | 4 | 3 | 4 | 1 | 2 | 1 |
| | FFT Repsonse rate ( returns as % of deliveries) | 50% | 75.3% | 100% + | 100%+ | 100% + | 88% | 95% | 100% + | not available |
| Training | Mandatory training | 90% | 78.0% | 82% | 83% | 86% | 86% | 78% | 79% | not available |
| | PROMPT/Emergency skills all staff groups | 60% | 74.1% | 52% | 55% | 55% | 62% | 74% | 76% | 93% |
| | K2/CTG training all staff groups | 60% | 80.1% | 22% | 22% | 23% | 48% | 80% | 88% | 80% |
| | CTG competency assessment all staff groups | 50% | 80.1% | 22% | 22% | 23% | 48% | 80% | 88% | 80% |
| | Core competency framework compliance | 50% | 84.7% | 83% | 87% | 87% | 80% | 85% | 80% | not available |
| | Coroner Reg 28 made directly to the Trust | | Y/N | N | N | N | N | N | N | N |
| | HSIB/CQC etc. with a concern or request for action | | Y/N | N | N | N | N | Y(CQC) | Y (CQC) | Y (CQC) |

## FINANCE

| FINANCIAL INDICATORS | Year to date | | |
|---|---|---|---|
| | Budget | Actual | Variance |
| | £'000 | £'000 | £'000 |
| Control Total Surplus/ (Deficit) | 410 | (4,221) | (4,631) |
| Capital Programme | 89,209 | 84,021 | 5,188 |
| Closing Cash Balance | 77,819 | 82,497 | 4,678 |
| Public Sector Payment Policy | 95.0% | 91.4% | (3.6)% |

| CAPITAL | Year to date | | |
|---|---|---|---|
| | Budget | Actual | Variance |
| | £'000 | £'000 | £'000 |
| Estates | 11,819 | 9,591 | 2,228 |
| IT | 5,516 | 3,558 | 1,958 |
| Medical Equipment | 1,309 | 876 | 432 |
| Donated Assets | 948 | 622 | 326 |
| Strategic Capital | 69,617 | 69,373 | 244 |
| **Total** | **89,209** | **84,021** | **5,188** |




**Commentary**

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 food and energy prices putting particular pressure on Trust budgets. Collectively, these pressures have resulted in a year to date deficit of £4.2 million.

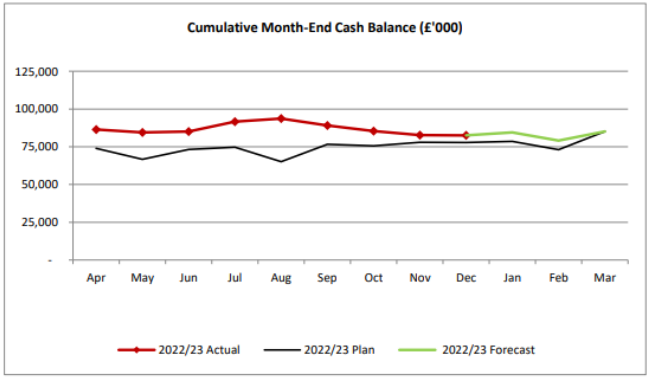
Despite the favourable forecast for December, the Trust recorded an adverse in-month variance of £192,000 reflecting the further step-up in operational pressures over the festive period. Additional, unplanned bed capacity was opened to mitigate risks to patients safety resulting in a further step up in premium agency expenditure. This has put even greater pressure on budgets increasing the year to date adverse variance to £4.6 million.

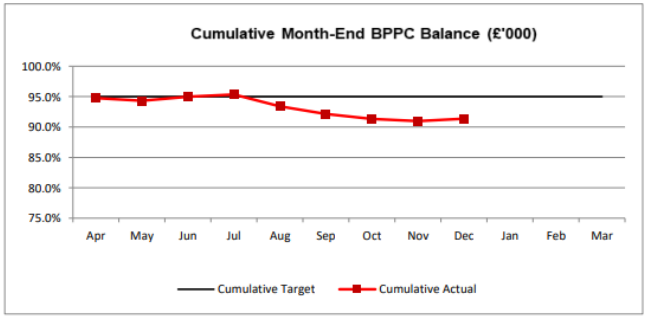
Whilst the Trust is currently holding to a forecast full year break-even position, this is now reliant upon additional income from NHS Dorset ICB which has yet to be formally agreed. Even with this assumption, there remains considerable risk within this forecast linked to further seasonal demand and capacity pressures, anticipated investment following the recent CQC inspections, and the potential financial impact of the planned industrial action.

The year to date capital position represents an under spend of £5.2 million, largely driven by under spends in IT and the One Dorset Pathology Hub schemes. A CDEL underspend of £538,000 is now forecast reflecting some anticipated programme slippage and as a contribution to the improvement in the Dorset ICS CDEL position.

The Trust ended December with a consolidated cash balance of £82.5 million, all of which remains fully committed against the medium-term capital programme. The phasing of the capital plan is the main driver for this increased cash holding against plan.

The Trusts payment performance recovered in December, however the previous impact of the national cyber attack continues to impact the year to date achievement which currently stands at 91.4%. Further improvement is expected in the remaining months of the year.



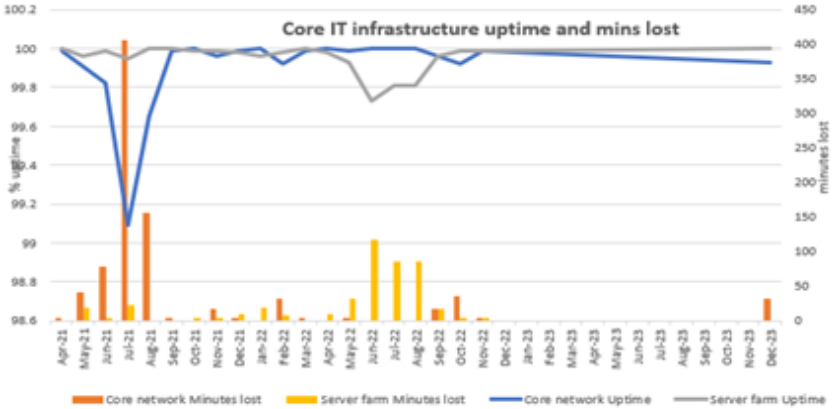



## Informatics - Jan 2023

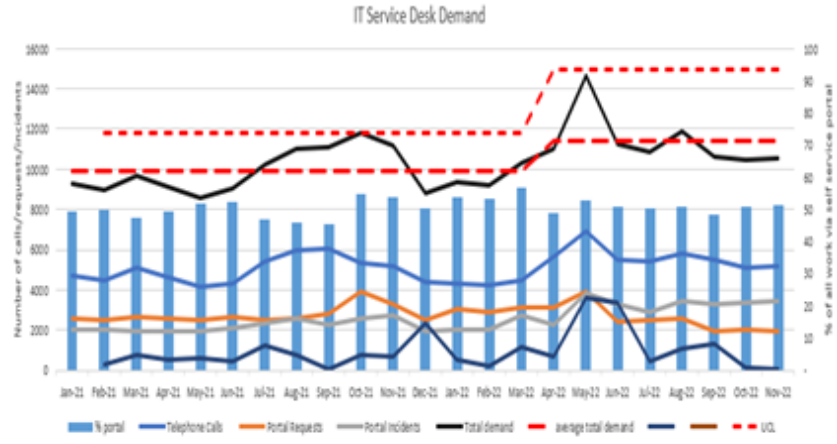
**Overall Commentary:** **Graph 1**: 99.9+% uptime on all our core infrastructure but unfortunately, we saw another short outage of our Electronic Patient Record. Enhanced monitoring has picked up a possible root cause which is being investigated. **Graph 2**: Awaiting December Service Desk demand data. **Table 3:** Informatics undertook a successful "Change Freeze" over the Christmas/New Year period to prevent any untoward impact on operational services. 4 Projects closed in December including a system for a Virtual Ward for patients with fractured neck of femur and an upgrade to the tracking system for patients going through the cardiac labs. This brings the total number of Informatics projects closed in 2022 to 123. **Table 5**: It is pleasing to see the percentage of unsupported desktop devices go below 10%, which is the target from NHS Digital. **Table 6:** As a result of the annual rebasing, the Information Asset Compliance is rebuilding again with the majority of assets being reviewed by their owners. **Graph 8:** Dorset Care Record continues to grow, with the expected slight reduction in December due to the bank

### Business As Usual/Service Management

Graph 1: core Infrastructure availability




Graph 2: Service Desk demand




### Projects/Developments/Security/IG

year.

| Informatics Projects since November 2018 | | | | | | |
|---|---|---|---|---|---|---|
| **Project Type** | **Pending Approval** | **Not Started** | **Deferred** | **In Progress** | **Completed** | **Total** |
| eForm/Automation Project | 0 | 12 | 4 | 58 | 228 | 302 |
| Infrastructure Mandatory | 0 | 2 | 1 | 6 | 27 | 36 |
| Projects | 1 | 46 | 9 | 80 | 362 | 497 |
| Service Improvement Projects | 0 | 0 | 0 | 1 | 3 | 4 |
| **Grand Totals** | **1** | **60** | **14** | **145** | **620** | **839** |

Table 4: Project Totals and Escalation

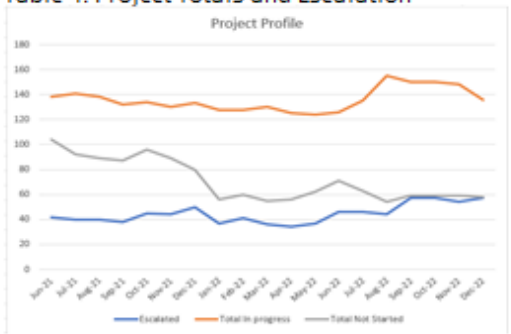


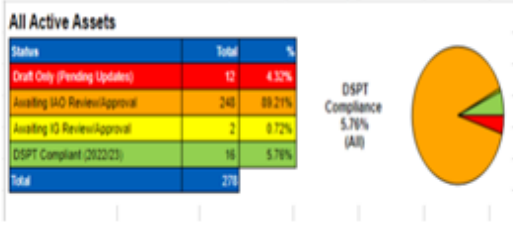

Table 5: Cyber Security - Obsolete system

| | Supported | Obsolete | Mitigated | Unsupported |
|---|---|---|---|---|
| Windows Desktops | 90.8% | 9.2% | 0.0% | 9.2% |
| Windows Servers | 84.4% | 15.6% | 15.5% | 0.2% |

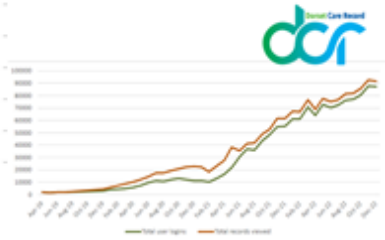
Table 7: FOI compliance

| Table 6 - FOI Compliance | | |
|---|---|---|
| | Total rec'd | Compliance |
| August '22 | 71 | 68% |
| September '22 | 69 | 77% |
| October '22 | 51 | 82% |
| November '22 | 56 | 77% |

Table 6: Information Asset Compliance




Graph 8: DCR growth



University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 6.2**

| | |
|---|---|
| **Subject:** | Risk Register |
| **Prepared by:** | Joanne Sims, Associate Director Quality, Governance and Risk<br>Janey Harbord, Head of Risk |
| **Presented by:** | Paula Shobbrook, Chief Nursing Officer |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☐<br>Be a great place to work ☐<br>Use resources efficiently ☒<br>Be a well led and effective partner ☒<br>Transform and improve ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | The paper provides details of the risks rated 12+ on the UHD NHS Foundation Trust risk register. |
| **Purpose of paper:** | Decision/Approval |

**Executive Summary**:

| | |
|---|---|
| Current risks rated at 12 and above on the risk register | 37 |
| **Risk(s) increased to 12 and above for review** | **3** |
| Reduced, closed or refreshed risk(s)rated at 12 and above to note | 2 |
| **Potential new risks for review** | **0** |

| Risks increased to 12 and above for approval | | | | | |
|---|---|---|---|---|---|
| Risk no: | Title | Proposed Grading | Update | Exec Lead | Papers |
| 1202 | Medical Staffing Women's Health | 15 | Discussed with Group Medical Director and Acting CMO. Reviewed and agreed at CG Board as Risk Rating 15. Discussed at Quality Committee 20/12/22 and 17/1/22 at 15 | Acting Chief Medical Officer | Verbal update from Care Group |
| 1642 | Midwifery Staffing | 12 | Reviewed in light of concerns regarding ability to cover all staffing gaps and need to support staffing maternity triage with 3rd Midwife. Discussed with Head of Midwifery, followed up | Chief Nursing Officer & Deputy COO - | Verbal update from Care Group |

| | | | | | |
|---|---|---|---|---|---|
| | | | at Care Group Board and discussed at Quality Committee 20/12/22 and 17/1/22 . | | |
| 1744 | Inability to provide 24hr Maternity Triage service | 12 | Risk reviewed and presented at Quality committee. Regular audit to triage times against 15 mins BSOTS standard identifies that compliance cannot be maintained at all times in times of surges at peak times and periods of staff shortages. Increased to 12. This continues to monitored and forms of part of ongoing monitoring at the Maternity Assurance Group. Discussed at QC 17/1/22 | Chief Nursing Officer & Deputy COO - | Verbal update from Care Group |
| | | | | | |

| To note - Current 12+ Risks decreased or closed in month | | | |
|---|---|---|---|
| Risk no: | Title | Risk Owner | Risk Trend |
| 1591 | Information Asset Management | Camilla Axtell- IG and Data Protection Officer | Decreased from 12 to 6 |
| 1447 | Adverse Outcomes For Orthodontic Patients due to COVID restrictions and lack of additional facilities and manpower | Barry Alborough-Duell, - Directorate Manager | Closed 06/12/22 |

| 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 |
| 40 | 37 | 93% | ⇧14% |

**Background:** The report is provided in accordance with the UHD Risk Management Strategy.

**Key Recommendations:** For approval

**Implications associated with this item:**

| | |
|---|---|
| Council of Governors | ☐ |
| Equality and Diversity | ☐ |
| Financial | ☒ |
| Operational Performance | ☒ |
| People (inc Staff, Patients) | ☒ |
| Public Consultation | ☐ |
| Quality | ☒ |
| Regulatory | ☒ |
| Strategy/Transformation | ☒ |
| System | ☒ |

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

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| Audit Committee | 12/01/2023 | For information |
| Quality Committee | 17/01/2023 | Risks 1202, 1642 and 1744 agreed for submission to Board for approval |

| Reason for submission to the Board in Private Only (where relevant) | | |
|---|---|---|
| | Commercial confidentiality | ☒ |
| | Patient confidentiality | ☐ |
| | Staff confidentiality | ☐ |
| | Other exceptional reason | ☐ |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 6.3**

| | |
|---|---|
| **Subject:** | Trust Annual Objectives 2022-2023: 6 month review |
| **Prepared by:** | Richard Renaut – Chief Strategy & Transformation Officer |
| **Presented by:** | Richard Renaut |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☒<br>Be a great place to work ☒<br>Use resources efficiently ☒<br>Be well governed and managed ☒<br>Transform and improve ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | This report covers the whole Board Assurance Framework (BAF) |
| **Purpose of paper:** | Review and Discussion<br>To provide a short overview of progress against the Annual Plan. This should be read in conjunction with the BAF and Integrated Performance Review (IPR) |
| **Executive Summary**: | The mid-year review of progress against Trust objectives is largely summarized as “amber” (making progress but significant risks to mitigate.<br>The review was undertaken at the November 2022 Trust Management Group meeting and will be repeated at year end (April 2023) when data is available.<br>The more detailed scrutiny, and management of the objectives occurs throughout the year. These are tracked through the governance processes of the Trust.<br>Looking forward to 2023/2024 annual objectives, as this will be a transition year to introducing Patient First as a new methodology for setting strategy and delivery. This will improve both the selection and prioritization, along with the BAF/IPR and governance for delivery. |
| **Background:** | The Annual Plan includes our corporate objectives |

| | |
|---|---|
| **Key Recommendations**: | 1. To note the amber ratings in the majority of objectives<br>2. To continue to track at Board committee and BAF<br>3. To prepare for transition to a new methodology in 2023/2024 |
| **Implications associated with this item:** | Council of Governors ☒<br>Equality and Diversity ☒<br>Financial ☒<br>Operational Performance ☒<br>People (inc. Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒<br>System ☒ |
| **CQC Reference:** | Safe ☒<br>Effective ☒<br>Caring ☒<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Trust Management Group | 22/11/2022 | Noted |

| | |
|---|---|
| **Reason for submission to the Board in Private Only (where relevant)** | Commercial confidentiality ☐<br>Patient confidentiality ☐<br>Staff confidentiality ☐<br>Other exceptional reason ☐ |

# University Hospital Dorset Specific Actions 2022/2023

## Mid-Year REVIEW

**KEY**

- On track for year-end completion, risks reasonably mitigated
- Making progress but significant risks to mitigate (reference risk register)
- Unlikely to get close to original target by year end, significant risk unlikely to be mitigated (reference risk register)
- Completed – objective largely achieved

| **Strategic Objective 1:** To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience | | **Exec Lead** | **Maintained from 21-22?** | **RAG** | **Assurance: Evidence of progress year to date** |
|---|---|---|---|---|---|
| 1.1 | To deliver wide range of **Patient Safety Quality Priorities,** using a quality improvement (QI) approach, across the Trust including:<br>• Quality account priorities including Deteriorating Patient and Safety Checklists.<br>• Priorities for 2022/23 including Acute Kidney Injury/Dialysis Management, Blood glucose management, the deteriorating patient in ED and medical/pharmacy communication.<br>• Improving against Stroke and Trauma pathway quality standards | CMO/ CNO | ✓ Updated to reflect TMG priorities replacing Dorset list, updated to reflect national priority B | Amber **(Detailed breakdown for each QI Priority on Page 9)** | Deteriorating patient group has delivered a UHD wide response framework for escalation/2222 aligned to new pagers.<br>Treatment escalation planning roll out continues with Phase 2 scheduled for November 2022<br><br>Stroke - Improvement plans in place – predicted level B for joint UHD SSNAP 22/23 Q2 when published. Plans for full-service centralisation to RBH site approved and will be implemented by April 2023<br><br>Trauma – Major Trauma working group fully embedded. TARN standards reviewed. Draft Operational Policy for Major Trauma for UHD developed and circulated, |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | pending ratification at December meeting. |
| 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 partners and improving our own processes to support safe and timely discharge from hospital. To 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 ambulance handover delays and same day emergency care outcomes supported by implementation of the UEC 10 Point Action Plan. | COO | ✓ Updated to reflect national priority D | Amber | Trust Hospital Flow Improvement Group focusing on 4 key workstreams – ED, SDEC, Operational Flow and Discharge. Rapid Plan for Decompressing ED in place. Action plans in place and relate to risks 1131, 1387, 1429, 1460 on the BAF. System mobilisation plan supporting identified bed capacity gaps and funded through national investment. |
| 1.3 | To redesign and transform **outpatient services** with a Digital First offer, improving access to care, diagnostics strategy delivery, reducing travel times, and through effective completion of care pathways. | COO | ✓ | Amber | Trust wide Transformation Programme established as part of the elective recovery programme. Five key themes established as part of the programme. Specific reference to a digital programme (Digital first) in place with clear timelines. External provider appointed as part of the phase 1 changes. Go live of phase 1 late Q3 with further work to progress in Q4. |

| **Strategic Objective 2:** To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best. | | **Exec Lead** | **Maintained from 21-22?** | **RAG** | **Assurance: Evidence of progress year to date** |
|---|---|---|---|---|---|
| 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. | CPO | ✓ Updated to reflect national priority A, B and culture champions | Amber | Phase 2 of Culture Programme completed, focusing on Reward and Recognition. Values recognition postcards active with electronic *Thank You* system in procurement. Introduction of monthly CEO Staff Excellence Awards with integrated approach to Long Service / Annual Staff Awards in planning phase for launch in 2023. Healthy Working Lives Group with NED sponsorship celebrates best practice across UHD with growing community of MHFA and Wellbeing Practitioners. Winter Boost campaign underway including UHD Responder, gift vouchers, subsidised restaurant meals and a definitive guide booklet for managers on how to support staff wellbeing. 2022 Staff Survey response rate will show in-year improvement [currently 41%]. |
| 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 the staff Integration Survey | CPO | ✓ Updated to reflect integration | Amber | OD actively supporting team development and coaching at care group, directorate and specialty level. Leadership and Management Skills Manager Modules launched including: Being a UHD Manager, Leadership |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Fundamentals, Leadership in Action, *Beyond Difference* and Level 7 MBA programme in collaboration with BU. |
| 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. | CPO | ✓ | Amber | HR actively working through policies in partnership with trades unions and making good progress. Workload post COVID is extremely high particularly around employee relations and the need for HR advice remains critically important. The introduction of "fair and just" processes and the move to informal and early intervention rolled out and being socialised. Pressure on recruitment teams and the temporary staffing services continue. Data cleansing post ESR merger progressing. |
| 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 (e.g. WRES and WDES).<br>Implement the National Patient Strategy requirement to develop a just culture across UHD as part of a ICS workforce plan.<br>Define and agree measures to monitor implementation of inclusive leadership, equal opportunities in career development and endorsement of staff networks. | CPO | ✓<br>national priority A and patient safety just culture | Amber / Red | 12-month targeted EDI plan [Sept 22] monitored quarterly by EDIG with outcome measures linked to 2021 Staff Survey, Model Employer and WRES / WDES. Progress in many areas, however Q4 to focus on mitigating risks linked to 'developing an inclusive culture', specifically a) career progression and under-representation of BAME in senior leadership roles b) challenging poor behaviour. |

| **Strategic Objective 3:** To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets. | | **Exec Lead** | **Maintained from 21-22?** | **RAG** | **Assurance: Evidence of progress year to date** |
|---|---|---|---|---|---|
| 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. | CFO | ✓ National objective I | Red (risks 1739, 1740, 1594, 1595, 1416) | Year to date (month 6) deficit of £5.4m being £5.9m adverse (including CIP achievement of £13.6m being 2.5m adverse). Continued break-even outturn supported by detailed directorate forecasts and assuming additional recovery actions. Significant risk remains within this forecast linked to seasonal pressures including potential strike action. |
| 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 for elective, cancer, diagnostics and emergency care. | COO | ✓ Updated to reflect national priority C | Amber | RTT waiting list 2.5% above plan at end of October, however on reducing trajectory since Sept 22. 104ww continue to be above plan, 78 and 52ww in line with operational plan. Diagnostics performance 16.38%, UHD best performer in SW and meeting 75% regional threshold. Cancer (Sept) FDS 64.7% and 62d 71.2%; both below threshold, continued improvement actions. Emergency care – High mean time in department and ambulance handover delays. Average daily NCTR patients exceeding 250 in October. Elective and Hospital Flow recovery programmes established. Elective portfolio programmes include: Outpatients, data and validation optimisation, theatres, cancer and |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | diagnostics. Digital transformation implemented through TIF. Action plans in place related to risks 1074, 1292, 1276, 1397, 1386, 1574, 1283. |
| 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. | CSTO | ✓ Updated to reflect 22-23 | Green | On track to deliver bulk of 22/23 plan. Potential governance transfer from dedicated Board Committee to be planned. |
| **Strategic Objective 4:** To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people. | | **Exec Lead** | **Maintained from 21-22?** | **RAG** | **Assurance: Evidence of progress year to date** |
| 4.1 | To improve **partnerships and engagement** with staff, governors, patients, local people and key stakeholders through:<br>• A communication and engagement plan delivered over the year.<br>• Further develop our BU partnership and tangible benefits<br>• Host the Dorset Innovation Hub on behalf of Dorset partner supporting spread of proven innovations. | CEO/ CSTO | ✓ Updated to reflect 22-23 | Amber | Communications very active, with dedicated community engagement role being recruited to.<br>BU partnership has completed and reported on 2nd year activity, strategic plan for year 3 in place with focus on research and education.<br>Dorset Innovation Hub in place. Work on long-term future starting. |
| 4.2 | Work with partners to address **health inequalities** and improve population health management, preventing ill health and promoting healthy lifestyles. | CFO | New, reflect national priority G | Amber | Health inequalities working group established and linked to ICB structures on health inequalities. Data collection has identified areas of inequality and strategic aims agreed. Programme of work aligned to ICB and is supporting patients to access care and attend appointments in areas where the greatest differential |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | according to deprivation and ethnicity have been demonstrated. |
| **Strategic Objective 5:** To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community. | | **Exec Lead** | **Maintained from 21-22?** | **RAG** | **Assurance: Evidence of progress year to date** |
| 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. To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/23. | CSTO | ✓ Updated | Amber | From an assurance perspective, Reconfiguration Oversight Group (ROG) has accountability for delivery and assurance comes from the Transformation Committee.<br><br>Risk escalation process in place from project level through to Corporate risk register – there are 2 BAF risks linked to this objective. (Risk 1604 - delay in securing UHD and wider Dorset NHP funding and Risk 1784 – critical path to deliver reconfiguration plan). Other risks all contained in monthly risk report to ROG. |
| 5.2 | Work with system partners in establishing the **Dorset ICS** and within that develop the Dorset provider collaborative. | CEO | ✓ Updated | Amber | The Provider collaborative is established and held first meetings. Forward programme to be agreed. ICS established with UHD represented. |
| 5.3 | Implement the UHD **Digital Transformation Strategy**:<br>• Progress digital transformation and play an active part in the key Dorset transformation plans programmes.<br>• Progress a Digital Dorset Shared Service | CIO | ✓ Update, national objective H | | • Informatics senior leaders are fully engaged in the design processes for the Digital Dorset Shared Service. |

| | | | | | |
|---|---|---|---|---|---|
| | • Procure and implement the Strategic Integrated Imaging Service: a digital diagnostics image sharing platform for Dorset.<br>• Create the Strategic Outline Case and Outline Business Case for the Dorset Electronic Patient Record system.<br>• 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.<br>• Achieve a compliant Data Protection and Security Toolkit submission. | | | Amber overall | • The procurement for the Strategic Integrated Imaging Service has launched with an estimated end date of March 2023.<br>• The EPR OBC has been signed off by all the Dorset NHS provider boards and ICB.<br>• Continuous dedicated effort maintains the UHD IT infrastructure and BAU support services in as close to optimal performance as possible. Notable outages to the EPR over the last quarter.<br>• UHD did not achieve a compliant DSPT for 21/22 (5 of the 110 requirements were not met). |

## 1.1 Patient Safety Quality Priorities

| | | |
|---|---|---|
| IV Fluids | • IV Prescription chart rolled out, reiterated, and has made a positive difference. Digital fluid balance is ready to deploy but awaiting assurance on IV Fluid input recording (paper practice) | G |
| Deteriorating Patient Programme | • Complex programme; 4/10 projects already completed successfully; some mothballed; others in progress | A |
| Difficult IV Access (DIVA) | • New UHD policy agreed, service established, and longer dwell cannulas rolled out | G |
| Safety Checklists | • CURRENTLY PAUSED – see slide | A |
| Cancer Care Programme Recovery | • Continuation of 21/22 initiative, likely to continue for all of 22/23 | G |
| Acute Kidney Injury | • Standardisation of various aspects across UHD has been done, especially intranet and patient information; checklist and education being worked on. Wider work needed on vision / strategy / leadership | A |
| Blood glucose management | • Project initiated in August 2022 – though progress has been inhibited by extended periods of operational pressures | A |
| Deteriorating patient in ED | • A new 22/23 priority (included within DP Programme). Agreed way forward that now needs to be formalised. | A |
| Medical and Pharmacy Communication | • Improve communication of prescribing queries between Medical and Pharmacy Teams – 22/23 priority. **REPLACED WITH "THINK STEROIDS". See slide** | R |

NHS Planning Guidance 10 Priorities mapped to UHD objectives

| National Priority | Priority Description | UHD Objective |
|---|---|---|
| A | Investing in workforce and strengthening a compassionate and inclusive culture | 1.1, 1.2 |
| B | Respond to Covid 19- vaccination programme and meeting the needs of patients with Covid 19 | 2.1 |
| C | Tackling the elective care backlog- reducing long waits and improve cancer waiting times | 3.2 |
| D | Improve responsiveness of UEC and build community capacity | 1.2 |
| E | Improve timely access to primary care | N/A |
| F | Improve mental health services and services for people with a learning disability and/or autism | N/A |
| G | Develop approach to PHM, prevent ill health and reduce health inequalities | 4.2 |
| H | Exploit potential of digital technologies | 5.3 |
| I | Moving back to and beyond pre-pandemic levels of productivity | 1.2, 1.3, 3.2 |
| J | Establish ICBs and collaborative system working | 5.2 |

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 7.1**

| | |
|---|---|
| **Subject:** | Key Issues and Assurance Report - Finance and Performance Committee<br>Meeting held on: 16 January 2023 |
| **Presented by:** | Philip Green, Chair of the Finance and Performance Committee |

| | |
|---|---|
| **Background:** | The reports received by the Committee at its meeting referred to above and the levels of assurance are set out below. |

| | |
|---|---|
| | Substantial assurance received by the Committee |
| | Partial assurance received by the Committee, but assurance received that appropriate plans in place to address |
| | Limited assurance received by the Committee - significant gaps in assurance and/or not sufficiently assured as to the adequacy of action plans |

| **Items rated Green** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| Operational Performance: the Committee was advised of the following:<br>• Reduction in elective longwaiters was on track at end of December 2022. 25 patients waiting more than 104 weeks were reported and waits over a year – ahead of plan.<br>• The Trust had achieved the best performance in the south west in December (18 December 2022) for diagnostics (DM01) – Number of patients are waiting 6 weeks or more for a diagnostic test.<br>• Cancer: numbers of patients waiting 63 days or more for treatment after referral for suspected cancer was reducing. | The Committee noted the areas of which it was advised.<br><br>In relation to the reduction in elective longwaiters, a potential risk of increases in the 104 week wait position was noted as a result of planned industrial action in January. | |

| | | |
|---|---|---|
| 232 at 18 December 2022 compared to 332 in September 2022. Expected rise at end of December as a result of reduced validation over Christmas/new year period but plan to address early January. | | |

| **Items rated Amber** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| Operational Performance: the following areas were alerted to the Committee:<br><br>• Daily average of medically ready for discharge patients consistently above 220;<br><br>• Significant levels of risk being managed within the Trust's emergency departments on a daily basis. Over 14,000 attendances in December (circa 16% increase compared to December 2021). SDEC and elective care areas escalated to meet surge of emergency demand. Significant IPC | The Committee received a report of the plans in place to seek to address each of the areas alerted.<br><br>This included: Dorset System agreement to expedite the implementation of the discharge to assess model to provide a step change to managing flow across the system. Covid-style response would be used to create a D2A implementation team. The NHS Dorset CNO team would be visiting the Trust to carry out a case panel on a selection of medically ready for discharge and ward visits to identify areas for further support and opportunities/enablers required for D2A.<br><br>Escalation capacity fully open, including second stage surge areas (84 beds). Virtual Incident Control Room remains established to manage periods when the Trust is in escalation. Weekly meeting between COO and ED team to review actions on decompressing ED. Corridor care supported by ECS. Increased cohort spaces at both sites to bring patients in from ambulances, supported by SWAST, releasing up to 3 in 4 ambulances back onto the road; ambulance handover clock continues to run for all patients. New national escalation process for handovers > 6 hours implemented. | To be presented to the Board as part of the Integrated Performance Report. |

| | | |
|---|---|---|
| challenges with increase in Covid-19 and Flu-A.<br><br>• Ambulance handover delays in December were the highest recorded during 2022/23 with more than 6,600 hours lost, SWAST regionally experienced an increase of 100% in hours lost.<br><br>• Achievement of improvement in cancer faster diagnosis and 62-day standard was off track. | It was noted that as with other trusts, in December, the Trust's position was very challenged including with it having been in critical incident for a period of time. This was very pressurized for staff. The Chief Executive and members of the Executive Team had visited ED and spoken with patients, apologizing for the length of wait times. Clinical and management teams had worked incredibly hard to reach the point where over the preceding weekend the ambulance waits had improved.<br><br>Funding bid application made to Wessex Cancer Alliance to support additional capacity. Cancer improvement programme in place. Additional insourcing capacity commencing in January for Dermatology and service expected to recover FDS performance by February. FIT< 10 Pathway was on track to launch in January 2023. | |
| 2022/23 Financial Performance – Month 9 | The Committee was informed that the Trust reported an adverse variance in month of £0.2 million taking the year to date deficit to £4.2 million. The Trust continued to forecast a full year break-even position; however, due to a further increase in expenditure commitments, this was now reliant upon additional income from the Dorset Integrated Care Board which had yet to be confirmed.<br>Capital expenditure remained under budget with a year to date variance of £5.2 million. A forecast underspend of £0.5 million had been agreed in support of the ICS-wide capital outturn. | Summary to be presented to the Trust Board as part of the Integrated Performance Report. |

| | | |
|---|---|---|
| | Operational pressures were continuing to drive the Trust's financial performance, increasing expenditure and limiting clinical and operational capacity to deliver efficiencies and transformation projects. This was exacerbated by rising inflation, with food and energy prices putting particular pressure on Trust budgets.<br>Controls in place in relation to agency spend were discussed and the root cause of increases in agency spend. | |
| Productivity and Efficiency Report – Month 9 including Cost Improvement Programme and Benefits Realisation | The Committee was presented with an update including the savings that had been identified and the associated shortfall. The expected actions in December had been largely delivered.<br>Operational capacity including the pressures related to strike planning was a key limiting factor for change with many projects requiring time to implement. The Trust has appointed Carnall Farrar for a 10 week period to support in developing the programme for the following year.<br>The merger financial savings stocktake report was received.<br>The committee recognised the issues in delivering and quantifying some of the benefits and highlighted importance of having a clear baseline position for future plans. It was essential to have ongoing robust monitoring and review of savings opportunities identified. | The Committee noted the report and would receive ongoing reporting in relation to the revised plan. |
| Estates Improvement | The Committee received a summary in relation to Estates across the Trust's sites. A multi-year programme was being developed: taking account of alignment of financials, access for the works to be performed and supply chain availability. Internal auditors had completed an assessment of the estates quality management system (Planet FM) at Poole which had been discussed at Audit Committee. The findings (substantial | The Committee noted the Estates Improvement report. |

| | | |
|---|---|---|
| | assurance in relation to the design opinion; moderate assurance for design effectiveness) were reported. An update was also provided to the Committee in relation to the maternity call bells at Poole hospital and completion of fire risk assessments. | |

| **Items rated Red** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| N/A | | |

| **Items not rated** | | |
|---|---|---|
| **Item** | **Comments** | **Actions/outcome** |
| Exception Report – Private Patients Strategy | The Committee received an update in relation to the pricing exercise being undertaken, capacity within the private patient unit and financial performance of Dorset Heart Clinic. | Exceptions reporting would continue to be provided to the Committee, together with quarterly standing reporting. This would include the strategy document being presented to the Committee and subsequently to the Board. |
| Operational Planning 2023/24 Update | The Committee received an update in relation to the 2023/24 priorities and operational planning guidance published by NHS England. | The Committee noted the work programme to develop a detailed organizational and system operational plan for the coming year. |
| Contract Decision Timetable | The Committee received the contract decision timetable report. | The Committee noted the report. |
| Consultancy Commitments | It was reported that there were no commitments that met the definition to be brought to the Committee's attention. | |
| Board Assurance Framework | It was noted that this would be discussed at a Board Development Session in February 2023. | The Board Assurance Framework would be discussed further at a Board Development Session in February 2023. In the meantime, a discussion would take place between relevant Executives and the Associate Director of Corporate Governance about the reporting to the Committee. |
| Exception Reports – Transformation and Sustainability | The Committee received an update in relation to progress with the New Hospitals Programme, which would | The Committee noted the reports. |

| | | |
|---|---|---|
| | be presented to the Board in January 2023.<br>An update was also provided in relation to the UHD Green Plan and decarbonization strategy. | Positive comment was made upon the internal audit review in relation to sustainability. |
| The Committee considered items that were presented to it for information. It also received recommendations for approval/endorsement. | | |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 7.2**

| | |
|---|---|
| **Subject:** | Key Issues and Assurance Report - Quality Committee Meeting held on: 17 January 2023 |
| **Presented by:** | Cliff Shearman, Chair of the Quality Committee |

| | |
|---|---|
| **Background:** | The reports received by the Committee at its meeting referred to above and the levels of assurance are summarised below. |

| | |
|---|---|
| | Substantial assurance received by the Committee |
| | Partial assurance received by the Committee, but assurance received that appropriate plans in place to address |
| | Limited assurance received by the Committee - significant gaps in assurance and/or not sufficiently assured as to the adequacy of action plans |

| **Items rated Green** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| Care Group reporting – Specialties Care Group | The Committee was presented with assurance in relation to learning from a radiology incident and outpatients on all sites having regularly completed peer reviews.<br><br>It was reported that pathology had received a number of visits from the UK Accreditation service to assess them against the Pathology Standard ISO15189:2012. Laboratories that had been visited had maintained their accreditation, which was noted as a very positive achievement. | The Committee noted the learning, the peer reviews and the outcome of the assessments. |
| Care Group reporting – Surgical Care Group | It was reported to the Committee that there had been an improvement in critical care capacity – delayed admission had previously been raised as a concern. There were no further reports or escalation of this. Step downs continued to be delayed. | |

| | | |
|---|---|---|
| Maternity Safety Champions report | An update was provided in relation to the existing call bell system which was safely working through observational feedback and LERN systems. Daily testing also occurred.<br>Separately, a new call bell system had been installed, with user acceptance testing to commence. | Plans for user acceptance testing in relation to the new system were in place and would commence imminently in a safe and planned manner. |

| **Items rated Amber** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| Care Group reporting – Specialties Care Group | The Care Group raised the following alerts to the Committee:<br>• Child Health Staffing, with new risks reported to the Committee in December 2022.<br>• Additional risks that would be presented to the Committee for approval in February 2023 relating to:<br>○ Chemotherapy production in pharmacy (1758), with increased waiting times for chemotherapy.<br>○ Lack of staffing resources in cellular pathology (1395). 22% increase in workload with capacity constraints leading to delays in diagnosis.<br>• Themes of risks: equipment issues and staffing.<br>The Committee was advised of progress with infection prevention control, resus trolley audit, complaints and two reported incidents for scoping. | The Committee noted the risks that would be presented to the Committee meeting taking place in February 2023.<br><br>It was reported that improvement was expected to the chemotherapy production in pharmacy by March 2023 with two additional aseptic pharmacists in post.<br><br>Of the two reported incidents for scoping, the scoping had been scheduled for one. For the other, the incident was being investigated to consider the escalation for review and treatment. |
| Care Group reporting – Surgical Care Group | The Care Group provided an update to the Committee in relation to:<br>• The ring-fenced critical bed at Bournemouth hospital for elective surgery.<br>• In relation to mortality and morbidity, shared learning across directorates would be identified.<br>• Hospital acquired harm – total number of falls had decreased significantly over previous 6 | Patient pathway opportunities were being explored.<br><br>Harm review process had been included in fractured neck of femur (‘NOF) admission and assessment documentation – |

| | | |
|---|---|---|
| | month period; number of falls with harm had increased. | work to audit and identify actions as a result of this was required.<br>Time to theatre #NOF (within 36 hours) had significantly improved from 2% to 58% over the six month period as a result of theatre capacity and radiology staffing. The Care Group reported that governance processes were improving around the #NOF pathway.<br>The Committee noted the positive movement. |
| Care Group reporting – Medical Care Group | The Care Group informed the Committee that:<br>• Saving lives data: this had seen some improvement and the matron teams continued to work with wards to draw up action plans.<br>• Mortality and morbidity were an area of care group focus, with risk and governance teams engaged to further review. | |
| Maternity Safety Champions Report | The Committee was updated on the APGAR score of less than seven in five minutes. No harm had been identified and other associated safety measures such as term admissions to the neonatal unit and episodes of hypoxic ischaemic encephalopathy compared well. | This would be re-presented to the next meeting of the Committee. |

| **Items rated Red** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| Care Group reporting – Surgical Care Group | The Care Group raised the following alerts to the Committee:<br>• Overall decrease in total number of pressure ulceration, but increase in deep tissue injuries. VTE compliance data was not available at the time of submission of the report. | Increase in deep tissue injuries were to form a focused review. |
| Care Group reporting – Medical Care Group | The Care Group raised the following alerts to the Committee:<br>• Falls particularly minor and no harm were increasing in comparison to December 2021. | |

| Items not rated | | |
|---|---|---|
| **Item** | **Comments** | **Actions/outcome** |
| Introduction | The Chief Nursing Officer provided an overview in relation to the concerns from the industrial action and work underway to mitigate the impact, including patient safety and impact to staff. Derogations continued to be worked through with the Royal College of Nursing.<br>An update was also provided in relation to the CQC maternity, medical and surgical reports and the publication of the inpatient survey for maternity. | A number of actions were in progress in relation to maternity services ahead of the reports being published. Discussions were also taking place with the national and regional team about support for maternity services.<br>Additional information was now available to maternity patients through Badgernet that was not available when the survey was undertaken. Reference was also made to the feedback published through the Maternity Voices Partnership. |
| 6-month update on Quality Priorities | The Committee received an update on the quality priorities. A full end of year report would be presented to the Committee in May 2023. | It was reported that good progress had been made against the priorities. |
| Care Group reporting – Medical Care Group | The Care Group raised an alert to the Committee in relation increasing numbers of corridor care and proposed that this be brought back to a future Committee meeting. | It was emphasised that this would not be normalised at the Trust, with reference made to the reason for this temporarily being in place. |
| Maternity Incentive Scheme | The Committee received a presentation in relation to the process for evidence and assurance and update on current status.<br><br>As part of this and the Maternity Safety Champions Report, the midwifery staffing mitigants and controls were noted and obstetric RCOG staffing processes commented upon. | Discussions were ongoing in relation to internal assurance and external reporting.<br>Internal auditors were being asked to review the assurance with directorate and care group, before presentation to the Board.<br><br>The Committee noted:<br>• the process for evidence and assurance;<br>• the examples of a deep dive into one of the areas of evidence;<br>• that the evidence had been reviewed by the clinical director, would be presented to the care group board; it had been reviewed by the Chief Finance Officer and Chief Nursing Officer. |
| Integrated Performance Report – Quality | The Committee received and noted the quality aspects of the IPR (which had been submitted on the morning | |

| | | |
|---|---|---|
| | of the Committee meeting. To note: the period covered by the data did not map to that provided by the Care Groups). | |
| LERN Report | Themes from the LERN report were presented including an update on coding and 7 day activity. | The Committee noted the LERN Report, with support expressed for continued learning and transparency. |
| National Standards for Food and Drink | The new National Standards of Hospital food that had been developed were referenced to the Committee, with a progress report against each provided. | Engagement and discussion with a wider patient group would be developed.<br>Reporting for assurance would be provided to the Committee on a quarterly basis going forward. |
| Risk Register: risks rated 12-25 (new and current) | It was discussed that the new risks provisionally rated 12 and above for consideration (futureproofing of CPD and workforce transformation; and BEAT VLE mandatory training) would be reviewed.<br><br>In relation to risk numbers 1202 and 1642, it was reported that the Medical Staffing Women's Risk was currently able to be mitigated with the actions that had been put in place. | Risks presented to be reviewed. |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 7.3**

| | |
|---|---|
| **Subject:** | Key Issues and Assurance Report - Audit Committee Meeting held on: 12 January 2023 |
| **Presented by:** | Stephen Mount, Chair of the Audit Committee |

| | |
|---|---|
| **Background:** | The reports received by the Committee at its meeting referred to above and the levels of assurance are summarised below. |

| | |
|---|---|
| | Substantial assurance received by the Committee |
| | Partial assurance received by the Committee, but assurance received that appropriate plans in place to address |
| | Limited assurance received by the Committee - significant gaps in assurance and/or not sufficiently assured as to the adequacy of action plans |

| **Items rated Green** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| Internal Audit Report - IAO Management | Substantial assurance in relation to Design Opinion; Moderate assurance provided for Design Effectiveness. | One medium priority recommendation in relation to user access reviews and one low priority recommendation in relation to training. Actions and implementation timescales agreed. |
| Internal Audit Report - Estates Compliance – Poole | Substantial assurance in relation to Design Opinion; Moderate assurance provided for Design Effectiveness. | Two medium priority recommendations: Planet FM updates and training. One low priority recommendation in relation to safety group agendas and terms of reference. Actions and implementation timescales agreed. |
| Internal Audit Report - HFMA Financial Sustainability | Internal auditors reported that overall the Trust had been able to demonstrate a good level of compliance with the questions set out in the assessment, with 69 of the 72 questions where the Trust had scored itself at a 4 or 5 confirmed | Actions to be developed in relation to three questions. |

| | | |
|---|---|---|
| | through testing and review of the evidence supplied. | |
| Q3 Clinical Audit Plan Report | Of the 72 national clinical audits reportable under the Quality Accounts return, at 30 December 2022 the Trust was confirmed as participating in 94% of eligible projects.<br>At the end of Q3, 77% of audits on plan had been started or completed.<br>It was reported to the Committee that a significant piece of quality improvement work was being undertaken in the Emergency Department relating to different workstreams such as flow and same day emergency care. | The Committee noted the Q3 Clinical Audit Report. |
| Cyber Security and Vulnerabilities Report | A report of recent highlights and status within four key aspects of cyber security: network, applications, information and operational was presented and considered by the Committee. | The Committee noted the Cyber Security and Vulnerabilities Report. |

| **Items rated Amber** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| Information Governance Q3 Update | Data security and protection toolkit audit work for the 2022/23 submission was well underway. However, an increasing imperative to comply with the requirements was noted.<br>Wider organization support was required to update IAO assurance work. | DSPT compliance to be discussed further with the Board. |

| **Items rated Red** | | |
|---|---|---|
| **Item** | **Rationale for rating** | **Actions/outcome** |
| N/A | | |

| **Items not rated** | | |
|---|---|---|
| **Item** | **Comments** | **Actions/outcome** |
| External Audit Progress Report | External auditors reported that the planning and risk assessment for the 2022/23 audit had commenced. The audit plan had been drafted. | The value for money risk assessment would be presented at the next Committee meeting. |
| External Audit Plan | External auditors provided an overview of the audit strategy for 2022/23, including the key risks | The Committee noted the report. |

| | | |
|---|---|---|
| | identified and planned approach to address them. Key audit risks for 2022/23 include:<br>• Valuation of land and buildings;<br>• Revenue recognition;<br>• Expenditure recognition; and<br>• Management override of controls. | |
| Internal Audit Progress Report | Internal auditors provided an update on progress made against the 2022/23 internal audit plan. Good support from Executives and management had been provided; there were no significant concerns to be raised. | Reports to be presented to the March 2023 Committee were KFS, Recruitment and DSP Toolkit. |
| Internal Audit Follow Up of Recommendations Report | Progress was reported against the implementation of recommendations arising from reports issued in 2021/22 and 2022/23. For 2022/23, 42% were not yet due, 30% were complete and 28% in progress. None were reported as overdue. | The Committee noted the report. |
| Counter Fraud Progress Report and Fraud, Bribery and Corruption Policy | The local counter fraud service (LCFS) reported upon key areas of proactive work undertaken against the counter fraud work plan.<br>There was no movement in the Trust's fraud risk score.<br><br>The report detailed allegations reported to LCFS and action taken as part of the investigation. Two new referrals had been received by LCFS since the last Committee meeting.<br><br>The Fraud, Bribery and Corruption Policy was presented to the Committee for consultation, prior to presentation to the Board for approval. | The Committee noted the report.<br><br>No comments were raised on the Fraud, Bribery and Corruption Policy. |
| Risk Register | The Committee discussed a deep dive being undertaken into certain risks. Members welcomed opportunities for triangulation (data, observing and listening). | The Committee noted the Risk Register. |
| Board Assurance Framework | It was noted that this would be discussed further at an upcoming Board Development Session. | The Committee noted the Board Assurance Framework. |

| | | |
|---|---|---|
| Managing Conflicts of Interest Policy | Off cycle updates to the policy were presented to the Committee for consultation. | It was proposed that the introduction to the policy be revised to encourage collaboration and research, while recognising the importance of transparency and compliance.<br>Subject to this, the Committee endorsed the policy for recommendation to the Board. |
| Audit of Non-Clinical Policies | In line with the Trust's Document Control Policy, a report on overdue policies was presented to the Committee. | It was agreed that the overdue policies would be further escalated with Executives. |
| Commercial Compliance Report | A report was presented to the Committee on the total number of Standing Financial Instruction waivers submitted, including those reviewed and found to be mitigated. The rationale for waiving SFIs was summarized against each within the report. | The Committee noted the report. |

The Committee was also presented with certain contract award recommendations.

| **Impact on Board Assurance Framework** |
|---|
| |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 8.1**

| | |
|---|---|
| **Subject:** | 2023/24 Priorities and Operational Planning |
| **Prepared by:** | Judith May, Director of Operational Performance and Oversight |
| **Presented by:** | Mark Mould, Chief Operating Officer |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☒<br>Be a great place to work ☒<br>Use resources efficiently ☒<br>Be a well led and effective partner ☒<br>Transform and improve ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | None |
| **Purpose of paper:** | Information |
| **Executive Summary**: | On Friday 23 December 2023, NHS England (NHSE) published 2023/24 priorities and operational planning guidance. The guidance sets out the key tasks for the next financial year, the most immediate being to recover core services and improve productivity.<br><br>A draft Operational Plan submission is required by 23 February 2023 to NHS England. |
| **Background:** | Each year NHS England issues detailed planning guidance for the year ahead. The attached document summarises this guidance for 2023/24. Key points include:<br><br>• The planning guidance sets a range of "national NHS objectives" for 2023/24, with expected performance against key operational standards. Including a return to the 4 hour wait target in ED. A table outlining the high-level national NHS objectives is included within the attached paper at appendix 1.<br><br>• NHSE will publish two-year revenue allocations for 2023/24 and 2024/25 – integrated care board (ICB) allocations are flat in real terms with additional funding available to expand capacity. Elective recovery funding (ERF) will be allocated to systems on a fair shares basis. |

| | |
|---|---|
| | • NHSE will agree targets with systems for 2023/24 to deliver 30% more elective activity than pre-pandemic levels by 2024/25. The long waiter target is to eliminate over 65 week waits by March 24. Included in this cohort for UHD are 72,114 patients (29/12).<br><br>• The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered.<br><br>• For 2023/24 NHSE plans to base agency spend limits on agency spending as a proportion of systems' total pay costs, set at 3.7% of a system's total pay bill. Agency spend in UHD currently (December) is at 4.2% of total pay<br><br>The Trust is currently developing its Operational Plan and further updates will be provided at future meetings. |
| **Key Recommendations**: | The Board is asked to note the planning guidance for 2023/24 and the work programme to develop a detailed organisational and system operational plan for the coming year. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality and Diversity ☐<br>Financial ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒<br>System ☒ |
| **CQC Reference:** | Safe ☒<br>Effective ☒<br>Caring ☒<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☒ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| Trust Management Group | 10/01/2023 | Guidance noted and operational planning process confirmed. |
| Finance and Performance Committee | 16/01/2023 | Meeting not taken place at the time of submission of this paper. |

| Reason for submission to the Board in Private Only (where relevant) | | |
|---|---|---|
| | Commercial confidentiality | ☐ |
| | Patient confidentiality | ☐ |
| | Staff confidentiality | ☐ |
| | Other exceptional reason | ☐ |

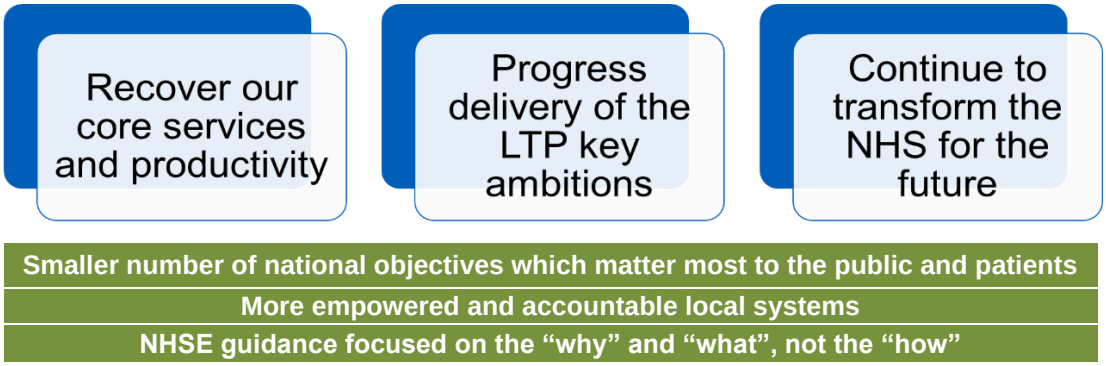
University Hospitals Dorset
NHS Foundation Trust

# 2023/24 Priorities and Operational Planning Guidance – Summary Paper

## 1. Introduction

On Friday 23 December 2023, NHS England (NHSE) published 2023/24 priorities and operational planning guidance. The guidance sets out three key tasks for the next financial year, the most immediate being to recover core services and improve productivity. As recovery continues, systems should renew focus on delivering the key ambitions set out in the NHS long term plan (LTP), and transforming the NHS for the future.

### Priorities for 2023/24




This summary briefing highlights the key requirements from the guidance documents.

**Key points**

- The planning guidance sets a range of **"national NHS objectives" for 2023/24**, with expected performance against key operational standards. Including a return to the 4 hour wait target in ED. A table outlining the high-level national NHS objectives is attached as an appendix 1.
- **NHSE will publish two-year revenue allocations for 2023/24 and 2024/25** – integrated care board (ICB) allocations are flat in real terms with additional funding available to expand capacity. Elective recovery funding (ERF) will be allocated to systems on a fair shares basis.
- NHSE will agree targets with systems for 2023/24 to deliver **30% more elective activity than pre-pandemic levels by 2024/25**. The long waiter target is to eliminate over 65 week waits by March 24.
- The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay **unit prices for activity** delivered.
- For 2023/24 NHSE plans to base **agency spend limits** on agency spending as a proportion of systems' total pay costs, set at 3.7% of a system's total pay bill.

## 2. Funding

The planning guidance emphasises the importance of delivering a balanced net system financial position in 2023/24, meeting the 2.2% efficiency target and improving productivity levels (including 10% in pathology and imaging networks). ICBs and providers are expected to clearly outline their performance monitoring processes and financial control procedures.

NHSE will publish two-year revenue allocations for 2023/24 and 2024/25 – integrated care board (ICB) allocations [including COVID-19 and ERF] are flat in real terms with additional funding available to expand capacity. NHSE will also increase the capital envelope for 2023/24 by £300m nationally – access to this additional capital funding will be prioritized for systems that deliver agreed budgets in 2022/23.

Other key funding headlines:

- The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay **unit prices for activity** delivered.
- System and provider activity targets will be agreed through planning as part of allocating **ERF** on a fair shares basis to systems. NHS England will cover additional costs where systems exceed agreed activity levels.
- **Targeted Investment Fund** put in place in 2022 - Further details will be set out in the forthcoming revenue finance and contracting guidance and capital guidance update.
- Systems are required to deliver on the **Mental Health Investment Standard** (MHIS).
- **Better Care Fund**- £600m in 2023/24 supporting timely discharge in addition £400m ring fenced LA grant for adult social care to support discharge amongst other goals.
- **Maternity**- NHSE investing additional £72m above the £93m baselined allocations into maternity programme in 2023/24 to address actions in the Ockenden Report.
- **Core funding growth for community health services** as part of overall ICB allocation growth, £77m, Service Development Funding maintained in 2023/24.
- Primary care allocations increased by 5.6% in 2023/24.
- Inequalities funding recurrent in 2023/24.
- ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a **balanced net system financial position** in collaboration with other ICS partners.
- Following the October 2021 spending review, £2.3bn of capital funding will be made available to systems over 2023/24 and 2024/25 to support **diagnostic service transformation.**

A consultation notice on the 2023/25 NHS Payment Scheme has been issued. This document describes best practice tariffs (BPTs) and gives detailed guidance on the implementation and eligibility criteria for each BPT.

To generate the required level of efficiency savings, systems must:

- **Reduce agency spending** across the NHS to 3.7% of the total pay bill in 2023/24.
- **Reduce corporate running costs** with a focus on consolidation, standardisation and automation to deliver services at scale across ICS footprints.
- **Reduce procurement and supply chain costs** via supply chain coordination limited (SCCL), and the specialised services devices programme.
- **Improve inventory management** by building an inventory management and point of care solution.
- **Purchase medicines at the most effective price point** through engagement with the commercial medicines unit and the national medicines value programme. The revenue finance and contracting guidance for 2023/24 will set out further information. This has not yet been published.

## 3. Recovering core services and regaining lost productivity

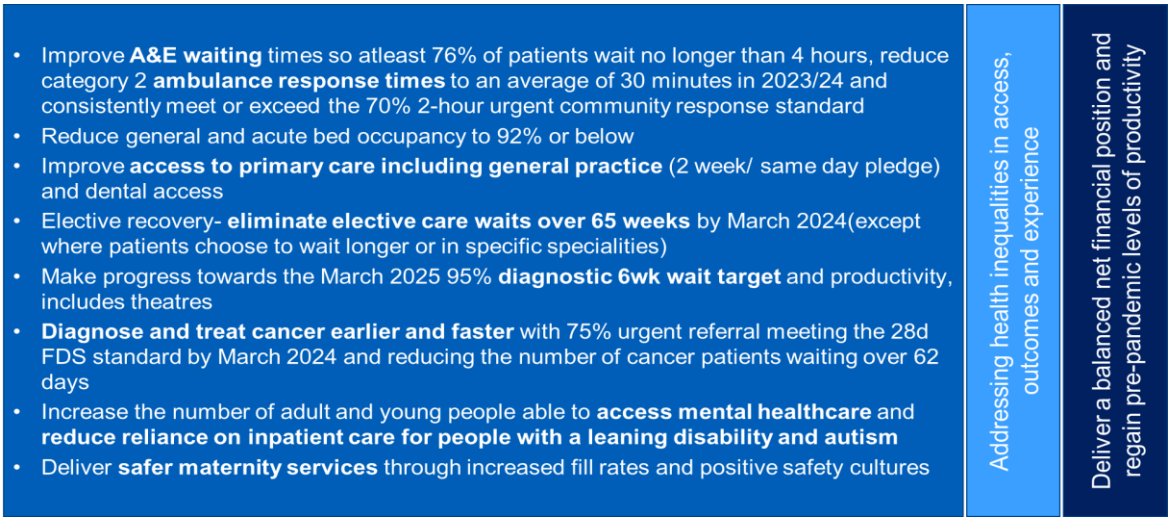
Three main areas of focus:

- Improve ambulance response and A&E waiting times.
- Reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard.

- Make it easier for people to access primary care services, particularly general practice.

The planning guidance sets a range of "national NHS objectives" for 2023/24, setting expected performance against key operational standards.

**Headline National NHS Objectives 2023/24**




The full list of objectives can be found in appendix 1 to this briefing. Essential actions also include reducing outpatient follow ups relative to first appointments and increasing day case rates and theatre utilisation.

Recovering productivity and improving whole system flow are critical to achieving these objectives, and the guidance requires systems to collectively address the challenge of staff retention and attendance.

### 3.1 Urgent and emergency care

The guidance sets key actions which are designed to increase capacity and improve patient flow to ease the pressures in emergency departments. These include:

- **Increasing physical capacity** through maintaining the additional beds which were funded for this winter and reducing bed occupancy to at least 92%. This also includes increasing the use of virtual wards to 80% by the end of September 2023. £1bn of funding will be incorporated into system allocations to enhance capacity in 2023/24.
- **Improving timely discharge** to ensure medically fit patients can be discharged from hospitals and inpatient units.
- **Increasing ambulance capacity**.
- **Managing system risk** by ensuring all ICBs operationalise clinically led system control centres (SCSs).

As announced in the autumn statement, NHS England will publish an urgent and emergency care recovery plan in early 2023 in collaboration with DHSC and the Department for Levelling Up, Housing and Communities.

### 3.2 Community health services and primary care

As well as maximising the number of referrals into urgent community response (UCR), the guidance sets out the need to expand direct access and self-referrals to ease the pressure on primary care.

- By September 2023, systems should implement **direct referral pathways for urgent and elective eye consultations and a range of self-referral routes**, including falls response services and weight management services.
- The guidance also focuses on **improving patient access to GP services** by ensuring that appointments can be secured within two weeks, and urgent issues can be seen on the same or next day based on clinical need. Systems are asked to develop plans to improve digital access to GP practices.
- The NHS will be expected to **deliver 50 million more primary care appointments** by the end of March 2024 on 2019/20 levels which will be supported by the recruitment of 26,000 roles through the additional roles reimbursement scheme (ARRS).
- ICBs' **primary care allocations** in 2023/24 will increase by 5.6% given the rise in GP contract entitlements and the increase in ARRS entitlements.
- Greater use of the **community pharmacist consultation service (CPCS)** is also intended to redirect lower acuity care away from general practice and NHS 111.

NHSE will also publish a recovery plan for general practice access in the new year

### 3.3 Elective care

NHSE will agree targets with systems for 2023/24 to deliver 30% more elective activity than pre-pandemic levels by 2024/25, and eliminate waits of over 65 weeks by March 2024 (except where patients choose to wait longer or in specific specialties).

The guidance sets out the key areas of focus for 2023/24:

- **Transform outpatient care** by reducing outpatient follow-up activity by 25% against 19/20 levels by March 2024. The ambition as set out in the 2022/23 planning guidance is to reduce follow-ups but it is not clear at what rate providers will be reimbursed.
- **Increase productivity** by meeting the 85% day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings.
- **Offer meaningful choice** at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS).

### 3.4 Cancer and diagnostics

The headline objectives for 2023/24 are to reduce cancer waiting times and support earlier diagnosis. To achieve those aims, systems are expected to:

- **Implement priority pathway changes** for lower GI, skin and prostate cancer pathways to enable earlier diagnosis. This should improve cancer waiting times as two thirds of patients waiting longer than the 62-day target are accessing treatment across these pathways.
- **Increase diagnostic capacity for cancer by 25% and treatment capacity by 13%** to keep pace with the growth in cancer-related demand.
- **Support early diagnosis** through an expansion of the targeted lung health check programme as well as other non-symptom specific pathways.

Systems must increase the proportion of patients who attend a diagnostic test within six weeks of referral and deliver sufficient levels of diagnostic activity. The ambition is for systems to maximise the pace of roll-out of **additional diagnostic capacity**, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely **implementation of new CDC locations** and upgrades to existing CDCs.

Systems will be asked to deliver a minimum **10% productivity improvement in pathology and imaging** networks by 2024/25 via digital capability enhancements.

### 3.5 Maternity and neonatal services

To achieve improved safety standards across maternity and neonatal services, the planning guidance asks for systems to:

- Improve the personalisation of care, and
- Implement local equity action plans to tackle the inequality of outcomes and experiences of Black, Asian and Mixed ethnic groups.

NHSE is also investing an additional £72m above the £93m baselined allocation into the maternity programme in 2023/24 to address the actions highlighted in the Ockenden report

## 4. Delivering the key Long Term Plan ambitions and transforming the NHS

Systems are asked to deliver the core goals of the NHS Long Term Plan. These include our commitments to:

- Improve **mental health services** and **services for people with a learning disability and autistic people.**
- Continue to support delivery of the **primary and secondary prevention priorities** and the **effective management of long-term conditions**.
- **Ensure that the workforce is put on a sustainable footing** for the long term, including publication of a NHS Long Term Workforce Plan.
- Level up **digital infrastructure** and drive **greater connectivity**, including development of the NHS App to help patients to identify their needs and get the right care in the right setting.

### 4.1 Mental Health, learning disability and autism

- Systems must continue to achieve the **Mental Health Investment Standard** as an absolute minimum.
- NHSE has also allocated funding to invest in the **growth of the improving access to psychological therapies (IAPT)** workforce through offering 60% salary support for new trainees in 2023/24, and will also expand services in line with the LTP's ambitions on mental health.
- The guidance highlights the need to **reduce pressure on mental health inpatient care**.
- Systems should **improve performance across autism diagnostic assessment pathways**.
- **Systems should also expand the size and improve the accuracy of GP learning disability registers**, with an ambition for 75% of people on the registers to be provided with an annual health check by March 2024. NHSE will support ICBs to develop plans to drive improvements in the quality of mental health and learning disability inpatient services, through an alignment and localisation of services, over a three year period.

### 4.2 Workforce

The guidance asks all systems to refresh system workforce plans in 2022/23 to ensure the following are reflected:

- **Improved staff experience and retention** – focusing on NHS People Promise and implementation of the Growing Occupational Health Strategy, improving attendance toolkit and Stay and Thrive Programme.
- **Increase productivity** by fully using skills, adapting skill mix, and accelerating the introduction of new roles.
- **Flexible working practices** and flexible deployment of staff across Organisational boundaries using digital solutions.

- **Regional multi professional education and training** investment plans (METIP) and ensure sufficient clinical placement capacity, including education/ trainer capacity to enable al NHS E Funded trainees and students to maintain pipeline.
- **Implement Kark recommendations** and Fit and Proper Person test.

NHSE plans to increase workforce education and training investment in real terms in each of the next two years.

### 4.3 Prevention and Health Inequalities

Throughout all the above will be a focus on narrowing health inequalities in access, outcomes and experiences, including across services for children and young people and maintaining quality and safety in our services, particularly in maternity services.

**Specific targets**

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84yrs with a CVD risk score greater than 20% on lipid lowering therapies to 60%
- Continue to address health inequalities on the CORE20PLUS5 approach

- Update plans for prevention of ill-health and incorporate them in the Joint Forward Plan – including:
  - CVD prevention
  - Diabetes
  - Smoking cessation
  - High impact interventions
  - Women's Health Strategy
- Deliver against the five strategic priorities for tackling health inequalities
- Adopt QI approach to addressing health inequalities and reflect CORE20PLUS5 approach
- CORE20PLUS5 Children and young people
- Establish high intensity use service to support demand management in UEC

### 4.4 Digital

To improve digital capabilities, more providers are expected to operationalise **electronic health records** and should work towards developing a **population health and planning data platform**. NHSE will provide targeted funding to enable ICSs to meet minimum digital capabilities and foundations. NHSE will also procure a federated data platform accessible to all ICSs and will improve the functionality of the NHS app.

## 5. System working

The guidance expects systems to have local objectives in place which will feed into the national NHS objectives. Key priorities for the development of ICSs in 2023/24 include:

- Developing ICP integrated care strategies and ICB joint forward plans.
- Maturing ways of working across the system including provider collaboratives and place-based partnership arrangements.
- ICBs will soon be given the responsibility of managing population healthcare budgets, and by April 2023 NHSE will fully delegate pharmacy, ophthalmology and dentistry (POD) services.
- NHSE and ICBs will work cooperatively via joint committees on the commissioning of specialised services from April 2023, and ICBs will take responsibility for commissioning appropriate specialised services from April 2024.

## 6. Next Steps

Of note the guidance did not include a submission timeline. Appendix 2 includes the Dorset ICB proposed timeline.

## Appendix 1: National NHS objectives 2023/24

| | Area | Objective |
|---|---|---|
| Recovering our core services and improving productivity | **Urgent and emergency care*** | Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 |
| | | Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 |
| | | Reduce adult general and acute (G&A) bed occupancy to 92% or below |
| | **Community health services** | Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard |
| | | Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals |
| | **Primary care*** | Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need |
| | | Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 |
| | | Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 |
| | | Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels |
| | **Elective care** | Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) |
| | | Deliver the system- specific activity target (agreed through the operational planning process) |
| | **Cancer** | Continue to reduce the number of patients waiting over 62 days |
| | | Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days |
| | | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 |
| | **Diagnostics** | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% |
| | | Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition |
| | **Maternity*** | Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury |
| | | Increase fill rates against funded establishment for maternity staff |
| | **Use of resources** | Deliver a balanced net system financial position for 2023/24 |
| | **Workforce** | Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise |
| | **Mental health** | Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) |
| | | Increase the number of adults and older adults accessing IAPT treatment |
| | | Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services |
| | | Work towards eliminating inappropriate adult acute out of area placements |
| | | Recover the dementia diagnosis rate to 66.7% |
| | | Improve access to perinatal mental health services |
| | **People with a learning disability and autistic people** | Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 |
| | | Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit |
| | **Prevention and health inequalities** | Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 |
| | | Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% |
| | | Continue to address health inequalities and deliver on the Core20PLUS5 approach |

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

## Appendix 2: Proposed Dorset ICB Timelines

### Timeframes- First Submission (note guidance didn't have timetable included

NHS Dorset

- 20 December 2022- High level activity profile from providers to ICB
- 9 January 2023- OFRG Special HRD/COOs/DoFs
  - agreement to approach post planning guidance including:
    - agree assumptions
    - finance – PbR, CIP
    - agree collective responsibility for delivery
    - agree timetable and next steps
- 17 January 2023- Providers to submit to updates plans in line with planning assumptions including gaps in performance to ICB e.g. performance against 65wks and specialities of concern
- 20 January 2023- ICB complete review of provider plans and understand:
  - Baselines
  - Current position
  - Gaps against planning guidance
- 20 January 2023- First draft narrative elements of plans from leads (post agreement of priorities at SLT on 20 December 2022)- *subject to change*
- 23 January 2023- First draft finance and workforce plans
- w/c 23 January 2023 – Elective Group Meeting to test elective element of plans (date TBC)
- w/c 23 January 2023- Draft operational plan presentation- finance, activity, workforce (date TBC)
- w/c 30 January 2023- OFRG meeting to share and test plans (date TBC)
- 6 February 2023- Provider to submit refined/ updated plans (post OFRG feedback) to inform F&P committee papers
- 16 February 2023- Finance and Performance Committee review of plans- finance/ activity/ workforce/ narrative
- 23 February 2023- 1st draft submission to NHSE

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 8.2**

| | |
|---|---|
| **Subject:** | Freedom To Speak Up (FTSU) Strategy 2023-2026 |
| **Prepared by:** | Helen Martin, Freedom to Speak Up Guardian |
| **Presented by:** | Helen Martin |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☒<br>Be a great place to work ☒<br>Use resources efficiently ☐<br>Be a well led and effective partner ☒<br>Transform and improve ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | BAF/ not applicable |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | This paper sets our an ambitious FTSU improvement strategy, with a clear and robust vision for speaking up in UHD until 2026. |
| **Background:** | There is an expectation from National Guardian Office (NGO) that each Trust has a clear, robust and ambitious FTSU improvement strategy articulating our speaking up vision and goals. It is best practice that this is then signed off by the senior team/board and requires full buy in from managers to ensure its successful delivery (NHSE, 2022). The strategy was built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy which will have planned progress updates. |
| **Key Recommendations**: | Approve the FTSU strategy for 2023 to 2026 |
| **Implications associated with this item:** | Council of Governors ☒<br>Equality and Diversity ☐<br>Financial ☐<br>Operational Performance ☐<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☐<br>Strategy/Transformation ☒<br>System ☐ |

| | |
|---|---|
| | It is good practice to share our speaking up strategy to our senior leaders and managers to ensure its successful delivery. The strategy sets out why speaking up is important for our people and how it improves the quality of care we deliver to our patients. |
| **CQC Reference:** | Safe ☒<br>Effective ☐<br>Caring ☐<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☐ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Workforce Strategy Committee | 14/12/2022 | Endorsed |

| | |
|---|---|
| **Reason for submission to the Board in Private Only (where relevant)** | Commercial confidentiality ☐<br>Patient confidentiality ☐<br>Staff confidentiality ☐<br>Other exceptional reason ☐ |

University Hospitals Dorset
NHS Foundation Trust

# Freedom to Speak Up (FTSU)

# Strategy 2023 – 2026

**If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version**

| A) SUMMARY POINTS |
|---|
| This strategy sets out the Trust's Freedom to Speak Up vision and strategy over the next 3 years. |
| This strategy aims to improve the experience of speaking up at University Hospitals Dorset (UHD) |
| It outlines how to measure the success of the strategy |
| **B) ASSOCIATED DOCUMENTS** |
| Policy: Freedom to Speak Up policy for the NHS |

| B) DOCUMENT DETAILS | |
|---|---|
| **Author:** | Helen Martin |
| **Job title:** | Freedom to Speak Up Guardian (FTSUG) |
| **Directorate:** | People Directorate |
| **Version no:** | 1 |
| **Target audience:** | All Trust employees including any healthcare professional, non-clinical worker, contractors, agency workers, temporary workers, students, volunteers and former workers. |
| **Approving committee / group:** | Trust Board of Directors |
| **Chairperson:** | Chair of Board |
| **Review Date:** | April 2025 |

| C) CONSULTATION PROCESS | | | |
|---|---|---|---|
| **Version No.** | **Review Date** | **Author** | **Level of Consultation** |
| 1 | 14.12.22 | Helen Martin | People and Culture Committee (Workforce Steering Committee) |
| | | | |
| | | | |

| D) VERSION CONTROL | | | | | | |
|---|---|---|---|---|---|---|
| **Date of Issue** | **Version No.** | **Date of Review** | **Nature of Change** | **Approval Date** | **Approval Committee** | **Author** |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## 1.0 Introduction and Purpose

> *"Speaking up is a gift – use it wisely and we can change the NHS for the better"*
> NGO Annual report 2021/22

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication "Freedom to Speak Up (FTSU)". He recognised that having a healthy speaking up culture helps protect patients and improves the experience of NHS workers. Listening and responding to people who speak up, and tackling the barriers to speaking up, is a natural ingredient of good leadership and a well led organisation. Consequently, he mandated that each Trust appoint a Freedom to Speak Up Guardian (FTSUG) which has now been part of the NHS standard contract.

Seven years have passed since the publication of the Francis Freedom to Speak Up Review. The speaking up culture of the health sector in England has changed with a network of over 857 Freedom to Speak Up Guardians in over 541 organisations hearing over 50 000 cases in the last 3 years (NGO, 2022). Such an increase of cases reflects how trusted FTSU Guardians (FTSUG) are as additional channel for speaking up.

Speaking up benefits everyone. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and improved patient experience. The purpose of this document is to set out the Freedom to Speak Up vision and strategy over the next 3 years for University Hospitals Dorset (UHD). This document should be read alongside the Trust's Freedom to Speak Up policy for the NHS.

## 2.0 Definitions

The following definitions apply to this strategy:

| | |
|---|---|
| **Freedom to speak up** | A process encouraging staff to raise concerns and speak up to protect patients and improve the experience of NHS workers. |
| **Freedom to Speak up Guardian (FTSUG)** | A named person who acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation |
| **Freedom to speak up Ambassador** | A member of the FTSU team who raises awareness of speaking up and refers cases to the FTSUG if needed. |
| **Vision** | An aspirational description of what an organization would like to achieve or accomplish in the mid-term or long-term future. |
| **Objective** | A plan that underlies all strategic activities |

| | |
|---|---|
| **Strategy** | a Board level approved document which identifies the aims and objectives for the Trust in a given subject area |

## 3.0 Roles and Responsibilities

| | |
|---|---|
| **Chief Executive and Chair** | Accountable for ensuring that FTSU arrangements meet the needs of the workers in the trust. |
| **Executive lead for FTSU** | Lead executive responsible for ensuring latest guidance is applied and ensuring the FTSUG role is implemented and supported. |
| **Non-executive lead for FTSU** | Lead non-executive ensuring implementation of latest guidance and alternative support for FTSUG. Oversees speaking up matters regarding board members. |
| **FTSUG** | • empower staff to raise concerns within organisations,<br>• provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled,<br>• ensure that organisational policies and processes in relation to the raised concern are in place and followed correctly,<br>• ensure shared learning amongst local/regional/national Networks,<br>• produce reports to monitor the outcomes and impact of FTSU. |
| **FTSU Ambassadors (FTSUA)** | Contribute to creating a culture of speaking up where staff feel safe and confident to raise concerns. The FTSUA will work alongside the FTSUG promoting, raising awareness and signposting (including to FTSUG) for support. |
| **National Guardian Office (NGO)** | Leads, trains and supports a network of FTSUG in England and provides support and challenge to the healthcare system on speaking up |

## 4.0 The National Perspective

The National Guardian's Office (NGO) is an independent, non-statutory body with the remit to lead culture change in the NHS in England. The NGO do this by supporting a network of FTSUGs within NHS Trusts, Foundation Truss and other organisations disseminating good practice, undertaking case reviews and working across the health system to tackle barriers to speaking up. Its vision is to make speaking up business as usual where speaking up is not only welcomed, but valued as an opportunity to learn and improve.

National Guardian
Freedom to Speak Up

**NGO Mission**
To make speaking up business as usual throughout the healthcare sector in England

## 4.1 The NGO Strategic Framework


The NGO Strategic Framework was launched in July 2021 and enables the NGO to build on the achievements of Freedom to Speak Up to date and to respond to wider changes in the healthcare landscape. It sets out a journey towards gaining greater assurance about speaking up culture and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented.

The Strategic Framework is made up of four pillars of support. Under each pillar the framework outlines the focus of the work going forward.

1. workers;
2. FTSUG;
3. leadership and
4. the healthcare system.

## 5.0 The Local Perspective

## 5.1 A Vision for Speaking Up at UHD

Speaking up at University Hospital Dorset (UHD) is the cornerstone of our culture. This is reflected in our set of values following the cultural review undertaken by our cultural champions back in 2020. Our people clearly described the need for a learning rather than blame culture, whereby we are able to make mistakes without feeling afraid to discuss them. Psychological safety and feeling confident to speak up were seen as contributing to safer, excellent quality care. As a result, UHD are proud to have "I will be open and honest" as one of our values. Speaking up is also within a key strategic objective for 2022/23, italiced below engaging with staff, listening and addressing issues that they may raise.

| | |
|---|---|
| | NHS<br>University Hospitals Dorset<br>NHS Foundation Trust |
| Purpose | To positively transform our health care services as part of Dorset ICS |
| Vision | Excellent healthcare to our patients and our community and to be a great place to work |
| Values | We are caring, one team, listening to understand, open and honest, always improving, inclusive |
| Strategic objectives 2022/23 | 1. Continually improve quality of patient care<br>2. Be a great place to work<br>*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.*<br>3. Use our resources well<br>4. Be well-led and an effective partner<br>5. Transform our services to better serve patients |

### 5.2 Our FTSU team and FTSU Model at UHD

Our Freedom to Speak Up (FTSU) team provide a route to enable workers to do this when they feel unable to speak to their line manager or use other established processes. The FTSU team have been in place since 2018. In 2021, The National Guardian Office published guidance on developing FTSU internal networks into the future. This has resulted in us reflecting on how we work together separating out our roles more clearly as FTSU Guardian (FTSUG) and FTSU Ambassador (FTSUA). Our FTSUAs raise awareness and promote the value of speaking up, listening up and following up. The FTSUG will handle cases and set the strategic direction of our speaking up culture, networking across the region and with the NGO. This model, whilst poses some limitations to our case management, has helped address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

### 5.3 Aim and Commitment of Speaking Up

We want our workers at UHD to feel valued and respected at work and to know that their views are welcomed. By meeting our worker's needs we recognise that this will enable us to deliver the best possible care. Consequently, we are committed to providing the best working environment where speaking up is not only welcomed but valued as an opportunity to learn and improve.

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

There are many ways that our people can speak up at UHD. This includes your line manager, human resources, using our LERN forms, staff governors, occupational health and our staff networks. You can also speak up with our freedom to speak up team and if you choose this route, they will provide the following commitment to each conversation.

## The Freedom To Speak Up commitment

**S** You're safe and secure to talk to us; we'll support you every step of the way to raise concerns.

**P** We are all about our people. When we look after each other we give the best to our patients. FTSU are here for you and hearing your voice is our priority.

**E** We treat all staff equally, empower you to make concerns and enable the trust to make change.

**A** We will listen and act with integrity to ensure your concerns are heard. We are approachable and here for you.

**K** We treat you kindly; we know what steps need to be taken when you raise a FTSU concern, we have the knowledge to help make a difference.

The key roles of the FTSU team are:

| FTSUG | FTSUA |
|---|---|
| empower staff to raise concerns within organisations | |
| provide awareness raising, promoting speaking up within groups, departments and locations. | |
| Role model values and behaviours associated with speaking up | |
| Detailed knowledge of local speaking up policy and process including escalation routes and useful contacts | |

| | |
|---|---|
| Provide information on options available and escalate issues that must be acted on involving safety or safeguarding. Understand when to signpost and when to escalate and when to seek support. | |
| Explore trends from surveys and data and lead link with key stakeholders | Signpost to key stakeholders including FTSUG |
| Develop and deliver training programmes to new and existing staff | Contribute and deliver training programmes to new and existing staff |
| Hear FTSU cases | Signpost any staff to FTSUG |
| Outward facing, leading networks alongside National Guardian Office (NGO) guidance and local merger and CSR plans | |
| National profile within NGO and supporting/mentoring other organisations | |
| Develop and deliver reports to monitor the outcomes and impact of FTSU with board and other key stakeholders | |
| Complete and Submit data to National Bodies including NGO, CQC, NHSI/E | |

## 6.0 Speaking Up Strategy at UHD

A strategy for speaking up was approved by the Board in May 2020 and set out our vision, ambition and aims based on a diagnosis of issues the trust was currently facing in relation to speaking up. The strategy had been aligned to legacy Trust objectives and a detailed work plan to measure its delivery within the terms of objectives. In light of the publication of the NGO 5-year strategy in 2021, the UHD FTSU strategy is now refreshed and presented to the board for 2023-26.

Last year the FTSU looked to focus its work on “embedding” and building on its success from previous years. This year, the FTSU team at UHD will create a challenging workplan mirroring the 4 pillars outlined by the NGO (section 4.1) but encompassing the objectives and challenges at UHD. The diagram below outlines the 4 key principles of work for the FTSU team.


### 6.1 The Workers

It is recognised nationally that more needs to be done to foster a speak up, listen up, follow up culture, where workers are listened to and appropriate action taken as a result. Suppression of the voices of workers and victimisation of those who speak up are still being reported and our staff at UHD also report this. Indeed, in 2021 our staff survey showed that if staff speak up about something that concerns them, only 50.1% felt confident that UHD address the concern. This question is highly regarded to reflect a speaking up culture and whilst above average is nonetheless disappointing. Since then however, in a more recent pulse survey (Sept 2022) this figure increased to 57%.

Speaking up is more than having a FTSU team. Our data shows us that staff at UHD view speak up through the FTSU team as an established channel. Indeed, the number of staff using this channel for speaking up is more than an average (similar sized) trust. This inevitably reflects the increase of size of our organisation following the merger across multiple sites. It is also well documented that at times of significant change such as merger, operational re-structuring, healthcare structural changes or building work will increase workloads for FTSU teams (NHSE, 2022). This is not a position however that we want to be in. We recognise that we will not have speaking up as business as usual if FTSGU are spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place.

Consequently, we have a vision that **Speaking up at UHD is everyone's business.** We acknowledge that all our leaders, and in fact everyone, needs to welcome, challenge and implement change when speaking up. All levels of our leaders play a vital role for setting the right cultural tone for speaking up and for handling speaking-up matters effectively. They influence how their teams and colleagues behave and so it is essential that they have to role model the speaking up principles. We are therefore committed to ensure our leaders are given the skills to be compassionate and inclusive by listening up and following up and taking appropriate action. We will encourage all our leaders to listen to our teams (with fascination),

acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change. Creating psychological safe working environments is also key and so we will follow leaders in this field such as Amy Edmondson and her 5 steps to enhance psychological safety including brave leadership, inclusion and acceptance, learning through pilots and experimentation, respectfully challenging the status quo and innovation.

To address this, we will

- Champion speaking up, encouraging that speaking up is everyone's business. #FTSUforEveryone
- Skill all our leaders to speak up, listen up and follow up through our management and leadership programmes and completion of HEE/NGO training modules
- Skill our leaders to create psychological safe working environments for our people to speak up.
- The FTSU team will support workers by reflecting the voice of workers in speaking up reviews, board reports and senior development.
- The FTSU team will support the themes and proactively address the barriers to speaking up
- Support the FTSU model to reflect both reactive and proactive functions of the role.
- The FTSU team will support and contribute to the wider cultural and transformation programme "patient first" to ensure speaking up is embedded in its programme going forward.

### 6.2 The FTSU team

The FTSU team perform a vital function in the workplace, as evidenced by the year on year increase of referrals at UHD. In 2021/2022 over 230 cases were raised by the FTSU team and heard by the FTSUG with 100% of staff evaluating the service positively.

As of April 2022, the NGO expects us to have a speaking up model which separates the roles of our FTSUG and FTSUA. It explicitly set expectations that our FTSUG works proactively, setting strategic direction and reactively by hearing cases. In contrast our FTSUA are limited to raising awareness and signposting (including to the FTSUG). We comply to this expectation however it now poses limitations to a sole individual handling cases.


With this in mind, and in the knowledge that staff at UHD use this channel for speaking up more than an average (similar sized) trust, it has resulted in the FTSUG working in a more reactive (listening to workers) rather than proactive (supporting the organisation to learn from the opportunities that speaking up brings and tackling the barriers). Speaking up will not become business as usual if FTSUG are spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place. It is essential that a sustainable future is planned for to meet the needs of our workers across multiple sites and reduce the risk of being a single point of failure with one FTSUG.

The role is also challenging and the cases that are handled can be sensitive and complex. The proactive element of the role requires the FTSU team to engage with a range of stakeholders, as they identify and seek to remove barriers to speaking up. To perform their role effectively, the FTSU team must have the necessary knowledge, confidence and credibility so that they meet the needs of the workers and organisations they support.

It is therefore essential that this strategy provides assurance that the FTSU team are supported, developed and made sustainable for the future. This will be done by;

- Regularly reviewing and updating the training, guidance and support to the FTSU team, nationally from the NGO but also locally from the board.
- Approve a sustainable FTSU model at UHD and develop a deputy role in the team.

### 6.3 The Leadership

Our leaders play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture. Whilst the insights from our FTSU team can act as an early warning system of where failings might occur and help understand the behaviours and culture that workers experience in practice, it is our leaders who are integral to how we learn, develop and improve. Every leader needs to embrace speaking up so to effectively contribute to the safety and quality of care and improvements in the working environment. This is not universally recognised to be the case in healthcare. Indeed, there is a growing picture nationally of Guardians themselves feeling victimised for doing the job expected of them.

When we explore as to why our staff come to speak with our FTSU team an initial hypothesis was that following significant staff changes in management, staff were not aware of whom to escalate issues to. This has not however appeared to be the case and data from April to end of July 2022, shows us that 52% of referrals to the FTSU team are because either their line manager was the issue of the concern or that the line manager was aware of the issue but not addressing the issue. This trend is mirrored in the staff survey (2021) Q21f, where only 50.1% reported saying that they are confident issues would be addressed. Furthermore, over this period there was a significant increase of staff who reported not feeling secure in raising concerns with line managers (21%). This was also reflected more recently in the people pulse survey (September 2022) which also showed 43% of staff did not raise a concern because they did not trust the process that their concern would be kept secure and confidential. A culture of speaking up needs a strong foundation of psychological safety.

This strategy will therefore support our leaders and encourage speak up, listen up and follow up to be a natural leadership behaviour by:

- Supporting the delivery of universal guidance and supportive tools for leaders to enable them to improve speaking up culture within UHD and across the system
- Provide learning to support leaders to recognise and utilise the potential for speaking up to accelerate improvement
- Provide training for workers, including leaders, to promote a speak up, listen up, follow up culture
- Promoting the use of data and intelligence to inform good practice, describing trends and challenges, and encouraging improvement

## 6.4 The Healthcare

Healthcare System Good practice fails to flourish when it is not supported by each-other. Systemic drivers need to promote effective co-ordinated and consistent speak up, listen up, follow up cultures. At UHD the FTSUG is the chair for our Dorset Network and co-chair for the south west FTSUG. Taking the lead in these roles allows UHD to shape our healthcare system and share/learn from best practice. Other roles taken include national mentoring of new FTSUGs and providing guidance to national policy.

We will continue to;

- Promote universal principles for speaking up and their application across the system
- Produce information on good practice and guidance
- Seek to establish a consistent set of metrics that allows speaking up culture to be understood at the organisational, system, and national level
- Bring national bodies together to develop a consistent and supportive response when workers speak up

## 7.0 Measuring success

There are a number of ways to measure the success of the speaking up strategy. These include:

- increase effective awareness training for all staff so they are clear about what concerns they can raise and how to raise them;
- provide regular communications to all staff (including those permanently employed on a full-time/part-time basis, temporary/ contracted workers and volunteers) to raise the profile and understanding of our speaking up arrangements;
- communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality;
- share good practice and learning from concerns raised, with the key aim of fostering openness and transparency, such as staff briefings, team meetings and the intranet;
- actively seek the opinion of staff to assess that they are aware of and, are confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experiences and learning;
- use local intelligence from exit interviews as way of example to understand and support staff and provide additional information on how culture can continue to be improved
- obtain feedback from staff who use the service for critical feedback and improvement.

## 8.0 Summary

Speaking up enhances our working lives and improves the quality and safety of care. Indeed, speaking up benefits everyone and by listening and acting to the views of our people, their improvement ideas and concerns it act as a valuable early warning system. *Speaking up is a gift – use it wisely and we can change the NHS for the better (*NGO Annual report, 2021/22*).* This strategy provides a clear and sustainable direction for UHD, meeting the local and national requirements. Speaking up has never been as important as it is today especially if we are to meet the challenges felt across healthcare. Speaking up needs to be everyone's business.

# APPENDIX 1: Equality Impact Assessment

| | |
|---|---|
| 1. Title of document | **Freedom to Speak Up (FTSU); Strategy 2023 – 2026** |
| 2. Date of EIA | 10.11.22 |
| 4. Directorate/Specialty | People Directorate, Organisational Development |

5. Does the document/service affect one group less or more favorably than another on the basis of:

| | Yes/No | Rationale |
|---|---|---|
| • Age – where this is referred to, it refers to a person belonging to a particular age or range of ages. | No | The strategy applies to all staff working for the trust |
| • Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities. | No | The strategy can be in braille or larger print if needed |
| • Gender reassignment – the process of transitioning from one gender to another. | No | The strategy applies to all staff working for the trust |
| • Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple. | No | The strategy applies to all staff working for the trust |
| • Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding. | No | The strategy applies to all staff working for the trust |
| • Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins. | No | The strategy applies to all staff working for the trust. The strategy can be made available in an alternative language |
| • Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. | No | The strategy applies to all staff working for the trust. |
| • Sex – a man or a woman. | No | The strategy applies to all staff working for the trust |

| | | |
|---|---|---|
| • Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes. | No | The strategy applies to all staff working for the trust |
| 7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified? | N/A | |
| 8. If the answers to any of the above questions is 'yes' then: | | **Rationale** |
| Demonstrate that such a disadvantage or advantage can be justified or is valid. | N/A | |
| Adjust the policy to remove disadvantage identified or better promote equality. | N/A | |

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 10.1**

| | |
|---|---|
| **Subject:** | Enabling Accountability Framework |
| **Prepared by:** | Judith May, Director of Operational Performance and Oversight<br>Yasmin Dossabhoy, Associate Director of Corporate Governance |
| **Presented by:** | Mark Mould, Chief Operating Officer |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☒<br>Be a great place to work ☒<br>Use resources efficiently ☒<br>Be a well led and effective partner ☒<br>Transform and improve ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | N/A |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | The current Enabling Accountability Framework document has been reviewed and updated to recognise changes the in structure or processes as outlined below.<br><br>Several formatting and other minor changes have been made to the document, however the key changes of note since the version approved by the Trust Board in November 2021 include:<br>• Section 1.4 – updates to the Trust's strategic objectives to mirror correct wording.<br>• Section 1.5 – updates to the strategy documents in conjunction with which the framework document should be read.<br>• Section 3 – update to refer to Accountability Framework taking account of the national NHS Oversight Framework 2022/23.<br>• Various updates in relation to the Dorset Integrated Care Board.<br>• Section 6.2 – amendments to reflect the changes to the Trust's Committees, coming into effect in January 2023. (Further updates are expected to be made to this section in due course).<br>• Section 7.3 – amendment to the key content areas and removal of benefit realization.<br>• Section 7.3.4 – updates to transformation and |

| | |
|---|---|
| | improvement section.<br>• Section 8.2 – modification to reference frequency of performance review meetings being increased in line with framework; addition of reference to intensive support.<br><br>A best practice review of accountability frameworks has also been undertaken referring to examples from other provider organisations.<br><br>Subsequently, it is proposed that the updated accountability framework attached is adopted for an interim period whilst the Trust fully revises its accountability framework. |
| **Background:** | The Enabling Accountability Framework describes the mechanisms, processes and lines of accountability within the Trust to illustrate how performance will be monitored and managed against the Trust's strategic objectives. It provides details of the mechanisms for oversight, escalation, and guidance and support to enable an organisational focus on quality of care and ensuring services are sustainable.<br><br>The Enabling Accountability Framework was approved by the Trust Board in November 2021. |
| **Key Recommendations**: | To approve the Enabling Accountability Framework, noting that a further updated version is being internally consulted upon and will be presented to the Board for approval. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality and Diversity ☐<br>Financial ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒<br>System ☒ |
| **CQC Reference:** | Safe ☒<br>Effective ☒<br>Caring ☒<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☒ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| Executive Team Meeting | 09/01/2023 | Supported |
| Trust Management Group | 10/01/2023 | Supported |

| Reason for submission to the Board in Private Only (where relevant) | | |
|---|---|---|
| | Commercial confidentiality | ☐ |
| | Patient confidentiality | ☐ |
| | Staff confidentiality | ☐ |
| | Other exceptional reason | ☐ |

University Hospitals Dorset
NHS Foundation Trust

# ENABLING ACCOUNTABILITY FRAMEWORK

| | |
|---|---|
| Version: | Master Version – V4 |
| This version issued: | January 2023 |
| Review date: | March 2023 |
| Authors: | Various |

# CONTENTS



**Appendices**

## 1. Introduction

1.1 An Enabling Accountability Framework is critical in supporting the delivery of University Hospitals Dorset NHS Foundation Trust's corporate strategy ('the Organisational Strategy'). Personal accountability underpins everything that we stand for as an organisation. The experience and outcomes for our patients and relatives, colleagues and families, and wider stakeholders depend on each of us giving our very best both as individuals and as members of the smaller and larger teams and communities which together make up UHD. This document describes the mechanisms, processes and lines of accountability to illustrate how performance will be monitored and managed against the Trust's strategic objectives. It provides details of the mechanisms for oversight, escalation, and guidance and support to enable an organisational focus on quality of care and ensuring services are sustainable.

1.2 The framework seeks to enable us as a trust to unleash the creativity, innovation and expertise across our clinical and managerial structures to support the delivery of a fully engaged workforce. It also enables us to support leaders, managers and staff in the delivery of continuous improvement, to achieve high class services and outcomes for our service users, patients and the local communities we serve.

1.3 The accountability framework sits within the context of:

- What we are here for ***(Mission)***
- What we stand for *(**Values**)*
- Where we wish to 'get to' *(**Vision**)*
- How we will progress our strategy (***Strategic Objectives**)*
- How we will measure the progression of our strategy *(**Accountability Framework; mechanisms, processes, and line of accountability for delivery measured through performance**)*

### 1.4 Mission, Values, Vision and Strategic Objectives

Our Mission statement is:

***"To provide excellent healthcare for our patients and wider community and be a great place to work, now and for future generations"***

This is supported by our vision statement, developed as part of the design phase of the culture programme:

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

The Trust's strategic objectives are:

- To enhance emergency care and hospital flow and **continually improve the quality of care** so that services are safe, compassionate, timely and responsive; achieving consistently good outcomes and an excellent patient experience.
- To be a **great place to work**, by creating a positive and open culture, and supporting and developing staff across the trust, so that they are able to realise their potential and give of their best.
- To arrange our people and services to best address the planned care backlog, ensuring that all **resources are used efficiently** to establish financially and

environmentally sustainable services and deliver key operational standards and targets.

- 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.
- 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.

1.5 The enabling accountability framework should be read in conjunction with:

- The Organisational Strategy (Annual Operational Plan), University Hospitals Dorset
- NHS Oversight Framework 2022/23 (June 2022)
- Quality Improvement Strategy
- Merger Benefits Realisation Strategy (V1.4)
- Quality Strategy
- Risk Management Strategy
- People Strategy 2021-2023

## 2 Purpose of the Accountability Framework

This framework is a key mechanism to ensure we deliver the Trust vision and strategic objectives by defining the processes in place and responsibilities that enable the Board of Directors and other key personnel to understand and monitor the Trust's achievement of quality, financial, workforce and operational performance/benefit realisation, in line with national and local standards.

The deployment of the accountability framework aims to be:

- Proportionate and consistent
- Open and transparent
- Respectful and supportive

### 2.1 Objective of the framework

The objective of this framework is to ensure that information is available which enables the Board of Directors and other key personnel to understand, monitor and assess the Trust's quality and performance, enabling appropriate action to be taken when performance against set targets deteriorates. This includes forward projections. The key to achieving this is a willingness - and self-confidence - to embrace an operating model that seeks to unleash the creativity, innovation, passion and skills of all 9,000 plus of our staff.

2.2 The implementation of this framework will ensure that there are clear processes for:

- Supporting the delivery of the Organisational Strategy, at both a 'macro' (Trust-wide) and 'micro' level (service).
- Escalating quality, operational, workforce and financial performance issues through the organisation to the relevant Boards / Committees/ Management forums as part of and outside the regular meeting cycle as required.
- Creating robust action plans, with clear ownership, timeframes and dependencies, all of which are monitored and followed up at subsequent meetings until they are resolved; and
- Linking performance with identified risks and risk appetite in accordance with the

Trust Risk Management strategy.

- Linking performance to the performance management of individuals, teams and functions.
- An accountability framework that enables a more devolved, high-trust and empowered way of working across our Care Group, Directorate, Service Management and local departmental team structures.

## 3. National Frameworks and Commissioning Plans

3.1 This Accountability Framework has been prepared taking account of the national NHS Oversight Framework 2022/23 (June 2022) to ensure the Trust is focused on managing its NHS resources to deliver high quality, sustainable care.

3.2 The University Hospitals Dorset Accountability Framework will be reviewed annually considering the revised national frameworks when these are available. It will also reflect the Dorset Integrated Care Board's (ICB) objectives and the commissioning plans of Dorset ICB, specialist commissioning and others where relevant.

## 4. Our Structure and People

University Hospitals Dorset manages the three acute NHS hospital sites in East Dorset. Poole Hospital site, Royal Bournemouth site and Christchurch Hospital site that are organised into care groups and corporate directorates under the leadership of the Chief Executive. Each of the corporate directorates are headed by an Executive Director. The operational management of the Trust is delivered through 3 Care Groups (Surgical, Medical and Specialties) and an operational support service, with clinical directorates feeding into the relevant care groups supported by the corporate functions.

## 5. Organisational Strategy

5.1 The Trust has a high-level single Organisational Strategy document, supported by a compelling strategic narrative that can be easily understood by patients, staff, regulators and members of the public that outlines our mission statement.

5.2 The strategy of the organisation reflects the wider strategy of the Dorset Integrated Care Partnership (ICP) 2022/23, which prioritises prevention and early help, thriving communities, and working better together. For University Hospitals Dorset NHS Foundation Trust, founded in October 2020, this involves the redesign of the vast majority of its services, the implementation of a complex capital programme and the introduction of a service model that requires the separation of emergency care from planned care. It also involves closer working with Dorset County Hospital to develop more networked services, along with more integrated working with Dorset Healthcare, primary care and Local Authority colleagues.

5.3 The COVID pandemic starkly reminds us of the critical importance of better addressing health inequalities. The trust is part of the system-wide Health Inequalities programme led by the Dorset Health Inequalities Group (HIG), and relevant sub groups.

5.4 To support this, it will be essential to operate enhanced monitoring to ensure that at both local and system level we can quickly identity unequal access or outcomes and respond. Through the accountability framework we will seek to strengthen leadership of and accountability for addressing health inequalities more widely.

**Key Elements of the Accountability Framework**

There are three key elements of the Accountability Framework:

1. **Levels of accountabilities**
2. **A reporting framework**
3. **Approach to performance management, review and escalation**

**Levels of Accountabilities**

## 6.0 The Role of the Trust Board

6.1.1 The Trust Board plays an important role in shaping the vision, setting the strategic direction – including quality, operational, workforce and financial performance and holding the organisation to account for the delivery of the strategy - and assuring the effective management and mitigation of risks. The Trust Board therefore has a critical part to play in the accountability framework. The Board is led by an independent chair and is comprised of executive and non-executive directors. However, the Board is a unitary Board that makes decisions as a single group, with collective responsibility for the Trust's performance.

6.1.2 As a foundation trust, the Trust has a Council of Governors. The general duties of the Governors include to hold the Non-Executive Directors individually and collectively to account for the performance of the Board and, to represent the interests of the members of the Trust as a whole and the interests of the public.

6.1.3 The fundamentals for the Board in holding the organisation to account for performance in the delivery of strategy include:

- drawing on Board 'insight', the Board monitors the performance of the organisation in an effective way and satisfies itself that appropriate action is taken to remedy problems as they arise,
- looking beyond written performance reports to develop an understanding of the daily reality for patients and staff, to make data more meaningful,
- seeking assurance where remedial action has been required to address performance concerns,
- offering appreciation and encouragement where performance is excellent,
- taking account of independent scrutiny and performance, including from regulators and overview and scrutiny committees,
- rigorous but constructive challenge from all Board members, Executive and Non-Executive as corporate Board members.
- Continuously learning and quality improvement, as a consistent methodology.

6.1.4 The Board is accountable for seeking assurance that the systems of control are robust and reliable in terms of:

- quality assurance and clinical governance,
- financial stewardship,
- risk management,
- legality,
- decision-making,
- probity, and

- acting as a corporate trustee (where relevant).

6.1.5 ***Quality assurance, clinical governance -*** The Board has a statutory duty of quality. In support of this, good practice suggests that:

- all Board members need to understand their ultimate accountability for quality,
- there is a clear organisational structure that clarifies responsibility for delivering quality performance from the Board to the point of care back to the Board,
- quality is a core part of main Board meetings both as a standing agenda item and as an integrated element of all major discussions and decisions, hence the Trust Board has established the Quality Committee,
- quality performance is discussed in more detail regularly by the quality committee with a stable, regularly attending membership,
- the Board becomes a driving force for continuous quality improvement across the full range of services.

The Board is responsible for the quality governance framework, giving appropriate scrutiny to the three key facets of quality:

- clinical effectiveness
- patient safety
- patient experience

The Trust Quality Strategy sets out the framework in place to assure the Board of Directors that the organisation has the ability to provide safe, high quality care, is compliant with the CQC regulations, and continues to strive for further quality improvements.

6.1.6 ***Financial Stewardship -*** The exercise of effective financial stewardship requires that the Board assures itself that the organisation is operating effectively, efficiently, economically and with probity in the use of resources. It is also required to ensure that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained hence the Trust Board has established the Finance and Performance Committee.

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

Risk management by the Board is set out in detail in the Risk Management Strategy. The Strategy refers to key processes for managing risk at a strategic level these are:

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

- The **Risk Register** – The Trust uses a risk register to record, prioritise and monitor risks across the organisation. Risks that are scored in excess of the

Trust appetite are presented to the Executive Directors and Committees in accordance with the relevant Governance cycles.

6.1.8 **Audit** – External and internal auditors play an important role in Board assurance on internal controls. The purpose of the Audit Committee is to monitor the integrity of financial statements, assisting the Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions. There needs to be a clear line of sight from the Board Assurance Framework to the programme of internal audit.

6.1.9 The **Annual Governance Statement** – This is signed by the Chief Executive as Accountable Officer and comprehensively sets out the overall organisational approach to internal control. It should be scrutinised by the Audit Committee to ensure that the assertions within it are supported by a robust body of evidence.

6.1.10 **Legality** - The Board routinely seeks assurance that the organisation is operating within the law and in accordance with its statutory duties.

6.1.11 **Decision making** - The Board routinely seeks assurance that processes for operational decision-making are robust and are in accordance with agreed schemes of delegation.

6.1.12 **Probity** - The Board adheres to the Nolan seven principles of public life. This includes implementing a transparent and explicit approach to the declaration and handling of conflicts of interest. Good practice here includes the maintenance and publication of a register of interest for all Board members; Board meeting agendas include an opportunity to declare any interests at the beginning; and, the adherence to the fit and proper policy on appointment and on an ongoing basis in line with the policy. Another key area in relation to probity relates to the effective oversight of top-level remuneration. Hence, the Board has established a Remuneration Committee. Boards are expected to adhere to HM Treasury guidance and to document and explain all decisions made.

6.1.13 **Corporate Trustees** - If the organisation holds NHS charitable funds as sole corporate trustee the Board members of that body are jointly responsible for the management and control of those charitable funds and are accountable to the Charity Commission. A Charitable Funds Committee has been established to oversee the effective management of the charitable funds.

## 6.2 Committees of the Trust Board that support accountability

6.2.1 The Trust operates a well-established committee structure to strengthen its focus on quality governance, finance, people and performance matters, and risk management. The structure has been designed to provide effective governance, and challenge to patient care and other business activities. The committees carry out detailed work of assurance on behalf of the Trust Board. A diagram illustrating the Board committee structure is set out in Appendix 1.

6.2.2 All the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Appointments and Remuneration Committee, which (in accordance with NHS guidance) comprise Non-Executive Directors exclusively. In line with good corporate governance, the Chairman of the Trust is not a member of the Audit Committee and does not

normally attend its meetings.

6.2.3 The **Audit Committee** meets quarterly and is established under powers delegated by the Trust Board with approved terms of reference. It provides an independent and objective view about the reliability and robustness of processes of internal control by for example, overseeing internal and external audit services, reviewing financial and information systems, and reviewing the arrangements in place to support the BAF process.

6.2.4 The **Finance and Performance Committee** meets monthly to oversee the effective management of the Trust's financial resources and performance across a range of measures. This includes close oversight of the Trusts working capital position and it monitors key national and contractual performance standards, such as access times. It receives reports relating to financial controls, quality, quantity and timeliness of financial and analytical information, which includes the Integrated Performance Report. It also receives updates on the long term strategic financial plans to include capital investment and financial risk.

6.2.5 The **Quality Committee** meets monthly and seeks assurances that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients. It serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely, cost-effective manner across a number of relevant areas. It acts as a means of internal assurance for compliance against the CQC regulating and inspection compliance framework. It seeks to provide the Board with assurance that high quality standards of care are provided and in particular adequate and appropriate clinical governance structures, processes and controls are in place throughout the Trust.

6.2.6 The **People & Culture Committee** meets quarterly, reporting to the Trust Board. It is responsible for the consideration of matters relating to workforce planning and development, HR policy and the People Strategy, ensuring workforce strategies are appropriate and, for gaining assurance by monitoring the management needed to deliver a workforce with the capacity and capability to provide high quality, safe patient care in line with strategic objectives, the Trust values and the relevant elements of the Board assurance framework.

6.2.7 The Chairman of each of the Board's Committees will provide a report to draw to the attention of the Trust Board any issues that require disclosure or further action. Each Board Committee has an agreed annual governance cycle with the opportunity for Governors to attend as observers. This provision has been written into all the Committees' Terms of Reference.

### 6.3 Executive Director Oversight

The Chief Executive leads a team of Executive Directors who (i) provide professional advice and (ii) take functional responsibilities that have been delegated to them. An Executive Directors' meeting occurs weekly whose purpose is to ensure all executives are up to date on issues that affect the Trust internally and externally and to oversee the process of decision-making in the Trust.

#### 6.3.1 Trust Management Group

The Trust Management Group (TMG) is the main executive leadership group of the Foundation Trust. It is the main "engine room" of the organisation, making

recommendations to the Board of Directors on matters relating to the strategy of the Trust and the management of its operational services. It ensures that the three Care Groups are fully involved in corporate decision-making, and that the voice of clinicians and professionals from across the organisation is fully considered.

### 6.3.2 Care Group Accountability Arrangements

The Trust subdivides the operational accountability of its clinical services into 3 Care Groups (CG's) and an Operational Support Group supported by corporate services. Within each Care Group, a leadership triumvirate has been established. The structure has been designed to support the delivery of the vision and strategic objectives for the Trust through devolving leadership and accountability to a local level, at the same time as ensuring that there is a mechanism for driving standardisation across hospital sites and that there is appropriate Trust level oversight. Clinical services delivered through the Care Groups are *one service in multiple sites* with a single leadership team. The team's role is to ensure the delivery of services and performance across all sites within the Trust and, include services that are provided across Dorset.

**6.4.1** **The Care Group Boards** have delegated decision-making responsibility for defined areas, within the parameters of annual operating plans agreed by the TMG (and the Trust's Standing Financial Instructions) and are accountable for delivering quality & performance targets within their respective Care Groups through the senior leadership teams of each directorate. They provide assurance to TMG about progress and performance in defined areas and do the work-up on recommendations to TMG about policy, resource allocation and change plans.

**6.4.2** The Leadership structure within each of the Care Groups consists of a Group Director of Operations (GDO), Group Medical Director (GMD) and Group Director of Nursing/AHP (GDN/A), as well as leads from Human Resources, Finance, Operations, Information, Transformation and Informatics. Each of the Care Groups is accountable under 'collective managerial and professional leadership' to the Chief Operating Officer, Chief Nursing Officer and Chief Medical Officer who hold the three triumvirate leaders in each Care Group to account for the delivery of Care Group specific KPIs. The Group Director of Operations (GDOs) will be responsible for all aspects of their Care Group performance (quality, finance, workforce and operational performance/benefit realisation) alongside the Group Medical Director (GMD) and Group Director of Nursing/AHP (GDN/A).

**6.4.3** The GMD and GDN/A will be managerially accountable to the GDOs through to the COO and the Board but will have a professional line of accountability to the offices of the Chief Medical Officer and Chief Nursing Officer. It is intended that the main axis of accountability for line management, service and budgetary performance will be vertically through the Care Groups and directorates, with the horizontal responsibilities of all Care Groups being for standard setting, quality assurance ensuring consistency of service across the organisation.

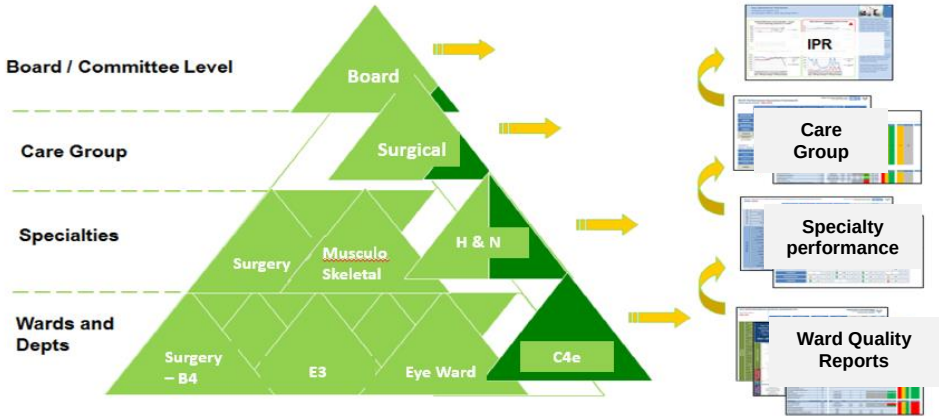
### 6.5 Corporate Site Based Support

Prior to the establishment of the planned and emergency sites, the Trust will have two acute hospitals and one local rehabilitation, outpatients and two palliative care hospitals. Clinical services, delivered through the Care Groups, will be viewed as one service in multiple sites, but strong site visibility through local leadership will be needed through the Deputy Chief Officers who will have oversight of the individual sites for the Chief officers working closely with the Care Group triumvirates. As such the staffing structure post-merger will be based on developing the structure for the future and the operational grip required today. The structure at site level will use the

established triumvirate model of operational, clinical and nursing leadership on the two acute sites to ensure the delivery of safe clinical services and site based aggregated operational performance.

## 7 The Trust Reporting Framework

7.1 The graphic below illustrates, at a high-level, the 'Ward to Board' reporting structures




which reflect the clinical services of the newly merged Trust and the performance reporting arrangements which will support the scrutiny of performance within each tier of the organisation.

7.2 Effective scrutiny relies primarily on the provision of clear comprehensive summary information to the Board and its Committees and through a range of documents, including:

- Integrated Performance Report (IPR)
- Care Group Performance and Quality reports
- Speciality Performance and Quality reports
- Ward Quality Dashboards and Quality performance reports

### 7.2.1 Integrated Performance Report (IPR)

The Integrated Performance Report (IPR) is in place for monitoring the agreed key performance indicators against key national and local quality, operational, finance and workforce targets. It provides the Trust Board and Committees with the Trust's performance against key indicators and draws attention to those areas requiring additional review by the Executive Team through an escalation report.

### 7.2.2 Care Group and Specialty Performance Review Reports

A range of Care Group performance reports are used for monitoring key performance indicators by the Care Group operational and clinical management team. They highlight Care Group performance against key targets and identify services doing well and those requiring further improvement and escalation to the Executive Team. Performance against key national and local quality, operational, finance and workforce targets is reviewed at Care Group Board meetings as well as key sub-groups of TMG. For example, Care Groups' operational performance against key constitutional standards is reviewed at the Operational Performance Group monthly. Performance at service, department and ward level remains the responsibility of the senior management teams, through the service managers, matrons and specialty leads. The performance reports at Care Group and specialty level are key tools for celebrating success and escalating issues to the quarterly performance review

meetings (PRM) held with each Care Group (CG).

### 7.2.3 Ward Quality Reports

Mechanisms are in place to provide two-way transfer of information from the front line staff up to the board and back again. The trust has an established governance structure which is outlined in the Trust Quality Strategy and Risk Management Strategy. Quality reporting through these structures supports to review, analysis and delivery of key metrics related to patient experience, safety and effectiveness of services up to the board of directors.

Quality reporting is based on the CQC key lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led). Board and Board subcommittee reporting supports and integrates with wider quality assurance processes such as peer review, annual self-assessment and internal and external audit.

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

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

7.3 There are four key content areas of the reporting framework:

- Quality, Safety and Risk
- Finance
- Workforce
- Operational Performance

### 7.3.1 *Quality, Safety and Risk*

High quality care is at the centre of everything we do and maintaining and improving the quality of patient care remains the top priority for the trust.

Similar to the Board and Quality Committee reports, Care Group and Directorate Quality reporting will routinely include:

- Risk issues, mitigations and action plans
- National requirements e.g. NICE, CQC, HSE, GIRFT, NCEPOD, National Audit, MHRA, NHS I standards and performance against them
- Investigation and learning reports (Trends – current and future risk, assurance and quality issues, Exception reporting and any associated risk based narrative commentary)
- Internal comparisons and external benchmarks where available
- Directorate, specialty, ward and consultant level data where appropriate

### 7.3.2 Finance

Achievement of the agreed financial plan is an important annual objective for the Trust and devolving responsibility for income and expenditure to Care Groups and

Corporate Directorates is an appropriate and fundamental component. The Financial Management Accountability Framework which is attached at appendix 2 supports the Trust performance management and accountability framework to formalise and more clearly define what is expected of Care Groups and Directorates in terms of the sign off of their annual budgets and their in-year management. Importantly, it also details how the performance management regime will operate, noting how adverse performance from plan will be handled.

As part of the annual planning and budget setting process each Care Group and Corporate Directorate is required to sign-off their annual plan and approved budget. It should be noted that any material failure to deliver on the part of one Care Group or Corporate Directorate may require other areas of the organisation to take additional supportive action.

7.3.3 **Workforce**

Oversight of the key workforce issues and metrics forms an important part of the Trust's performance management and accountability arrangements. Accordingly, a suite of key performance indicators forms part of the balanced scorecard for each Care Group and scrutiny is led by the Chief People Officer.

7.3.4 **Transformation and Improvement**

The benefits of merger, clinical integration, reconfiguration and improvement will be tracked to ensure clinical, non-clinical and financial benefits are achieved. These will form part of the Care Groups reporting and care group performance reviews, as well as being tracked centrally through the Benefits Realisation Assurance Group (BRAG). Integration will be assessed using the Integration Assessment and also the Integration Checklist – with results reported via the Care Group Transformation Groups. The Patient First improvement programme will be tracked via the Patient First Board reporting via TMG.

7.3.5 **Operational Performance.**

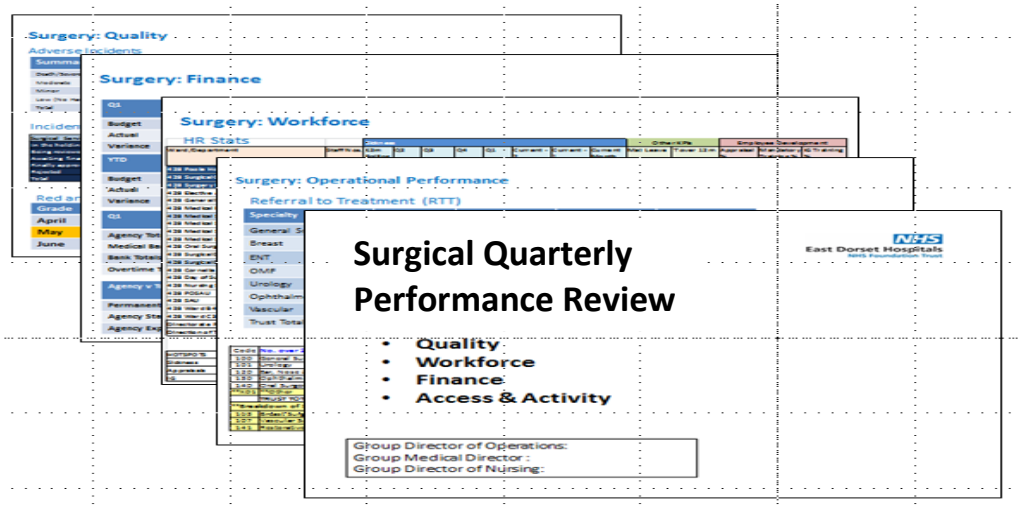
Achievement of the mandated national NHS performance targets is a key priority for the Trust and includes the following groups of standards:

- Cancer Performance Standards
- Emergency/Urgent care Standards
- Diagnostics (DMO1)
- Referral to Treatment (RTT)
- Organisational flow
- Activity

## 8 Approach to performance management, review and escalation

### 8.1 Care Group Performance Review Meetings (PRM's)

Quarterly performance review meetings (PRM) are held with each Care Group triumvirate, chaired by the Chief Operating Officer and involves the Chief Executive, Chief Financial Officer, Chief Nursing Officer, Chief Medical Officer, Chief Strategy and Transformation Officer and Chief People Officer. The purpose of these meetings is to scrutinise Care Group performance in the round. Critical issues will be escalated to the relevant forum if required, including quality, operational performance, workforce and finance.




**8.2** The review meeting will consider Operational Performance, Quality and Safety, Finance, Workforce and Quality Improvement. Where performance is within the identified thresholds, management of any adverse performance remains within the remit of the Care Group Management Team. Where performance is adverse, the Care Group is expected to prepare a time defined rectification plan to be reviewed at subsequent Performance Review meetings. The frequency of these meetings will be increased in line with the framework set out below. In specific circumstances, the team would receive targeted support from outside of the Care Group. In the event that performance remains adverse, then the Care Group may be designated as in need of enhance or intensive support.

| RAG | Performance Assessment | Actions / Interventions / Support |
|---|---|---|
| G | GOOD | Continued Quarterly Performance Review Meetings to ensure continued delivery and focus on further, continuous improvement. |
| RI | REQUIRES IMPROVEMENT/ENHANCED SUPPORT | Consideration of increasing frequency of PRM meetings, with additional requirements in terms of performance assurance reports. Potential requirement for additional exception reporting between PRMs to relevant executive directors. Progress together with corrective plans which have measurable objectives and milestones to delivery. |
| I | INADEQUATE/INTENSIVE SUPPORT | Consideration of Bi-weekly PRM meetings with additional requirements in terms of performance assurance reports. Additional subject matter resource may be identified to support areas for urgent improvement. Rectification plan with measurable objectives and milestones to delivery with formal meeting with the COO and appropriate Executive Director. Intensive support If a material or protracted variance from an agreed trajectory within a rectification plan manifests itself, it may also be escalated to the Chief Executive for further formal action |

Any Care Group asked to produce a rectification plan may also be requested to attend the Trust's Finance and Performance Committee, People and Culture Strategy Committee or Quality Committee, where a review of the plan will be undertaken. If any group or body is tasked with addressing any adverse performance, a summary update on progress will be expected.

8.3 The principles within this document are equally applicable to the system of performance service level reviews undertaken by Care Groups when reviewing the performance of their portfolio of clinical services. In this respect the Care Group is acting under its span of control. The system of performance management at this level includes routines and reports including, but not limited to:

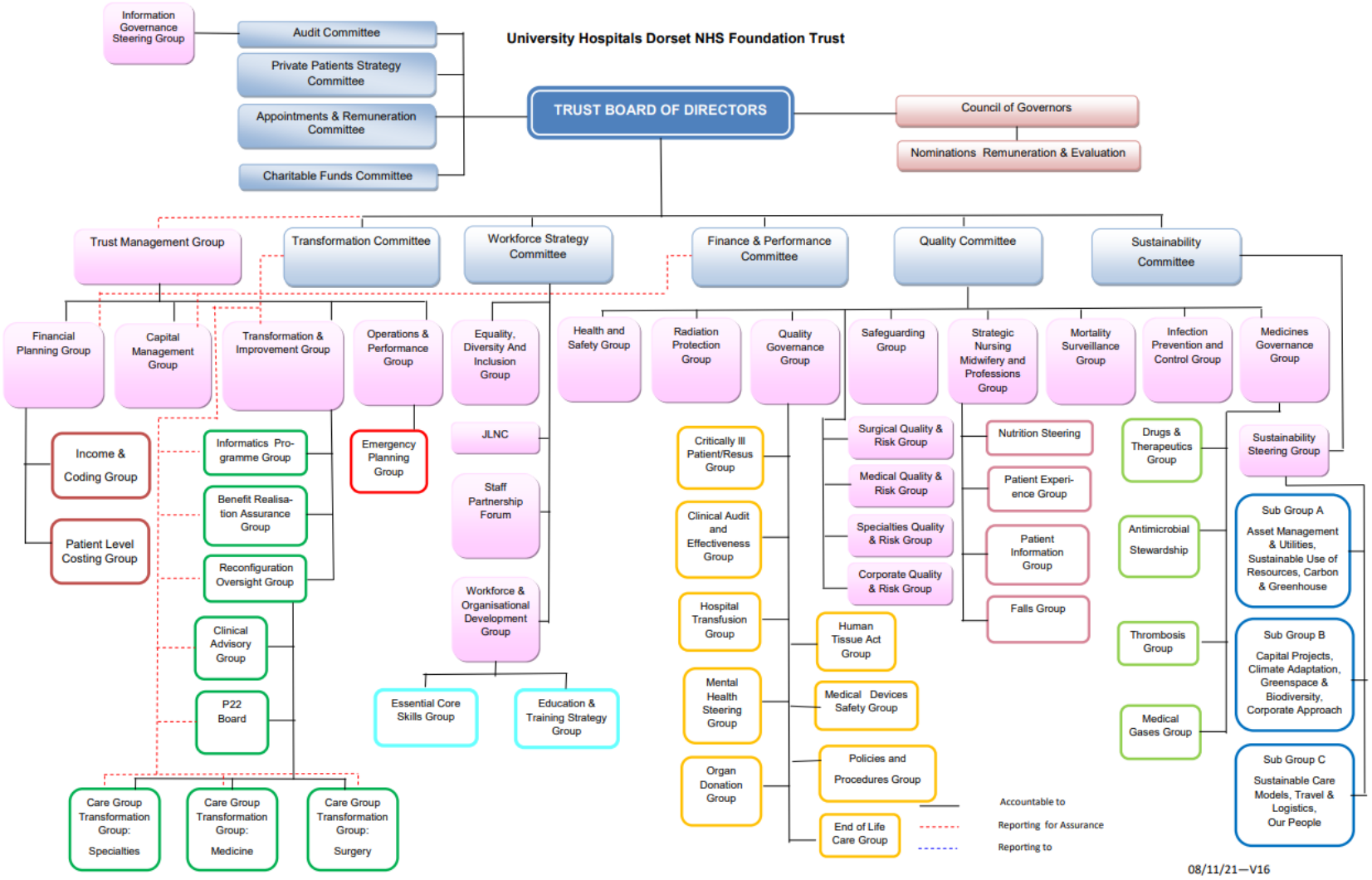
- Care Group to meet at least monthly with a standard agenda, minutes and action tracking where required;
- the agenda will include a minimum range of review areas such as quality, workforce, activity and performance, finance and risk; and
- escalation triggers are expected to be as robustly applied as those applicable to Care Groups.

8.4 **Corporate functions - performance management**

The Corporate Directors are held to account for their individual portfolios and objectives by the Chief Executive. Corporate functions' performance is generally measured through existing performance reporting at a corporate level e.g. financial and workforce information. The Corporate Directors are held to account by other Corporate functions as part of the whole Trust response to key indicators such as budget monitoring, vacancy control and absence management information.

Corporate Services will be formally reviewed on a quarterly basis, in the same way as other clinical services/Care Groups. On request, Corporate Directorates may be required to present their performance and achievements directly to any of the Trust's relevant Committees.

# Appendix 1 - A diagram illustrating the Board committee structure (as at 1 November 2022)
**UNDER REVIEW**



University Hospitals Dorset
NHS Foundation Trust

# *Financial Management Accountability Framework*

## Introduction

The Financial Management Accountability Framework sets out the process for devolving financial resource to Care Groups and Corporate Directorates, together with the expectations in relation to the subsequent management of these agreed budgets.

This initial Framework brings together much of what is already in place within Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, together with elements of best practice from other successful NHS organisations. It is expected that this will continue to evolve post-merger.

## Context

Each year the Trust is required to operate within a set of financial parameters agreed within the Dorset Integrated Care System and with its regulator, NHS Improvement. Achievement of this agreed financial plan is a crucial annual objective for the Trust.

Devolving financial decisions to those individuals and teams best placed to make them is a key part of the Trusts financial management process and supports strong and appropriate financial governance.

## Purpose

The Financial Management Accountability Framework seeks to formalise and more clearly define what is expected of Care Group and Corporate Directorate leadership teams in agreeing and managing their devolved budgets.

It supports the Trusts Standing Orders, Scheme of Delegation and Standing Financial Instructions and covers how Care Groups and Corporate Directorates provide information and assurance to the Chief Finance Officer and Executive Team in relation to their financial performance. Importantly, it also details how adverse performance from plan will be managed.

It should be noted that this framework is not a comprehensive suite of financial management documents and guidance. It is not therefore intended to focus on the variety of mechanisms in place to ensure that individuals and teams are appropriately trained and supported to successfully manage their budgets. These resources are available separately.

## Financial Risk Appetite

It is important to be explicit that nothing within this framework should detract from the Trusts appetite for financial risk, which can be summarised within the following risk appetite statement:

*"We will strive to deliver our services within the budgets modelled in our financial plans. However, budgetary constraints will be exceeded if required to mitigate risks to patient safety. All such financial responses will ensure optimal value for money."*

This makes clear our position that the safety of our services takes precedence over everything else and that we will not compromise patient safety to deliver within our

financial plans.

## Financial Management Accountability Framework

Each year the Trust will undertake a comprehensive operational planning process. Care Groups and Corporate Directorates will be required to fully support and engage with this process and sign-off their resulting annual budget.

This ensures that the overall resources available to the Trust are appropriately prioritised and delegated prior to the start of the financial year. It also allows financial risks and opportunities to be identified and managed.

This budget sign-off process will require physical signatures as follows:

| Care Groups | Corporate Directorates | Finance Directorate |
|---|---|---|
| Chief Finance Officer<br>Chief Operating Officer<br>Group Director of Operations | Chief Finance Officer<br>Corporate Chief Officer | Chief Executive<br>Chief Finance Officer |

Each month, the Trust is required to submit detailed financial returns to NHS Improvement and report its financial performance through the Finance and Performance Committee to the Board. This reporting includes detailed analysis of the in-month and year to date position, together with the forecast for the remainder of the financial year.

To support this; prior to the start of each quarter each Care Group and Corporate Directorate is required to provide an assurance statement confirming that they will continue to operate within their agreed budget for the year.

This assurance statement will follow a standard format and will be signed-off by the Group Director of Operations, on behalf of the Care Group Leadership Team, and the relevant Corporate Directorate Chief Officer. The assurance statement will be based on activity forecasts (where appropriate) and will include the following:

- month by month income, pay and non-pay forecast including recurrent and non-recurrent analysis;
- month by month cost improvement programme forecast including recurrent and non-recurrent analysis;
- month by month projection of any recovery actions required to mitigate adverse variances to plan, including recurrent and non-recurrent analysis; and
- details of all identified opportunities and risks, to include the identification of potential investment decisions.

Following submission of the assurance statement the Care Group or Corporate Directorate

will be risk rated by the Chief Finance Officer. In the case of the Finance Directorate, the risk rating will be determined by the Chief Executive, following a recommendation from the Deputy Chief Finance Officer.

This risk rating will be reviewed following each month's financial results.

It should be noted that any material failure to deliver on the part of one Care Group or Corporate Directorate may require other areas of the organisation to take additional action, to support the collective achievement of the overall Trust financial plan.

Risk ratings will be defined using the following criteria:

| | | |
|---|---|---|
| Green | Low risk of failure to deliver within the agreed financial plan | • YTD adverse variance of less than or equal to 1% of budget; and<br>• Forecast break-even or underspend. |
| Amber | Medium risk of failure to deliver within the agreed financial plan | • YTD adverse variance to plan of greater than 1% of budget; and<br>• Forecast to deliver break-even or underspend.<br><br>OR<br><br>• YTD favourable variance or YTD adverse variance of less than 1% of budget; and<br>• Forecast to deliver an overspend. |
| Red | High risk of failure to deliver within the agreed financial plan | • YTD adverse variance to plan of greater than 1% of budget; and<br>• Forecast to deliver an overspend.<br>OR<br>• Having been rated as Amber for two consecutive quarters. |

It is crucial that Care Groups and Corporate Directorates manage the recurrent underlying financial position in addition to the in-year financial position. As such, it is expected that as the new Trust develops, the financial risk ratings will similarly develop to include recurrent CIP performance.

However, this has currently been excluded from the Financial Management Accountability Framework to ensure there is no dis-incentive for identifying and achieving non-recurrent savings. This will be kept under review.

Escalation based on the monthly risk rating will be as per the table below:

| Rating | Monitoring | Incentives and Escalation Measures |
|---|---|---|
| Green | Quarterly | • Detailed financial performance review required quarterly.<br>• Full delegated autonomy to make decisions within agreed budget envelope.<br>• Freedom to make recurrent investment decisions if affordable through internal recurrent budget virements.<br>• If requested to improve the financial position in support of the overall trust financial position:<br>▪ This under spend will be discounted from budget setting in the following year (i.e. will be retained by the Care Group or Corporate Directorate); and<br>▪ up to 50% of this underspend will be made available to the Care Group or Corporate Directorate either non recurrently or as capital the following year on the condition that this is spent on appropriately prioritised business cases and is manageable within the agreed Capital Delegated Expenditure Limit. |
| Amber | Monthly | • Formal letter from the Chief Finance Officer requesting a detailed financial recovery plan within one month.<br>• Detailed financial performance review required monthly.<br>• Authority to make decisions within agreed budget envelope temporarily withdrawn pending successful recovery actions.<br>• Authority to make recurrent investment decisions temporarily withdrawn pending successful recovery actions.<br>• If graded amber for two consecutive quarters the Care Group or Corporate Directorate will be re-graded Red. |
| Red | Fortnightly | • Formal letter from the Chief Finance Officer requiring a detailed recovery plan within two weeks of being |

| | | |
|---|---|---|
| | | graded Red.<br><br>• Detailed financial performance review required fortnightly.<br><br>• The Care Group or Corporate Directorate will be required to attend the Finance and Performance Committee to present its detailed recovery plan.<br><br>• Authority to make decisions within agreed budget envelope withdrawn.<br><br>• Authority to make recurrent investment decisions withdrawn.<br><br>• If graded red for a full quarter the Care Group or Corporate Directorate will enter formal escalation including:<br><br>▪ Enhanced recruitment control (central approval of all recruitment through weekly Executive Team meeting).<br><br>▪ Fortnightly meetings with the Chief Executive, Chief Finance Officer and Chief Operating Officer (Care Groups only) to discuss performance against the recovery plan.<br><br>▪ Review of delegated authority and financial approval limits, with the potential for these to be reduced.<br><br>• If graded red for two consecutive quarters further escalation measures may be imposed, including but not limited to:<br><br>▪ Further review of delegated authority and financial approval limits with the potential for these to be removed altogether.<br><br>▪ A competency review of the senior management team may be conducted regarding the failure to deliver a material part of the Trust's strategy and annual plan. |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 10.2**

| | |
|---|---|
| **Subject:** | Board Committee Terms of Reference |
| **Prepared by:** | Yasmin Dossabhoy, Associate Director of Corporate Governance |
| **Presented by:** | Rob Whiteman, Trust Chair |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☒<br>Be a great place to work ☒<br>Use resources efficiently ☒<br>Be a well led and effective partner ☒<br>Transform and improve ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | All |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | Following a review of the Board Committee structures and discussions at Board Development Sessions, the Board is asked to approve changes to the Board Committees as described below and revised Terms of (ToR) :<br>• Appointments and Remuneration Committee (re-aligned ToR);<br>• Audit Committee (replacement ToR);<br>• Charitable Funds Committee (re-aligned ToR);<br>• Finance and Performance Committee – whose remit is to be expanded to include that previously covered by the Private Patients Strategy, Sustainability and Transformation Committees (replacement ToR);<br>• People and Culture Committee, formerly known as the Workforce Strategy Committee (replacement ToR);<br>• Quality Committee (replacement ToR).<br><br>The Board is asked to approve:<br>• The dissolution of the Private Patients Strategy, Sustainability and Transformation Committees; and<br>• The establishment of a Population Health and System Committee, terms of reference for which will be presented to a future meeting of the Board. |

| | |
|---|---|
| **Background:** | Having regard to the opportunity for more agile governance and system working, the structure and remit of the Trust's Board Committees have been reviewed. |
| **Key Recommendations**: | To review and if thought fit approve the changes to the Board Committee structures outlined above and the Terms of Reference. |
| **Implications associated with this item:** | Council of Governors ☒<br>Equality and Diversity ☒<br>Financial ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☒<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒<br>System ☒ |
| **CQC Reference:** | Safe ☒<br>Effective ☒<br>Caring ☒<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Board Development Sessions | 24/08/2022<br>30/11/2022 | In principle agreement in relation to the opportunity for more agile governance and changes to the Board Committee structures. |

| | |
|---|---|
| **Reason for submission to the Board in Private Only (where relevant)** | Commercial confidentiality ☐<br>Patient confidentiality ☐<br>Staff confidentiality ☐<br>Other exceptional reason ☐ |

University Hospitals Dorset
NHS Foundation Trust

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Appointments & Remuneration Committee



**January 2023**

# DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance (Company Secretary) |
| **Signed:** | |
| **Date:** | January 2023 |
| **Version No:** (Author Allocated) | 2.0 |
| **Next Review Date:** | January 2024 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| October 2020 | 1 | 2022 | October 2020 | Company Secretary | New document |
| January 2023 | 2.0 | January 2024 | | Company Secretary | Re-draft to align with approach to other Committee Terms of Reference. |

# TABLE OF CONTENTS



| **INDIVIDUAL APPROVAL** | | | |
|---|---|---|---|
| Job Title | N/A | Date | N/A |
| Print Name | N/A | Signature | N/A |

| **BOARD OF DIRECTORS/COMMITTEE APPROVAL** | | | |
|---|---|---|---|
| If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |
| Name of approving body | Board of Directors | Date | |
| Print Name | | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**APPOINTMENTS & REMUNERATION COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

1.1 The primary purpose of the Committee is to identify and appoint candidates to fill all the Executive Director positions on the Board and to determine the remuneration and other conditions of service for the Chief Officers and Very Senior Managers.

1.2 The Committee shall have delegated authority from the Board to:

- Oversee and take forward the process for the appointment/removal of the Chief Executive. The appointment/removal of the Chief Executive is subject to the approval of the Council of Governors;
- Oversee and take forward the process for the appointment/removal of the Chief Officers of the Trust;
- Set the remuneration allowances and other terms and conditions of office for the Trust's Chief Officers.

1.3 The Committee has no executive powers other than those specifically delegated in these terms of reference.

## 2. RESPONSIBILITIES

2.1 To regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board with regards to any changes. With regard to changes in the Non-Executive Director appointments, the Committee will work with the Nomination, Remuneration and Evaluation Committee of the Council of Governors to take account of the skills and experience required for Non-Executive Directors identified by the Board.

2.2 To give full consideration to succession planning for the Chief Executive and other Chief Officers taking into account the challenges, risks and opportunities facing the Trust and the skills and expertise needed on the Board to meet them.

2.3 To keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy. To have an input into the recruitment of or continuation of a Very Senior Manager role.

2.4 To be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

2.5 To ensure there is a formal, rigorous and transparent procedure and support processes for the appointment of the Chief Executive and Chief Officers of the Trust by:

- Considering candidates from a wide range of backgrounds and consider candidates on merit against objective criteria;

- Evaluating the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search;
- Ensuring that a proposed Chief Officer's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise;
- Ensuring that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

2.6 To consider any matter relating to the continuation in office of any Chief Officer including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

2.7 To report formally to the Council of Governors and seek their approval of the appointment/removal of the Chief Executive.

2.8 To establish and review a remuneration policy in respect of Chief Officers and Very Senior Managers and in doing so the Committee shall have regard to the Trust's overarching reward and benefit strategy for all staff, the arrangements in the wider NHS and any extant guidance from the Treasury.

2.9 In accordance with all relevant laws, regulations and Trust policies, to determine the terms and conditions of office for those referred to above and in doing so the Committee shall review and agree:

- The overall market positioning of the remuneration package;
- Individual base salaries and increases;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses;
- Compensation payments;
- Any annual and long-term incentive/bonus arrangements and the relevant targets for performance related schemes.

2.10 To consult the Chief Executive about proposals relating to the remuneration of the other Chief Officers.

2.11 In adhering to all relevant laws, regulations and Trust policies;

- To determine levels of remuneration which are sufficient to attract, retain and motivate Chief Officers of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, considering all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements, and at a level which is affordable to the Trust;
- To use national guidance and market benchmarking analysis in the annual determination of remuneration of Chief Officers and Very Senior Managers, while ensuring that increases are not made where Trust or individual performance do not justify them;
- To be sensitive to pay and employment conditions elsewhere in the Trust.

2.12 To advise upon and oversee appropriate contractual arrangements for the Chief Executive and Chief Officers, including the calculation and scrutiny of termination

payments, taking account of appropriate Treasury and national guidance and the Code of Governance for NHS Foundation Trusts to avoid rewarding poor performance.

2.13 To agree and review the extent to which a full time Chief Officer takes on a Non-Executive Director or Chairman role of another organisation of comparable size and complexity to University Hospitals Dorset NHS Foundation Trust.

2.14 To monitor and assess the output of the evaluation of the performance of individual Chief Officers and consider this output when reviewing changes to remuneration levels.

## 3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee comprises of the Non-Executive Directors of the Trust

3.2 For any decisions relating to the appointment or removal of the Chief Officers, membership of the Committee shall include the Chief Executive who will count in the quorum for the meeting. The Chief Executive shall not be present when the Committee is dealing with matters concerning his or her appointment, removal or remuneration.

3.3 In addition, the Chief People Officer will be invited to be in attendance (except when issues regarding his/her own appointment, removal or remuneration are discussed) to act as expert advisor on personnel and remuneration policy.

3.4 Only members of the Committee have the right to attend Committee meetings. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate. The Company Secretary will be invited to attend meetings of the Committee on a regular basis. Any attendee will be asked to leave the meeting when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

3.5 The Committee will be chaired by the Trust Chair. In his or her absence, the Trust Vice Chair may chair meetings of the Committee.

3.6 Committee members should aim to attend all scheduled meetings and shall notify the Company Secretary in advance of any meetings that they are unable to attend. The Company Secretary (or their nominee) will maintain a register of members' attendance.

## 4. AUTHORITY

4.1 The Committee is authorised by the Board to obtain legal, remuneration or other professional advice as and when required, at the Trust's expense, and to appoint and secure the attendance of external consultants and advisors if it considers this beneficial.

4.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

4.3 The Committee is authorised to decide on the most appropriate action needed by the Board in the achievement of its Terms of Reference.

## 5. CONDUCT OF BUSINESS

5.1 The Constitution, Scheme of Delegation and Standing Orders of the Trust, as far as they are applicable, shall apply to the Committee and any of its meetings.

5.2 The Committee will meet at least once in each year and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least three members present, including the Trust Chair (or Trust Vice Chair in his or her absence). For the appointment/removal or remuneration of the Chief Officers (other than the Chief Executive), the quorum shall include the Chief Executive.

5.4 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair or any of its members.

5.5 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee and/or Board at the next meeting.

5.7 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

## 6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.2 The Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting of the Board.

## 7. MONITORING

7.1 Attendance will be monitored at each committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's annual report will include sections describing the work of the Committee including its remuneration policies, details of the remuneration paid to executive

directors and the process it has used in relation to the appointment of executive directors.

## 8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

## APPENDIX A

## ATTENDANCE AT CHARITABLE FUNDS COMMITTEE MEETINGS

| **NAME OF COMMITTEE:** | Quality Committee | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Present (*include names of members present at the meeting)*** | **Meeting Dates** | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **In Attendance** | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Was the meeting quorate? Y / N<br><br>(*Please refer to Terms of Reference*) | | | | | | | | | |

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Audit Committee

**January 2023**

# DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance |
| **Signed:** | |
| **Date:** | January 2023 |
| **Version No:** (Author Allocated) | 2.0 |
| **Next Review Date:** | January 2024 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| October 2020 | 1 | October 2021 | July 2020 | Company Secretary | New Document |
| October 2021 | 1.1 | October 2022 | | Company Secretary | Deleted 9.1 Requirement for Committee minutes to be reported to the Trust Board<br><br>Added 9.1 These minutes will be available to the Board fo Directors<br><br>Remove a phrase at 11.4 i)<br><br>Amend 11.6, |
| January 2023 | 2 | January 2024 | | Associate Director of Corporate Governance | Alignment of formatting with other Committee ToR; full review and update. |

# TABLE OF CONTENTS



| INDIVIDUAL APPROVAL | | | |
|---|---|---|---|
| Job Title | N/A | Date | N/A |
| Print Name | N/A | Signature | |

| BOARD OF DIRECTORS / COMMITTEE APPROVAL | | | |
|---|---|---|---|
| If the Board / Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |
| Name of approving body | Board of Directors | Date | |
| Print Name | | Signature of Chair | |

# UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

# AUDIT COMMITTEE

# TERMS OF REFERENCE

## 1. PURPOSE

1.1 The Board of Directors (Board) has resolved to establish a Committee of the Board to be known as the Audit Committee (the Committee"). The Committee is comprised of Non-Executive Directors and accounts to the Board.

The Committee will provide an independent and objective view of internal control by:

- Overseeing internal and external audit services;
- Reviewing financial and information systems, monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control;
- Monitoring compliance with Standing Orders and Standing Financial Instructions;
- Reviewing schedule of losses and compensations and making recommendations to the Board;
- Reviewing the arrangements in place to support the board assurance framework process prepared on behalf of the Board and advising the Board accordingly on:
    - Integrated Governance;
    - Risk Management;
    - Internal Audit;
    - Board Assurance;
    - Production of the Annual Report;
    - Schedule of Losses and Compensations;
    - Freedom to Speak Up – Whistleblowing;
    - Clinical Audit;
    - Counter-Fraud;

in order to provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the organisation's activities (clinical and non-clinical), both generally and in support of the Annual Governance Statement (including letters of representation).

1.2 The Committee will seek the view of the Trust's external auditors and consider the Executives' response to the auditors' work.

1.3 The Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

## 2. RESPONSIBILITIES

**Governance, risk management and internal control**

2.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the

achievement of the organisations' objectives. In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement, annual report, quality accounts, annual financial statements, annual draft licence compliance, annual draft code of governance compliance, assurance process for licence condition compliance, assurance process for corporate governance statement together with any accompanying internal audit statement, external audit opinion or other appropriate independent assurances), prior to submission to the Board;
- The underlying assurance processes that indicate the degree of the achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;
- The wording in the annual governance statement and other disclosures relevant to the Terms of Reference of the Committee;
- The clinical audit system plan to ensure that it is robust, reflecting both national and local priorities, comprehensive and embedded across all clinical teams with the outcomes used to drive improvement and enhance the overall quality of clinical care.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.

**Counter-fraud**

2.2.1 To review the adequacy and effectiveness of policies and procedures for all work related to counter-fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service;

2.2.2 To ensure that the counter fraud function has appropriate standing within the organisation.

2.2.3 To review the counter fraud programme, consider major findings of investigations (and management's response), and ensure co-ordination between the internal auditors and counter fraud.

**Internal Audit**

2.3 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

2.3.1 Considering the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal;

2.3.2 Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework;

2.3.3 Considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;

2.3.4 Ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust; and

2.3.5 Monitoring the effectiveness of internal audit and carrying out an annual review.

**External Audit**

2.4 To review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process, more particularly, reviewing the work and findings of the external auditors and considering the implications and management's response to their work. This will be achieved by:

2.4.1 Considering the appointment and performance of the external auditors, including providing information and recommendations to the Council of Governors in connection with the appointment, reappointment and removal of the external auditors in line with criteria agreed by the Council of Governors and the Committee;

2.4.2 Discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan;

2.4.3 Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

2.4.4 Reviewing all external audit reports, including reports to the Board and the Council of Governors, and any work undertaken outside the annual external audit plan together with any significant findings and the appropriateness and implementation of management responses;

2.4.5 Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.

**Financial reporting**

2.5.1 To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

2.5.2 To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

2.5.3 To review the annual report, annual governance statement and annual financial statements before these are presented to the Board to determine their completeness, objectivity, integrity and accuracy and the letter of representation addressed to the external auditors from the Board including:

2.5.3.1 The annual governance statement and other disclosures relevant to the work of the Committee;

2.5.3.2 Areas where judgment has been exercised;

2.5.3.3 Appropriateness and adherence to accounting policies and practices;

2.5.3.4 Explanation of estimates or provisions having material effect and significant variances;

2.5.3.5 The schedule of losses and special payments, which will also be reported on separately during the financial year;

2.5.3.6 Any significant adjustments resulting from the audit and unadjusted audit differences; and

2.5.3.7 Any reservation and disagreements between the external auditors and management which have not been satisfactorily resolved.

**Freedom to speak up**

2.6 To review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in matters of financial reporting and control, fraud, bribery and corruption, clinical quality, patient safety or other matters.

**Emergency Preparedness, Resilience and Response (EPRR)**

2.7 To receive assurance that the Trust is complying with EPRR legal and policy requirements, including sufficient experience and qualified resource having been allocated prior to this being presented to the Board.

## 3. MEMBERSHIP & ATTENDANCE

3.1 Membership of the Committee comprises of four independent Non-Executive Directors (other than the Trust Chair), one of whom will be a qualified accountant and one of whom will also be a member of the Quality Committee.

3.2 The following will be invited to attend meetings of the Committee to provide information and advice with prior agreement of the Committee Chair on a regular basis:

- Representative(s) from the external auditor;
- Representative(s) from the internal auditor;
- Representative(s) from the local counter fraud service;
- Chief Finance Officer;
- Chief Nursing Officer; and
- Associate Director of Corporate Governance/Company Secretary;

and others will attend as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (not the Trust Chair, Trust Vice-Chair or Senior Independent Director), appointed by the Board. A Non-Executive Deputy Chair should be nominated (not the Trust Chair). In the absence of the Committee Chair and/or any appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings.

3.5 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Company Secretary (or their nominee) will maintain a register of members' attendance.

3.6 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director. The Chief Executive Officer will be invited to attend meetings of the Committee, at least annually, to discuss with the Committee the process for assurance supporting the annual governance statement.

3.7 There may be up to two governors attending each meeting as observer(s). Observers are not members of the Committee. These governor(s) will have been nominated to attend by the Council of Governors.

## 4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within its Terms of Reference.

4.2 The Committee is authorised to approve its own governance cycle

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

4.5 The Committee is authorised to approve policies in accordance with the Document Control Policy.

## 5. CONDUCT OF BUSINESS

5.1 The Standing Orders of the Trust, as far as they are applicable, shall apply to the Committee and any of its meetings.

5.2 The Committee will meet at least four times in each financial year and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if the Committee Chair (or their nominated deputy) and one other Non-Executive Director member are present.

5.4 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Committee Chair or any of the Committee's members, or, if they consider it necessary, external or internal auditors.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.7 The agenda and papers shall be made available upon request to members of the Board.

5.8 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee and/or Board at the next meeting.

5.9 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.10 Proceedings and decisions made will be formally recorded by the Company Secretary team in the form of minutes, which will be submitted to the next meeting of the Committee for approval. Once approved by the Committee, minutes of the meetings of the Committee shall be circulated to all other members of the Board, unless the Committee Chair is of the opinion that it would be inappropriate to do so.

5.11 At each meeting, there will be an opportunity for the Committee to meet with representatives of external and internal auditors without management being present to discuss their remit and any issues arising from their audits.

5.12 Outside of the formal meeting programme, the Committee Chair will maintain a dialogue with key individuals involved in the Trust's governance, including external and internal audit.

## 6. RELATIONSHIPS & REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 Where the Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Committee Chair should raise the matter at a full meeting of the Board. The matter may be referred to the Chief Finance Officer in the first instance.

6.3 The Committee Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting of the Board. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being presented as necessary.

6.4 The Committee shall refer to the Finance & Performance Committee, Quality Committee, People & Culture Committee and/or Population Health & System Committee any matters requiring review or decision in such forum(s).

6.5 The Committee shall receive reports from sub-groups of the Trust Management Group and/or Board Committees that specify matters requiring escalation to the Committee. The Committee shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Committee's responsibilities.

## 7. MONITORING

7.1 Attendance will be monitored at each committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include a section describing the work of the Committee in discharging its responsibilities including:

7.2.1 The significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;

7.2.2 An explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or

reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm, when a tender was last conducted and advanced notice of any retendering plans; and

7.2.3 If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

## 8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

**APPENDIX A**

## ATTENDANCE AT AUDIT COMMITTEE MEETINGS

| **NAME OF COMMITTEE:** | Finance and Performance Committee | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Present *(including names of members present at the meeting)*** | **Meeting Dates** | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Was the meeting quorate? Y/N<br><br>*(Please refer to Terms of Reference)* | | | | | | | | | | | | |

University Hospitals Dorset
NHS Foundation Trust

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Charitable Funds Committee



**January 2023**

# DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance |
| **Signed:** | |
| **Date:** | January 2023 |
| **Version No:** (Author Allocated) | 2.0 |
| **Next Review Date:** | January 2024 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| September 2020 | 1 | September 2022 | September 2020 | Company Secretary | New Terms of Reference |
| November 2021 | 1.1 | November 2023 | | | |
| January 2023 | 2.0 | January 2024 | | Company Secretary | Re-draft to align with approach to other Committee Terms of Reference. |

# TABLE OF CONTENTS



| **INDIVIDUAL APPROVAL** | | | |
|---|---|---|---|
| Job Title | N/A | Date | N/A |
| Print Name | N/A | Signature | N/A |

| **BOARD OF DIRECTORS/COMMITTEE APPROVAL** | | | |
|---|---|---|---|
| If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |
| Name of approving body | Board of Directors | Date | |
| Print Name | | Signature of Chair | |

# UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

## CHARITABLE FUNDS COMMITTEE

## TERMS OF REFERENCE

## 1. PURPOSE

1.1 These Terms of Reference relate to the operation of the University Hospitals Dorset NHS Foundation Trust Charitable Funds (Charity Registration Number: 1057366).

1.2 The Charitable Funds Committee (Committee) is formally established as a committee of the Corporate Trustee (the Trustee), with the Board of Directors of University Hospitals Dorset NHS Foundation Trust acting as the Board of the Trustee. Part 9, s177 of the Charities Act 2011 defines "charity trustees" as "the persons having the general control and management of the administration of the charity".

1.3 The Committee provides the Board of Directors of the Trust (Board) with a means of assurance regarding the administration of the Charity in accordance with applicable legislation.

1.4 The Committee has no executive powers other than those specifically delegated in these terms of reference.

## 2. RESPONSIBILITIES

2.1 To monitor and authorise the application of all charitable funds in accordance with the Charities Acts, external guidance and applicable legislation and to ensure that decisions on the use or investment of such funds are compliant with the explicit conditions or purpose of each donation or bequest.

2.2 To make decisions involving the investment of charitable funds with regards to the existing and subsequent legislation, policy and guidance from the Charity Commission.

2.3 To ensure compliance with the Trust's Standing Financial Instructions and Scheme of Delegation as applicable to charities.

2.4 To monitor the performance of the investment portfolio, to include the review of spending plans and balances held within individual charitable funds.

2.5 To review and recommend approval to the Board of the Annual Report and Accounts of the Charity for submission to the Charity Commission.

2.6 To receive and review the quarterly charitable funds income and expenditure accounts together with any other supporting information.

2.7 To ensure that expenditure is controlled and utilised on suitable projects.

2.8 To establish policies and procedures to ensure the effective day to day management of the charitable funds and to ensure that these procedures are followed.

2.9 To review detailed business cases relating to major investment decisions and to recommend investment or otherwise.

2.10 To ensure legacies are realised in a timely and complete manner.

2.11 To safeguard donated money.

2.12 To review annually the overall fundraising strategy and fundraising projects and recommend schemes to the Board for approval.

2.13 To enact the overall strategy, as set by the Board, on the use of the Charitable Fund.

## 3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee comprises of three Non-Executive Directors, the Chief Finance Officer and the Chief People Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Chief Strategy and Transformation Officer;
- Head of Charity;
- Associate Director of Finance;
- Associate Director of Communications;

and others (external or internal) as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust. A Non-Executive Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting.

3.5 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Company Secretary (or their nominee) will maintain a register of members' attendance.

3.6 Any Non-Executive Director who is not a member of the Committee may attend any meeting of the Committee with prior agreement of the Committee Chair.

3.7 There may be up to two governors attending each meeting as observer(s). Observers are not members of the Committee. These governor(s) will have been nominated to attend by the Council of Governors.

## 4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.2 The Committee is authorised to approve its governance cycle.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

4.5 The Committee is authorised to recommend approval to the Board, the Annual Report and Accounts for submission to the Charity Commission.
.

4.6 The Committee is authorised to develop and agree an investment policy.

4.7 The Committee is authorised to agree expenditure of charitable funds up to £250,000 per individual item of expenditure. Charitable applications above £250,000 will be considered and recommended for approval by the Board.

4.8 The Committee is authorised to review and approve annually the overall fundraising strategy for the Fundraising Department.

## 5. CONDUCT OF BUSINESS

5.1 The Constitution, Scheme of Delegation and Standing Orders of the Trust, as far as they are applicable, shall apply to the Committee and any of its meetings.

5.2 The Committee will normally meet on a quarterly basis and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least three members present, which will include the Chair (or a Non-Executive Director deputy), another Non-Executive Director and one Executive Director. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

5.4 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.7 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any

decisions made in this manner must be formally ratified by the Committee and/or Board at the next meeting.

5.8 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.9 Proceedings and decisions made will be formally recorded by the Company Secretary team in the form of minutes, which will be submitted to the next meeting of the Committee for approval. Once approved by the Committee, minutes of the meetings of the Committee shall be circulated to all other members of the Board, unless the Committee Chair is of the opinion that it would be inappropriate to do so.

## 6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Trustee. It falls to the Board to act on behalf of the Trustee in making trustee decisions.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.3 The Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting of the Board. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being provided as necessary.

## 7. MONITORING

7.1 Attendance will be monitored at each committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include a section regarding the work of the Committee.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

## 8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

## APPENDIX A

## ATTENDANCE AT CHARITABLE FUNDS COMMITTEE MEETINGS

| **NAME OF COMMITTEE:** | Quality Committee | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Present (*include names of members present at the meeting)*** | **Meeting Dates** | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **In Attendance** | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Was the meeting quorate? Y / N<br><br>(*Please refer to Terms of Reference*) | | | | | | | | | |

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Finance & Performance Committee

**January 2023**

# DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy and Ewan Gauvin |
| **Job Title:** | Associate Director of Corporate Governance, Corporate Governance Manager |
| **Signed:** | |
| **Date:** | January 2023 |
| **Version No:** (Author Allocated) | 2.0 |
| **Next Review Date:** | January 2024 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| 2020 | 1 | 2021 | 29 07 2020 | Company Secretary | New Document |
| 2021 | 1.1 | Oct 2021 | 26 05 2021 | Assistant Company Secretary | Removed CEO as member of the committee at section 2.1<br>Added the CEO's attendance at section 2.3<br>Added CEO's receipt of papers at section 4.2 |
| October 2021 | 1.2 | October 2022 | | Company Secretary | 'Excluding VAT' added to 8.3 |
| January 2023 | 2.0 | January 2024 | | Company Secretary | Full review and redraft. |

# TABLE OF CONTENTS



| **INDIVIDUAL APPROVAL** | | | |
|---|---|---|---|
| Job Title | N/A | Date | N/A |
| Print Name | N/A | Signature | |
| **BOARD OF DIRECTORS / COMMITTEE APPROVAL** | | | |
| If the Board / Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |
| Name of approving body | Board of Directors | Date | |
| Print Name | | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**FINANCE & PERFORMANCE COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Finance and Performance Committee is to support the Trust in achieving its strategic objectives: "**To arrange our people and services to best address the planned care backlog, ensuring that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets**" and **"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"**.

1.3 The Finance and Performance Committee will do this including through:

- Providing input and recommendations to the Board for the development of the Annual Operating Plan, Productivity and Efficiency Plan (including savings opportunities and merger benefits realisation), Quality Improvement Strategy, Estates Strategy (Masterplan), Sustainability Strategy (Green Plan), Digital Strategy and Private Patients Strategy;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to finance, performance, digital, sustainability and transformation;
- Obtaining assurance on the implementation of the Annual Operating Plan, the Productivity and Efficiency Plan, Quality Improvement Strategy, Estates Strategy (Masterplan), Sustainability Strategy (Green Plan), Digital Strategy and Private Patients Strategy;
- Monitoring risks relating to the efficient use of resources (physical and financial, but excluding workforce which shall be reviewed by the People and Culture Committee), including financial performance;
- Monitoring implementation progress and obtaining assurance of:
    - Delivery of financial and non-financial benefits of merger integration and reconfiguration;
    - all components of post-merger benefits realisation;
    - the Clinical Services Review implementation; and
    - Mitigations to climate change;
- Overseeing coordination and coherence of the entire transformation agenda, including both major programmes of changes, as well as creating a culture of empowerment and continuous quality improvement.

1.4 The Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

## 2. RESPONSIBILITIES

**Strategies and delivery of the strategic agendas**

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives and
- the relevant strategic initiatives

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

2.3 Statutory requirements

2.3.1 To review the Trust's draft Annual Report and Accounts, in conjunction with the Audit Committee, and following satisfactory external audit, making recommendations jointly to the Board for approval, signature, submission and filing.

2.4 Financial and operational performance

2.4.1 To review for recommendation to the Board the annual plan and medium-term financial plans, including, to the extent necessary and relevant considering the wider Dorset system's annual plan.

2.4.2 To review and make comment to the Board on the long term strategic financial plans of the Trust, and to the extent necessary the wider Dorset system, including consideration of the level of capital investment and financial risk.

2.4.3 To review and make comment to the Board on the substance of the annual revenue and capital budgets of the Trust, and to the extent necessary the wider Dorset system, and to consider and make recommendations to the Board of Directors on tenders, contracts and business cases for capital and revenue schemes which exceed the Committee's delegated limits set out in the Schedule of Delegation of the Board.

2.4.4 To review the financial and operational performance and controls reporting of the Trust, and to the extent necessary the wider Dorset system, to include overall financial and operational performance, financial performance of each Care Group, cash flow, debtors and creditors, transformation, merger and cost improvement programmes, capital spend against plan and resources available.

2.4.5 To review and examine monthly and year to date financial management variances both revenue and capital and report to the Board.

2.4.6 To keep under review the quality, quantity and timeliness of financial, operational and analytical information provided to the Board and recommend any required changes, particularly in response to changes required to regain budget trajectory or in national requirements on a monthly or annual basis as appropriate.

2.4.7 In respect of major capital projects of the Trust, and to the extent necessary the wider Dorset system, to consider business cases in detail and where necessary advise on strengthening prior to making recommendations to the Board for its approval or otherwise. To monitor these projects post-approval and scrutinise any cost or time variances.

2.4.8 To review and make comment to the Board on borrowing against Prudential Borrowing Code and other ratios.

2.4.9 To monitor and recommend improvements to Treasury and Financial Systems, meeting the objectives of strengthening the use of financial resources.

2.4.10 To review and recommend individual investments of cash balances/cash advances.

2.4.11 To monitor banking arrangements, including approving tenders of banking services.

2.4.12 To support the Trust in fulfilling the requirements of its licence and commissioner contracts in relation to key performance indicators.

2.4.13 To keep the Board updated on any identified regulatory and statutory duties related to financial performance of the Trust and how this impacts delivery against the control total.

2.4.14 To consider the impact of accounting policies for external reporting, taking into account the requirements of NHS England and other appropriate bodies.

2.4.15 To review the estates strategy and Estates masterplan, providing input and recommendations to the Board, and to monitor progress against and risks associated with the strategy and monitoring other estates-related improvement plans.

2.4.16 To review the Private Patient Strategy, the Benefits Realisation Strategy and the Quality Improvement Strategy, providing input and recommendations to the Board and to monitor progress against and risks associated with such strategies.

2.4.17 To review the development and delivery of commercial strategies of the Trust, including partnership arrangements with other organisations, providing input and recommendations to the Board.

2.4.18 To review the Trust's procurement strategy including having regard to the priorities at national and integrated care system (ICS) level and challenges to the delivery of change and providing input to the Board.

2.5 Digital

2.5.1 To review the Digital Strategy and provide input and recommendations to the Board for approval.

2.5.2 To monitor the implementation of the Trust's information management, technology and digital plans as enablers to efficiency and transformation, receiving regular progress reports to scrutinise delivery and the meeting of key milestones.

2.5.3 To receive reporting in relation to cyber security including regular maintenance of critical systems and equipment and minimising impact on clinical services during downtime.

2.6 Sustainability

2.6.1 To review the Sustainability Strategy (Green Plan) and provide input and recommendations to the Board for approval.

(For this purpose, sustainability means meeting the needs of the current generation without compromising future generations of the ability to meet their needs, in social, economic or environmental terms. The Trust and the wider NHS are also assessing the health and wellbeing of the population for environmental changes, including the impacts of a warming planet, air quality and mitigations for these negative changes).

2.6.2 To monitor the implementation of the Trust's sustainability plans, receiving regular progress reports to scrutinise delivery and the meeting of key milestones.

2.6.3 To review the Trust's draft Annual Report prior to recommendation to the Board for matters of sustainability, climate adaptation and carbon reduction and related areas of corporate social responsibility.

2.7 ICS

2.7.1 To receive and review financial and other relevant reports of or relating to the Dorset ICS and provider collaborative.

**Risk Management**

2.8.1 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.8.2 To be kept appraised of all new and current risks rated 12-25 applicable to the Committee's scope identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

## 3. MEMBERSHIP & ATTENDANCE

3.1 Membership of the Finance and Performance Committee comprises of three Non-Executive Directors (at least one of whom should have recent and relevant financial experience), the Chief Finance Officer, the Chief Strategy and Transformation Officer and the Chief Operating Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy Chief Finance Officer;
- Head of Productivity & Efficiency;
- Group Directors of Operations;

Group Directors of Operations will attend on a quarterly basis and as invited, and others including, but not limited to:

- the Chair of the Medical Advisory Committee for Private Health UHD;
- the Chair of the Medical Advisory Committee for Dorset Heart Clinic;
- the Associate Director of Estates;
- the Trust Sustainability and Carbon Manager;
- a representative from Communications;

- a representative from Bournemouth, Christchurch and Poole Council;
- a representative from Bournemouth University
- the Director of Transformation;
- the Director of Improvement and Integration;
- the Director of Organisational Development;

as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (not the Trust Chair or the Chair of the Audit Committee), appointed by the Board of Directors. A Non-Executive Deputy Chair should be nominated (not the Trust Chair or the Chair of the Audit Committee). In the absence of the Committee Chair and/or any appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.5 and 3.6 below, only members of the Committee have the right to attend Committee meetings. If an executive director member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. The Chief Executive Officer will attend on an ad-hoc basis or as required.

3.5 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Company Secretary (or their nominee) will maintain a register of members' attendance.

3.6 Any member of the Board of Directors may attend any meeting of the Committee with prior agreement of the Chair.

3.7 There may be up to two governors attending each meeting as observer(s). Observers are not members of the Committee. These governor(s) will have been nominated to attend by the Council of Governors.

## 4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference and to make decisions within its delegated authority limits.

4.2 The Committee is authorised to approve its own governance cycle

4.3 The Committee shall have delegated authority to approve or reject tenders, award contracts and approve business cases for capital and revenue schemes up to the value delegated to it by the Board.

4.4 The Committee is authorised to approve Treasury Management Policies and Investments.

4.5 The Committee is authorised to approve the policies and procedures for ensuring economy, efficiency and effectiveness in the use of resources.

4.6 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.7 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

4.8 The Committee is authorised to approve policies in accordance with the Document Control Policy.

## 5. CONDUCT OF BUSINESS

5.1 The Constitution, Scheme of Delegation, Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Committee and any of its meetings.

5.2 The Committee will normally meet on a monthly basis (and not less than 10 times in each financial year) and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there are at least three members present which will include two Non-Executive Directors and one Executive Director. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

In the absence of the Chief Finance Officer, his/her deputy must be present.

5.4 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair or Chief Finance Officer.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair, with the Chair consulting with the Chief Finance Officer, Chief Operating Officer and Chief Strategy and Transformation Officer as considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.7 The agenda and papers shall be made available upon request to members of the Board.

5.8 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee and/or Board at the next meeting.

5.9 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.10 Proceedings and decisions made will be formally recorded by the Company Secretary team in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

## 6. RELATIONSHIPS & REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.3 The Committee Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting of the Board. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being presented as necessary.

6.4 The Committee shall refer to the Audit Committee, Quality Committee, People & Culture Committee and/or Population Health & System Committee any matters requiring review or decision in such forum(s).

6.5 For the avoidance of doubt:

- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process; and
- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

6.6 The governance of Private Health UHD is within the Surgical Care Group and Dorset Heart Clinic within the Medical Care Group. There are operational management groups for these, who report via the Care Group management governance.

6.7 The Committee shall receive reports from sub-groups of the Trust Management Group and/or Board Committees that specify matters requiring escalation to the Committee. The Committee shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Committee's responsibilities.

## 7. MONITORING

7.1 Attendance will be monitored at each committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within

its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

## 8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

**APPENDIX A**

## ATTENDANCE AT FINANCE AND PERFORMANCE COMMITTEE MEETINGS

| **NAME OF COMMITTEE:** | Finance and Performance Committee | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Present *(including names of members present at the meeting)*** | **Meeting Dates** | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Was the meeting quorate? Y/N<br><br>*(Please refer to Terms of Reference)* | | | | | | | | | | | | |

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# People & Culture Committee

**January 2023**

We are caring one team listening to understand open and honest always improving inclusive

## DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance |
| **Signed:** | |
| **Date:** | January 2023 |
| **Version No:** (Author Allocated) | 2.0 |
| **Next Review Date:** | January 2023 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| August 2020 | 1 | August 2021 | August 2020 | Company Secretary | New document |
| October 2021 | 1.1 | October 2022 | 24 November 2021 | Company Secretary | Addition of two Groups at 9.1 Addition of an Attendee at 2.2 |
| January 2023 | 2.0 | January 2024 | | Company Secretary | Full review and re-draft. |

# TABLE OF CONTENTS



| **INDIVIDUAL APPROVAL** | | | |
|---|---|---|---|
| Job Title | N/A | Date | N/A |
| Print Name | N/A | Signature | N/A |

| **BOARD OF DIRECTORS/COMMITTEE APPROVAL** | | | |
|---|---|---|---|
| If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |
| Name of approving body | Board of Directors | Date | |
| Print Name | | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**PEOPLE & CULTURE COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the People & Culture Committee is to support the Trust in achieving its 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**".

1.3 The People & Culture Committee will do this through:

- Providing input and recommendations to the Trust's Board of Directors (Board) for the development of the People Strategy and the Equality, Diversity & Inclusion Strategy;
- Assisting the Board in its oversight of achievement of breakthrough objectives and strategic initiatives relating to the People & Culture domains;
- Obtaining assurance on the implementation of the People Strategy and Equality, Diversity & Inclusion Strategy; and
- Receiving and reviewing information and data relating to workforce reporting to the Board.

1.4 The Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

## 2. RESPONSIBILITIES

**People Strategy and delivery of the People Agenda**

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

**Risk Management**

2.3.1 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in

accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.2 To review the Trust's significant risks report and receive updates on directorate workforce risk issues, action plans or unresolved matters/concerns for escalation.

**Oversight and Assurance**

A great place to work

2.3.4 To review reports from the Guardian of Safe Working and Freedom to Speak Up Guardian as well as Safe Staffing reviews.

2.3.5 To consider reports on national and local surveys including the staff survey and GMC survey as they relate to workforce, monitoring the implementation of actions agreed to be taken to address areas of concern identified.

2.3.6 To obtain assurance that appropriate feedback mechanisms are in place for those raising incidents and that a culture of openness and transparency in respect of incident reporting is encouraged by supporting the Speaking Up agenda.

2.3.7 To oversee and monitor the implementation of the Equality, Diversity and Inclusion strategy.

2.3.8 To obtain assurance in relation to the Trust's security management - violence prevention and reduction strategy.

Compassionate inclusive leadership, focused on improvement of quality and efficiency of services for patients

2.3.9 To oversee the development by the Trust of an effective staff structure and workforce operating model across the organisation.

2.3.10 To monitor delivery of staff engagement plans to ensure there are clear communication channels across the organisation which provide staff with key information during the transformation of services.

2.3.11 To monitor organisational integration and cultural development and the implementation of action plans as necessary.

Building skills and capabilities

2.3.12 To receive reporting relating to changes in Professional Education and Essential Core Skills training to ensure compliance and continued provision of high quality care.

2.3.13 To monitor the provision of training and development and implementation of solutions which deliver a skilled, flexible modernised workforce improving productivity, performance and reducing health inequalities.

2.3.14 To obtain assurance that effective performance management systems are in place in support of delivery by the Trust of improving capability and capacity to provide high quality, safe patient care.

Strategic workforce planning

2.3.15 To monitor major workforce transformation programmes, including to obtain assurance that no such programme has an unforeseen adverse impact on workforce or on the performance of the Trust.[1]

2.3.16 To receive and monitor workforce indicators including recruitment, retention/turnover, sickness, appraisals and training.

Mandated/Statutory requirements

2.3.17 To oversee and monitor progress against national NHS England workforce standards and reporting including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

2.3.18 To review the Trust's Equality and Diversity Monitoring Report.

2.3.19 To review the Gender Pay Gap Report.

2.3.20 To review the annual consultant revalidation report.

2.4 ICS

To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.

## 3. MEMBERSHIP/ATTENDANCE

3.1 Membership of the People & Culture Committee comprises of three Non-Executive Directors, the Chief People Officer, the Chief Medical Officer, Chief Nursing Officer and the Chief Operating Officer:

3.2 In addition, the following will attend the Committee to provide information and advice with the prior agreement of Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy to Chief People Officer x 2;
- Associate Director of Communications;
- Director of Organisational Development;
- Care Group Directors of Operations;
- Associate Director for Allied Health Professionals & Healthcare Scientists;

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (other than the Chair of the Audit Committee). A Non-Executive Deputy Chair may be nominated (other than the Chair of the Audit Committee). In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

[1] Existing ToR provide for "Strategy Planning: the committee will monitor the implications of the Clinical Services Review, Cost Improvement Plans and major service changes".

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting.

3.5 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Company Secretary (or their nominee) will maintain a register of members' attendance.

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

3.7 There may be up to two governors attending each meeting as an observer. Observers are not members of the Committee. These governor(s) will have been nominated to attend by the Council of Governors.

## 4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.2 The Committee is authorised to approve its governance cycle.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

4.5 The Committee is authorised to approve policies in accordance with the Document Control Policy.

## 5. CONDUCT OF BUSINESS

5.1 The Constitution, Scheme of Delegation and Standing Orders of the Trust, as far as they are applicable, shall apply to the Committee and any of its meetings.

5.2 The Committee will normally meet on a quarterly basis and at such other times as the Chair of the Committee shall require.

5.3 Meetings of the Committee shall be quorate if there at least four members present, which will include at least one Non-Executive Director and one Executive Director. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

5.4 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair, with the Chair consulting with the Chief Nursing Officer, as considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.7 The agenda and papers shall be made available upon request to members of the Board.

5.8 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee and/or Board at the next meeting.

5.9 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.10 Proceedings and decisions made will be formally recorded by the Company Secretary team in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

## 6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.3 The Committee Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting of the Board. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being provided as necessary.

6.4 The Committee shall refer to the Audit Committee, Finance & Performance Committee, Quality Committee and/or Population Health & System Committee any matters requiring review or decision in such forum(s).

6.5 For the avoidance of doubt:

- the Finance and Performance Committee will have oversight of coordination and coherence of the entire transformation agenda;
- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

6.6 The Committee shall receive reports from sub-groups of the Trust Management Group and/or Board Committees that specify matters requiring escalation to the Committee.

The Committee shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Committee's responsibilities.

## 7. MONITORING

7.1 Attendance will be monitored at each committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

## 8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

**APPENDIX A**

## ATTENDANCE AT PEOPLE & CULTURE COMMITTEE MEETINGS

| **NAME OF COMMITTEE:** | People & Culture Committee | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Meeting Dates** | | | | | | | | |
| **Present (*include names of members present at the meeting)*** | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **In Attendance** | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Was the meeting quorate? Y / N<br><br>(*Please refer to Terms of Reference*) | | | | | | | | | |

University Hospitals Dorset
NHS Foundation Trust

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Quality Committee



**January 2023**

We are caring one team listening to understand open and honest always improving inclusive

# DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy and Ewan Gauvin |
| **Job Title:** | Associate Director of Corporate Governance and Corporate Governance Manager |
| **Signed:** | |
| **Date:** | January 2023 |
| **Version No:** (Author Allocated) | 2.0 |
| **Next Review Date:** | January 2024 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| October 2020 | 1 | October 2021 | July 2020 | Company Secretary | New document |
| May 2021 | 1.1 | October 2021 | 26 May 2021 | Assistant Company Secretary | Removed CEO as member of the committee at section 2.1<br>Added the CEO's attendance at section 2.4<br>Added CEO's receipt of papers at section 5.4 |
| October 2021 | 1.2 | October 2022 | November 2021 | Company Secretary | Added the Care Group Quality & Risk Groups to the reporting groups in sections 1.4 and 9.1<br>Added Associate Director of AHP/HCS as an attendee in section 2.2 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Added that the Clinical Lead for Clinical Audit is to attend for the Annual Audit Plan and Annual Report in section 2.2. |
| January 2022 | 1.3 | January 2023 | | Corporate Governance Assistant | Changed "Quality Governance Group" to "Clinical Governance Group" in sections 1.4 and 9.1. |
| January 2023 | 2.0 | January 2024 | | Company Secretary | Full review and re-draft. |

## TABLE OF CONTENTS

| **INDIVIDUAL APPROVAL** | | | |
|---|---|---|---|
| Job Title | N/A | Date | N/A |
| Print Name | N/A | Signature | N/A |

| **BOARD OF DIRECTORS/COMMITTEE APPROVAL** | | | |
|---|---|---|---|
| If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |
| Name of approving body | Board of Directors | Date | |
| Print Name | | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**QUALITY COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Quality Committee is to support the Trust in achieving its strategic objective: "**To enhance emergency care and hospital flow and continually improve the quality so that services are safe, compassionate, timely and responsive, achieving consistently good outcomes and an excellent patient experience**".

1.3 The Quality Committee will do this including through:

- Providing input and recommendations to the Board for the development of the Quality Strategy, Risk Management Strategy and Clinical Audit Strategy and the End of Life Care Strategy;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services;
- Promoting a culture of learning and continuous improvement;
- Obtaining assurance on the implementation of the quality strategy; and
- Receiving and reviewing information and data relating to quality performance reporting to the Board.

1.4 The Committee serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely and cost-effective manner across the following areas: quality, patient experience, patient safety, clinical outcomes, risk management, health and safety, safeguarding (children and adults), infection prevention and control, medicines management, learning from deaths and end of life care.

1.5 The Committee acts as a means of internal assurance for compliance against the Care Quality Commission regulating and inspection compliance framework.

1.6 The Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

## 2. RESPONSIBILITIES

**Quality Strategy and delivery of the Quality Agenda**

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

**Risk Management**

2.3.1 To oversee that the Trust has robust management systems and processes in place for ensuring high standards for quality of care.

2.3.2 To oversee that the Trust has an effective framework to support assurance regarding Trust systems relating to patient safety, patient outcome and patient experience.

2.3.2 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.3 To be kept appraised of all new and current risks rated 12-25, clinical and non-clinical, identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

**Assurance**

2.4 Statutory requirements

2.4.1 To review the annual quality report.

2.4.2 To review the quarterly and annual mortality reports.

2.4.3 To review the annual adult and children safeguarding report and statement.

2.4.4 To review the annual reports on claims.

2.4.5 To review the annual infection prevention and control report and statement.

2.5 External reviews

2.5.1 To receive assurance from other significant assurance functions, both internal and external, on review of the findings of external reviews and consider the implications to the Trust. These will include, but not be limited to, regulators and inspectors.

2.5.2 To monitor the Trust's responses to relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission.

2.5.3 To receive and monitor the CQC Insight Model Report.

2.5.4 To receive and monitor the CQC in-patient survey reports and associated action plans.

2.6 Safe

2.6.1 To review reports on serious incidents, mortality, learning from deaths, never events, claims and inquests to receive assurance that appropriate thematic review, investigation and learning to reduce risk has been undertaken.

2.6.2 To receive reports including:

- identification of areas of concern and escalations; and
- in the context of quality risks and assurances over the Trust's system of internal control as reflected in the Board Assurance Framework;

from defined sub-groups of the Trust Management Group and/or Board Committees (including, as considered required, Safeguarding, Infection Prevention & Control, Radiation Protection, Medicines Governance, Health and Safety, Mortality Surveillance, Clinical Governance Group and Strategic Nursing Midwifery and Professions Group).

2.6.3 To review and monitor Quality Impact Assessments relating to cost improvement programmes and transformation programmes to obtain assurance that there will be no unforeseen detrimental impact on the quality of care for patients.

2.6.4 To obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and adults.

2.6.5 To obtain assurance over the Trust's maternity services including receipt of reports from the Maternity Safety Champion and relevant maternity safety and performance dashboards.

2.6.6 To obtain assurance over the safe delivery of the Trust's palliative and end of life care services including receipt of the annual End of Life Care Report and Care of the Dying Audit.

2.6.7 To obtain assurance in relation to the safe delivery of the Trust's resuscitation services.

2.6.8 To obtain assurance in relation to the safe delivery of the Trust's children's services.

2.6.9 To obtain assurance in relation to the delivery of the Trust's falls and dementia services.

2.6.10 To review reports in relation to Getting It Right First Time.

2.6.11 To receive relevant reports from national bodies in relation to standards or practice of clinical care.

2.7 Effective

2.7.1 To ensure a comprehensive clinical audit programme is in place to support and apply evidence-based practice, implement clinical standards and guidelines and drive quality improvement. This shall include through monitoring progress against the Clinical Audit Strategy.

2.7.2 When requested by the Board, or where determined by the Committee, to monitor the implementation of action or improvement plans in relation to quality of care, particularly in relation to incidents and similar issues.

2.8 Caring

2.8.1 To consider reports from the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on formal and informal patient feedback and to consider action in respect of matters of concern.

2.8.2 To consider the results of issues raised and the trends in patient surveys of in-patients and out-patients activities and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of suitable improvement and the completion of action to address the issues raised.

2.9 Well-Led

2.9.1 To receive and consider the Trust's clinical governance and risk management reports and review recommendations on actions for improvement.

2.9.2 To provide assurance reporting to the Board that the Care Quality Commission's fundamental standards for quality and safety are monitored and highlight any gaps in compliance, controls or assurance.

2.9.3 To review, make comment and provide assurance reporting to the Board on the care and safety issues which are subject to other regulatory scrutiny (for example, NICE).

2.9.4 To oversee, through receipt of periodic status reporting, the update of clinical policies.

2.10 Responsive

2.10.1 To identify key themes from complaints, PALS and patient engagement, good practice and learning and provide oversight on behalf of the Board.

2.10.2 To identify key themes from patient experience, quality indicators and provide oversight of action plans to attain assurance.

2.10.3 To receive, by exception, reports relating to patient experience following review at relevant groups.

2.11 ICS

To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.

## 3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Quality Committee comprises of three Non-Executive Directors, one of whom will be a member of the Audit Committee, the Chief Nursing Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief People Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy Chief Nursing Officers;
- Deputy Chief Medical Officers;
- Director of Infection Prevention and Control;
- Care Group Medical Directors;
- Associate Director of Pharmacy;
- Associate Medical Director (Chair of CGG);
- Care Group Directors of Nursing;
- Associate Director of Quality Governance and Risk;
- Clinical Lead for Clinical Audit;
- IR(ME)R Lead/Chair of Radiation Group;

- Associate Director of Allied Health Professionals & Healthcare Scientists

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (other than the Chair of the Audit Committee or Finance and Performance Committee). A Non-Executive Deputy Chair (other than the Chair of the Audit Committee or Finance and Performance Committee) may be nominated. In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. The Chief Executive Officer will attend on an ad-hoc basis or as required.

3.5 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Company Secretary (or their nominee) will maintain a register of members' attendance.

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

3.7 There may be up to two governors attending each meeting as observer(s). Observers are not members of the Committee. These governor(s) will have been nominated to attend by the Council of Governors.

## 4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.2 The Committee is authorised to approve its governance cycle.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

4.5 The Committee is authorised to approve policies in accordance with the Document Control Policy.

## 5. CONDUCT OF BUSINESS

5.1 The Constitution, Scheme of Delegation and Standing Orders of the Trust, as far as they are applicable, shall apply to the Committee and any of its meetings.

5.2 The Committee will normally meet on a monthly basis (and not less than 10 times in each financial year) and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least five members present, which will include the Chair (or a Non-Executive Director deputy), and two Executive Directors, one of whom must be the Chief Medical Officer or Chief Nursing Officer. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

5.4 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair, with the Chair consulting with the Chief Nursing Officer, as considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.7 The agenda and papers shall be made available upon request to members of the Board.

5.8 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee and/or Board at the next meeting.

5.9 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.10 Proceedings and decisions made will be formally recorded by the Company Secretary team in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

## 6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.3 The Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting of the Board. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being provided as necessary.

6.4 The Committee shall refer to the Audit Committee, Finance & Performance Committee, People & Culture Committee and/or Population Health & System Committee any matters requiring review or decision in such forum(s).

6.5 For the avoidance of doubt:

- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

6.5 The Committee shall receive reports from sub-groups of the Trust Management Group and/or Board Committees that specify matters requiring escalation to the Committee. The Committee shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Committee's responsibilities.

## 7. MONITORING

7.1 Attendance will be monitored at each committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Trust's Annual Report disclosures.

## 8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

## APPENDIX A

## ATTENDANCE AT QUALITY COMMITTEE MEETINGS

| **NAME OF COMMITTEE:** | Quality Committee | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Present (*include names of members present at the meeting)*** | **Meeting Dates** | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **In Attendance** | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Was the meeting quorate? Y / N<br>(*Please refer to Terms of Reference*) | | | | | | | | | |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 10.3**

| | |
|---|---|
| **Subject:** | Composition of Board Committees |
| **Prepared by:** | Yasmin Dossabhoy, Associate Director of Corporate Governance |
| **Presented by:** | Rob Whiteman, Trust Chair |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☒<br>Be a great place to work ☒<br>Use resources efficiently ☒<br>Be a well led and effective partner ☒<br>Transform and improve ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | All |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | Following a review of the Board Committee structures, and consideration having been given by the Trust Chair to the Chairs and membership of such Committees, the Board is asked to consider and approve the following appointments to the Committees constituted by the Board each with effect from 1 January 2023.<br>This is other than Population Health and System Committee which, subject to it being established by the Board on 25 January 2023, shall have the Chair and membership set out below with effect from its establishment date:<br><br>• **Audit Committee – Stephen Mount (Chair).** Other members: John Lelliott, Cliff Shearman. (1 Non-Executive Director vacancy to be filled).<br><br>• **Charitable Funds Committee – John Lelliott (Chair).** Other members: Pankaj Davé, Philip Green, Chief Finance Officer (Pete Papworth) and Chief People Officer (Karen Allman).<br><br>• **Finance and Performance Committee – Philip Green (Chair)**. Other members: John Lelliott, Pankaj Davé, Chief Finance Officer (Pete Papworth), Chief Operating Officer (Mark Mould) and Chief Strategy and Transformation Officer (Richard Renaut). |

| | |
|---|---|
| | • **Quality Committee – Cliff Shearman (Chair)**. Other members: Caroline Tapster, Stephen Mount, the Chief Nursing Officer (Paula Shobbrook), the Chief Medical Officer ((Ruth Williamson – Acting CMO), the Chief Operating Officer (Mark Mould) and Chief People Officer (Karen Allman).<br><br>• **People and Culture Committee – Pankaj Davé (Chair).** Other members: Philip Green, Caroline Tapster, Chief People Officer (Karen Allman), the Chief Medical Officer (Ruth Williamson – Acting CMO), Chief Nursing Officer (Paula Shobbrook) and Chief Operating Officer (Mark Mould).<br><br>• **Population Health and System Committee – Caroline Tapster (Chair).** Other members: Stephen Mount, 1 Non-Executive Director vacancy, Chief Medical Officer (Ruth Williamson – Acting CMO) and Chief Informatics and IT Officer (Peter Gill). |
| **Background:** | Pursuant to section 6.3 of Annex 7 (Standing Orders for the Practice and Procedure of the Board of Directors) to the Trust's Constitution, the Board may appoint Committees of the Board consisting of the Trust Chair and Directors of the Trust. The Trust is to determine the membership and terms of reference of such Committees.<br><br>Pursuant to section 6.7 of such Annex, the Board is to approve the appointments to the Committees that it has formally constituted. |
| **Key Recommendations**: | To review and if thought fit approve the appointments to the Board Committees set out above. |
| **Implications associated with this item:** | Council of Governors ☒<br>Equality and Diversity ☒<br>Financial ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☒<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒<br>System ☒ |
| **CQC Reference:** | Safe ☒<br>Effective ☒<br>Caring ☒<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☒ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| N/A | N/A | N/A |

| Reason for submission to the Board in Private Only (where relevant) | | |
|---|---|---|
| | Commercial confidentiality | ☐ |
| | Patient confidentiality | ☐ |
| | Staff confidentiality | ☐ |
| | Other exceptional reason | ☐ |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 10.4**

| | |
|---|---|
| **Subject:** | Managing Conflicts of Interest Policy<br>Anti-fraud, Bribery & Corruption Policy |
| **Prepared by:** | Heather Greenhowe, RSM<br>Ewan Gauvin, Corporate Governance Manager<br>Yasmin Dossabhoy, Associate Director of Corporate Governance |
| **Presented by:** | Pete Papworth, Chief Finance Officer |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☐<br>Be a great place to work ☐<br>Use resources efficiently ☒<br>Be a well led and effective partner ☒<br>Transform and improve ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | None. |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | **Managing Conflicts of Interest**<br><br>**Substantive changes to the policy:**<br>Decision-making staff (1.7):<br>• Retained Agenda for Change Band 8d, in line with NHSE guidance on Managing Conflicts of Interests and in consultation with LCFS.<br>• Amended conflicting statements (7.8, 21.6).<br>• Proposed removal of "estates staff" from the decision-making staff category (effective from 1 April 2023). Decision-makers from estates would be covered within the remaining scope.<br><br>Strategic Decision-making groups (20):<br>• Updated list of Committees.<br><br>Association of British Pharmaceutical Industry (ABPI):<br>• Added section on ABPI declarations (22).<br><br>NHS Standard Contract 2021/22:<br>• Added requirement from NHS Standard Contract 2021/22 General Conditions to publish the name and position of any decision-making staff that fails to complete a declaration of interest or nil return within the contract year. (21.7) |

| | |
|---|---|
| | **Next steps:**<br>• Issue appropriate privacy statement in relation to NHS Standard Contract 2021/22 requirement.<br>• Update the "short guide for staff" on Managing Conflicts of Interest.<br>• Launch of new declaration of interests process for the new financial year.<br><br>**Anti-fraud, Bribery & Corruption**<br>• Updated reference in 5.4 from Director of Finance to Chief Finance Officer. |
| **Background:** | **Managing Conflicts of Interest**<br>The NHS Standard Contract 2021/22 General Conditions (Full Length) was updated to include a requirement for NHS Providers to publish the name and position of any decision maker that fails to complete a declaration of interest or a nil return within the contract year. The Managing Conflicts of Interest Policy has been updated to reflect this, with the opportunity taken to make other amendments as per the executive summary.<br><br>**Anti-Fraud, Bribery & Corruption**<br>This policy is due for review. |
| **Key Recommendations**: | Both policies are presented to the Board of Directors for approval, in line with the document control policy. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality and Diversity ☐<br>Financial ☐<br>Operational Performance ☐<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☐<br>Regulatory ☒<br>Strategy/Transformation ☐<br>System ☐ |
| **CQC Reference:** | Safe ☐<br>Effective ☐<br>Caring ☐<br>Responsive ☐<br>Well Led ☒<br>Use of Resources ☒ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| Audit Committee | 12/01/2023 | **Managing Conflicts of Interest**<br>Endorsed, subject to update to the policy introduction to put greater emphasis on encouraging collaboration.<br><br>**Anti-fraud, Bribery & Corruption**<br>Endorsed. |

| Reason for submission to the Board in Private Only (where relevant) | | |
|---|---|---|
| | Commercial confidentiality | ☐ |
| | Patient confidentiality | ☐ |
| | Staff confidentiality | ☐ |
| | Other exceptional reason | ☐ |

University Hospitals Dorset
NHS Foundation Trust

# MANAGING CONFLICTS OF INTEREST POLICY

**If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version**

| **A) SUMMARY POINTS** |
|---|
| • Policy and procedure for maintaining strict ethical standards in the conduct of Trust business<br>• Consistent principles and rules to help staff manage conflict of interest risks effectively |
| **B) ASSOCIATED DOCUMENTS** |
| • Counter Fraud Policy |
| • Trust Constitution |
| • Standing Financial Instructions |
| • Standing Orders (set within the Trust Constitution) |
| • The relevant clauses in the Staff Handbook - Statement of Main Terms & Conditions of Service |
| • Trust Secondary and Other Employment Policy |
| • Procurement policies and procedures on contracts and tendering and dealing with company/commercial representatives |
| • Managing Conflicts of Interest in the NHS - Guidance for staff and organisations – NHS England |

| **C) DOCUMENT DETAILS** | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job title:** | Associate Director of Corporate Governance |
| **Directorate:** | Chief Executive's Office |
| **Version no:** | 2 |
| **Target audience:** | All staff including all agency and contract staff and any agents or intermediaries acting on behalf of the Trust |
| | |
| **Approving committee / group:** | Board of Directors |
| **Chairperson:** | Rob Whiteman, Trust Chair |
| **Review Date:** | October 2025 |

**D) VERSION CONTROL**

| Date of Issue | Version No. | Date of Review | Nature of Change | Approval Date | Approval Committee | Author |
|---|---|---|---|---|---|---|
| Oct 20 | 1 | Oct 23 | New Policy | 15/10/20 | Audit Committee | Carrie Stone, Company Secretary |
| Jan 2023 | 2 | Jan 2026 | Updated policy following changes to NHS Standard Contract 2021/22 | | Board of Directors | Ewan Gauvin, Corporate Governance Manager & Yasmin Dossabhoy, Associate Director of Corporate Governance |

**E) CONSULTATION PROCESS**

| Version No. | Review Date | Author | Level of Consultation |
|---|---|---|---|
| 1 | New document | Company Secretary | Consulted with Counter Fraud Service, and the Chairman of the Audit Committee |
| 2 | Jan 2023 | Corporate Governance | Audit Committee |

| | | | |
|---|---|---|---|
| | | Manager & Associate Director of Corporate Governance | |

**CONTENT** **PAGE NO.**

## 1. Introduction

1.1 University Hospitals Dorset NHS Foundation Trust and the people who work with us and for us, collaborate closely with other organisations, delivering high quality care for our patients. As an organisation we encourage this collaboration.

1.2 These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely.

1.3 It is recognised that there is a risk that conflicts of interest may arise. Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles of the NHS Constitution. The Trust is committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely, so that the Trust is using its finite resources in the best interests of patients.

1.4 In promoting and safeguarding the Trust's reputation and standing within the local community, with customers and suppliers and with service users and carers, it is the Trust's policy that the professional and social conduct of staff reflects the highest standards of personal integrity, and that the business affairs of the Trust are conducted in an ethical and honest manner and in full compliance with all legal requirements. By following this policy, staff will take the best action and protect themselves and the Trust from allegations that they have acted inappropriately.

1.5 Under NHS England's "*Managing Conflicts of Interest in the NHS guidance for staff and organisations"*, the Trust is required to develop a policy on managing conflicts of interest for all staff and ensure that its policy, as a minimum, meets the standards of the guidance and that it has clear and well communicated processes in place to help staff understand what they need to do. This obligation is reinforced in the terms on which the Trust's services for patients are commissioned.

1.6 For the purposes of this policy, "staff" means:

- All salaried employees;
- All prospective employees – who are part-way through recruitment;
- Contractors and sub-contractors;
- Temporary and agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust).

It also applies to the Board of Directors, Governors and volunteers.

1.7 Some staff are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this policy, these people are referred of as "decision making staff". Decision making staff in this organisation are:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money;
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services;
- Those at Agenda for Change band 8d (or equivalent) and above;
- Heads of Department;
- Budget Holders;

- Procurement and commercial services staff;
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation (not covered by the above groups);
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions (not covered by the above groups).

1.8 This policy should be read in conjunction with the Trust's Counter Fraud Policy ("Fraud, Bribery & Corruption Policy") which the Trust shall invoke whenever appropriate.

## 2. Purpose

2.1 This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules;
- Requires conflicts of interest to be registered and managed appropriately, fairly and in accordance with legislation and guidance, whether such conflicts are actual or potential;
- Provides simple advice about what to do in common situations;
- Supports good judgement about how to approach and manage interests;
- Makes all staff aware of the Trust's expectations of their conduct and behaviour;
- Makes all staff aware of the Trust's requirements in respect of staff interests, outside employment and the receipt of gifts, hospitality and sponsorship;
- Gives staff the knowledge, advice and information they need to protect themselves from situations that may draw criticism, disciplinary action or criminal sanction.

## 3. Key terms and Definitions

3.1 A 'conflict of interest' is:

- "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold".

3.2 A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is, could be, is seen to be or could be seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances it could be reasonably considered that a conflict of interest exists even when there is no actual conflict. In these cases, it is important to manage these perceived conflicts of interest in order to maintain public trust. The individual does not need to exploit his or her position to obtain an actual benefit, financial or otherwise for there to be a conflict of interest. A potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest. Therefore, the perception of wrongdoing, impaired judgement or undue influence can sometimes be as damaging as this occurring. Whether or not an

interest held by another person gives rise to a conflict of interest will depend upon the nature of the relationship between that other person and upon the individual, and the role of the individual within the Trust.

3.3 A conflict of interest may be:

- Actual – there is a material conflict between one or more interests;
- Potential – there is the possibility of a material conflict between one or more interests in the future.

3.4 Staff may hold interests for which they cannot see a potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

3.5 The policy covers the following subject areas:

- Interests
- Receipt of Hospitality
- Provision of Hospitality
- Gifts
- Sponsorship
- Employment Issues
- Confidentiality
- Tendering and Contracting Procedures.

## 4 Principles

4.1 The principles of good governance for consideration include those set out in the following:

**Nolan Principles of Public Life**

The Trust embraces the Nolan Principles of Public Life:

***Selflessness***

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

***Integrity***

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

***Objectivity***

In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

***Accountability***

Holders of public office are accountable for their decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

***Openness***

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

***Honesty***

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

***Leadership***

Holders of public office should promote and support these principles by leadership and example.

The Good Governance Standards of Public Services

The Seven Key principles of the NHS Constitution

The Equality Act 2010

The UK Corporate Governance Code

Standards for members of NHS Boards and CCG Governing Bodies in England.

4.2 In addition, to support the management of conflicts of interest the Trust will follow the principles listed below

- Do business appropriately: conflicts of interest become much easier to identify, avoid and/or manage when the processes for needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, because the rationale for all decision making will be clear and transparent and should withstand scrutiny.
- Be balanced, sensible and proportionate: rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision making is transparent and fair whilst not being overly constraining, complex or cumbersome.
- Create an environment and culture where individuals feel supported and confident in declaring relevant information and raising any concerns.

## 5 Bribery Act 2010

5.1 The Bribery Act (the Act) makes it an offence for a person to request, agree to receive or accept a financial or other advantage as an inducement to, or as a reward for, the improper performance of any function or activity (e.g. any duty performed by a member of staff as an employee of the Trust).

5.2 The Act also makes it an offence for a person to offer, promise or give a bribe to another person (e.g. a potential purchaser or commissioner of Trust services) as an inducement to, or as a reward for, them improperly performing any duty.

5.3 The Act also imposes a responsibility on relevant commercial organisations, including NHS Trusts to have adequate procedures in place to prevent a member of staff from committing bribery (where the member of staff is the person making the bribe).

5.4 This policy has been drafted to take into account the provisions of the Act and provides guidance to ensure that neither staff nor the Trust breach the legislation.

**Corruption / Bribery** – '*the offering of or receiving a bribe to bring about or reward improper performance of a function or activity'*.

Bribes do not need to be monetary and can amount to some other advantage, as described in the Bribery Act 2010."

**Fraud** – *'a deliberate and dishonest misrepresentation, intended to cause gain for oneself or loss to another'.*

This definition implies deliberate intent and thus excludes negligence or simple error. It can also be an offence to fail to declare something where there is a legal duty to do so and to abuse a position of trust and authority to act against the interests or the organisation, as defined by the Fraud Act 2006.

Suspicions of Fraud, Bribery and Corruption can be reported to the NHS Fraud and Corruption Reporting line on free phone 0800 0248 4060, in strict confidence, or via the online reporting form at https://cfa.nhs.uk/reportfraud or within the Trust to the Local Counter Fraud Specialist. Details for the Local Counter Fraud Specialist are available in the Freedom to Speak Up policy available on the intranet..

## 6. Interests

6.1 Interests can generally fall into the following categories:

- **Financial interests**: where an individual may get direct financial benefit (this may be a financial gain, or avoidance of a loss, from the consequences of a decision they are involved in making;
- **Non-financial professional interests**: where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career;
- **Non-financial personal interests**: where an individual may benefit personally in whys which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career;
- **Indirect interests**: where an individual has a close association (a common sense approach should be applied to the term), with another individual who has a financial interest, a non-professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

## 7 Declarations of Interest

7.1 All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Failing to declare a relevant interest within the 28 days could lead to disciplinary action by the Trust. Declarations should be made:

- On appointment with the Trust;
- When staff move to a new role or their responsibilities change significantly;
- At the beginning of a new project/piece of work;
- As soon as circumstances change, and new interests arise (for instance in a meeting when interests staff hold are relevant to the matters in discussion).
- Whenever gifts or hospitality (in excess of the amounts set out below) are offered, regardless of whether these are accepted.

A declaration of interests form is available [updated link to be included] (the Declaration of Interests Form)

After expiry, a relevant interest will remain on the register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

7.2 A relevant interest is defined as follows:

- Any directorship of a company.
- Any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding is less than 2% of the total shares in issue) held by a member of staff in any firm or company or business which, is trading with the Trust or is likely to be considered as a potential trading partner with the Trust.
- Any interest in an organisation providing health and social care services to the NHS.
- A position of authority in a charity or voluntary organization in the field of health and social care.
- Any other interest that may conflict or be perceived to conflict with the performance of the member of staff's duties as a Trust employee.

7.3 An interest will be deemed relevant if it is held by the member of staff, their spouse/partner or immediate relative.

7.4 For the avoidance of doubt relevant interest includes employment (including self-employment or private work).

7.5 The Code of Accountability for NHS Boards requires Trust Board Directors to declare relevant interests which may influence or may be perceived to influence, their judgement. This declaration should be made to the Company Secretary as soon as the Director becomes aware of it.

7.6 All Trust staff must ensure that their private and personal interests do not influence their decisions, and that they do not use their positions to obtain personal gain of any sort, either for themselves directly, or their families, friends or associates.

7.7 All staff must declare relevant interests on appointment or at the time they arise to their line manager and also in writing to the Company Secretary using the Declaration of Interests Form for recording in the Trust's register of interests. It may be necessary to bring entries in this register to the attention of senior officers and/or the Board and it will be made available to the Trust's auditors, if requested.

7.8 Annual returns using the Declaration of Interests Form (including 'nothing to declare') by decision making staff are mandatory. Failure to complete a return will be notified to the relevant Clinical Lead/Matron/General Manager who will be responsible for ensuring that the member of staff completes a return.

## 8 Acceptance of hospitality/entertainment/travel expenses by the Trust or its staff (referred to collectively as hospitality)

8.1 The principle of probity requires that staff should not place themselves under an obligation that might influence, or be perceived to influence, the conduct of their duties. This means that the receipt of hospitality must be subject to clear controls, and that any that is offered, whether or not accepted, must be declared and recorded.

8.2 Hospitality must not, under any circumstances, be solicited.

8.3 Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement or which could be interpreted as a way of exerting an improper influence over the way they carry out their duties.

8.4 Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

8.5 Examples of hospitality which may be accepted, include:

- Invitation to a society or institute dinner or similar function
- Attendance at an event at which there is a genuine need to impart information or represent the Trust in the community.
- Attendance at an event which is clearly part of the life of the community or where the Trust should be seen to be represented.
- The hospitality arises during attendance at a relevant conference or course, where it is clear that the hospitality is corporate rather than personal.

8.6 Examples of hospitality which would not be regarded as acceptable include:

- Offers of holidays, hotel accommodation or tickets for theatres, shows, concerts or sporting events
- Corporate hospitality events or other similar types of activity
- Use of a company flat or hotel suite: and
- Any form of hospitality extended to immediate family members
- Meals and refreshments over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given.

8.7 Even in the context of acceptable types of hospitality, their frequency and/or scale should not be significantly greater than the NHS, as an employer, would be likely to offer.

8.8 Hospitality may also be an issue in relation to sponsorship by external organisations from industry (see later section of this policy for sponsorship issues in general). Travel and subsistence expenses of staff attending suppliers, potential suppliers or third parties in connection with purchases by the Trust should be paid by the Trust unless prior written approval to external funding has been given by the Head of Department or Clinical Manager (see the Declaration of Interests Form).

8.9 With the exception of paragraph 8.10, all hospitality offered (even if declined) or received must be notified in writing, by the recipient, to the Company Secretary using the Declaration of Interests Form, who will enter the notification into the Trust's Hospitality Register. Notification should be made as soon as practically possible after the offer and, whenever possible, before the hospitality is due to take place. If in doubt, staff should always err on the side of making a declaration.

8.10 Staff may accept modest working meals and light refreshments (or more significant hospitality which is clearly integral to a training course etc) without making any declaration, if it is under a value of £25. Meals and refreshments of a value between £25 and £75 may be accepted but must be declared

8.11 Travel and accommodation: modest offers to pay some or all of the travel and accommodation costs related to attendance at any events may be accepted and must be declared. When a specific, external person or body has a matter currently in issue with the Trust, for example they are being considered as a potential supplier following a tendering exercise common sense dictates that an offer of hospitality be refused, even if, in normal circumstances, it would be regarded as hospitality of an acceptable nature.

8.12 When staff decline hospitality, they should do so in a polite but firm manner and draw the attention of the person making the offer to the existence of this policy. If necessary, staff should pay their share of any costs and, where eligible under Trust rules, claim these from the Trust in the usual way.

## 9 Provision of hospitality by the Trust or its employees

9.1 The proposed use of public funds for hospitality and/or entertainment should be considered very carefully. Inappropriate or excessive spending can cause lasting damage to the reputation of the Trust and the NHS and could lead to criminal liability under the Bribery Act 2010. Hospitality is not the "norm" when conducting business; it should be provided only when necessary and appropriate. Advice should always be sought in cases of doubt. All expenditure on hospitality provided should be capable of justification to the Trust's internal and external auditors.

## 10 Gifts

10.1 A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.

10.2 Staff should not accept gifts that may affect, or be seen to affect, their professional judgement and personal gifts (of any kind, whatsoever) must not, under any circumstances, be solicited. Staff should not, under any circumstances, accept personal gifts with a significant financial value, or any benefits in kind, such as offers of holiday accommodation.

10.3 Individual staff must not, under any circumstances, accept money including bequests from the estates of deceased persons (but see paragraph 10.6 regarding accepting donations for charitable funds).

10.4 Gifts from suppliers or contractors doing business or likely to do business) with the Trust should be declined, whatever their value and reported immediately to the member of staff's line manager and the Company Secretary using the Declaration of Interests Form . Low cost branded promotional aids such as pens, calendars or post-it notes may, however, be accepted where they are under the value of £6 in total and need not be declared.

10.5 Any person (other than a contractor) who wishes to make a financial donation to the Trust should be advised on how to make a donation to the Trust's charitable funds.

10.6 Gifts of cash and vouchers from other sources (e.g. patients, their relatives or carers) should always be declined. Small, one off, tokens of gratitude from patients, their relatives or carers, of low intrinsic value (less than £50) may be accepted and need not be declared. If in doubt, Staff should consult their line manager. However, substantial gifts should be politely declined, quoting this policy. Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust as a charitable donation to the Trust Charity and not in a personal capacity. These gifts should always be declared. The giving of a substantial gift by a patient, relative or carer, can compromise the professional nature of the Staff/patient relationship.

## 11 Sponsorship and sponsored events

11.1 In this policy Sponsorship is defined as:

> Funding from an external source, including funding of all, or part of, the costs of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.

11.2 Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the Trust and the NHS.

11.3 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

11.4 No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

11.5 At the Trust's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.

11.6 The involvement of a sponsor in an event should always be clearly identified.

11.7 Staff within the Trust who are involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

11.8 In all cases, members of staff must declare sponsorship, or any commercial relationship linked to the supply of goods or services to the Company Secretary using the Declaration of Interests Form and be prepared to be held to account for it.

11.9 Acceptance by a member of staff of sponsorship for attendance at relevant courses or conferences is acceptable providing that the member of staff has obtained permission in

advance from their manager, who must be satisfied that acceptance will not compromise purchasing decisions or performance of the employees duties in any way. Acceptance of sponsorship must be reported to the Company Secretary using the Declaration of Interests Form for inclusion in the Gifts and Hospitality Register. Medical staff should also refer to the Trust's procedure on Study/Professional leave for Senior Medical and Dental Staff.

## 12 Sponsorship of Posts

12.1 Where such collaborative partnerships involve a pharmaceutical company, the proposed arrangements must comply fully with the Medicines (Advertising) Regulations 1994 (regulation 21 'Inducements and hospitality').

12.2 Whatever type of agreement is entered into, a clinician's judgment must always be based upon clinical evidence that the product is the best for their patients. However, rolling sponsorship of posts should be avoided unless appropriate checkpoints are in put in place to review and withdraw if appropriate.

12.3 Before entering into any sponsorship agreement the Trust will:

- Satisfy itself, with reference to information available, that there are no potential irregularities that may affect a company's ability to meet the conditions of the agreement or impact on it in any way, for example checking financial standing by referring to company accounts;

- Satisfy itself that there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which the Trust has the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

- Assess the costs and benefits in relation to alternative options where applicable, and to ensure that the decision-making process is transparent and defensible;

- Ensure that legal and ethical restrictions on the disclosure of confidential patient information, or data derived from such information, are complied with;

- Determine how clinical and financial outcomes will be monitored.

- Ensure that the Sponsorship agreement has break clauses built in to enable the Trust to terminate the agreement if it becomes clear that it is not providing expected value for money and/or clinical outcomes.

12.4 The Trust will apply the following principles:

12.4.1 Purchasing decisions, including those concerning pharmaceutical and appliances, will always be taken on the basis of best clinical practice and value for money. Such decisions will take into account their impact on other parts of the health care system, for example, products dispensed in hospital which are likely to be required by patients regularly at home.

12.4.2 When the Trust is offered significant discounts on drugs, it will consult the relevant commissioners about possible implications for subsequent prescribing in primary care.

12.4.3 When making purchasing decisions on products which originate from NHS intellectual property, ethical standards will ensure that the standard is based on best clinical practice and not on whether royalties will accrue to an NHS body.

12.4.4 Deals whereby sponsorship is linked to the purchase of particular products, or to supply from particular source, will not be allowed, unless as a result of a transparent tender for a defined package of goods and services.

12.4.5 Patient information attracts a legal duty of confidence and is treated as sensitive under Data Protection legislation. Professional codes of conduct also include clear confidentiality requirements. The Trust will assure itself, taking advice when necessary, that sponsorship arrangements are both lawful and meet appropriate ethical standards.

12.4.6 Where a sponsorship arrangement permitting access to patient information appears to be legally and ethically sound (for example, where the sponsor is to carry out or support NHS functions, where patients have explicitly consented), a contract will be drawn up which draws attention to obligations of confidentiality, specifies security standards that should be applied, limits use of the information to purposes specified in the contract and makes it clear that the contract will be terminated if the conditions are not met;

12.4.7 Where the major incentive to entering into a sponsorship arrangement is the generation of income rather than other benefits, then the scheme should be properly governed by income generation principles rather than sponsorship arrangements. Such schemes should be managed in accordance with income generation requirements, i.e. they must not interfere with the duties or obligations of the Trust. A memorandum trading account should be kept for all income generation schemes;

12.4.8 As a general rule, sponsorship arrangements involving the Trust will be at a corporate, rather than individual level.

12.4.9 If publications are sponsored by a commercial organisation, that organisation should have no influence over the content of the publication. The company logo can be displayed on the publication, but no advertising or promotional information should be displayed. The publication should contain a disclaimer which states that sponsorship of the publication does not imply that the Trust endorses any of the company's products or services.

12.4.10 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

12.4.11 The Trust will ensure that all sponsorship deals are documented through the use of a register held by the Company Secretary, which can be audited as appropriate.

## 13 Sponsored research

13.1 Funding sources for research purposes must be transparent

13.2 Any proposed research must go through the relevant health research authority or other approvals process

13.3 There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

13.4 The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

13.5 Staff should declare involvement with sponsored research to the organisation, in line with the above principles and rules.

## 14 Tendering and contracting procedures

14.1 Staff involved in purchasing, procurement and managing contracts are perhaps more vulnerable than other colleagues to accusations of impropriety. Even the appearance of impropriety can be highly damaging to the staff and to the Trust.

14.2 Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour, which is against the interest of patients and the public.

14.3 Those involved in procurement exercises for and on behalf of the Trust should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of the procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

14.4 Staff who are in contact with suppliers and contractors, especially those who are authorised to sign purchase orders or place contracts for goods materials or services, must therefore adhere to the professional standards set out in the Ethical Code of the Chartered Institute of Purchasing and Supply. This requires fair and open competition between prospective contractors or suppliers for Trust business.

14.5 No private, public or voluntary organisation or company which may bid for Trust business should be given any advantage over its competitors, such as advance notice of Trust requirements. This applies to all potential contractors, whether or not there is a relationship between them and the Trust, such as a long-running series of previous contracts.

14.6 Each new contract should be awarded solely on merit, taking into account the requirements of the Trust and the ability of the contractors to fulfil them.

14.7 No special favour may be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

14.8 For further guidance please refer to Trust's Standing Financial Instructions and the Trust's detailed Quotations and Tendering Procedure.

## 15 Outside employment and clinical private practice

15.1 Staff should not engage in any outside employment which could have a bearing on their ability to perform their normal contractual obligations or may conflict with their Trust employment e.g. by the use of any confidential or commercial information obtained in the course of their duties for the Trust.

15.2 Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation.

15.3 This does not mean that staff cannot work outside the Trust, for example, as an agency nurse in a private care home, but all outside employment must be approved by the Trust (see the Trust's policy on Secondary Employment for further information about this). Staff should

declare any existing outside employment on appointment and any new outside employment when it arises. Where a risk of conflict of interest arises, the principles in this policy should be considered and applied to mitigate risks. Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the Trust, to engage in outside employment. Anybody who thinks that they are risking a conflict of interest in this area should seek guidance from their line manager and/or Human Resources.

15.4 There are special conditions relating to Hospital Medical and Dental Staff as specified in the relevant terms and conditions of employment and national circulars. Specific guidance can be obtained from the Medical Staffing Department. Consultants shall comply with Schedule 9 under Terms and Conditions, England 2003 and 'A Code of Conduct for Private Practice – Recommended Standards of Practice for NHS Consultants. Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises including:

- Where they practice
- What they practice (specialty, major procedures)
- When they practice (identified sessions/time commitment)

15.5 Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval from the Trust before taking up private practice
- Ensure that, where would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work (paras 5 and 20 Sch. 9 of the Terms and Conditions – England 2003)
- Not accept direct or indirect financial incentives from private providers other than those allowed by the Competitions and Markets Authority guidelines.

15.6 Hospital consultants should not initiate discussions about providing private professional services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

## 16 Shareholdings and other ownership issues

16.1 Staff should declare as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

16.2 Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then this policy should be considered and applied to mitigate risks.

16.3 There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

## 17 Patents and other intellectual property rights

17.1 Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.

17.2 Staff should seek prior permission from the Trust before entering into any agreement with bodes regarding product development, research, work on pathways etc where this impacts on the organisation's own time or uses its equipment resources or intellectual property.

17.3 Where holding of patents and other intellectual property rights gives rise to a conflict of interest then the actions outlined in this policy should be applied to mitigate risks.

## 18 Loyalty interests

18.1 Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role;
- Sit on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money;
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates and business partners;
- Are aware that the organisation does business with an organisation in which close family members and relatives, close friends and associates and business partners have decision making responsibilities.

## 19 Donations

19.1 Donations made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

19.2 Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust or is being pursued on behalf of the Trust's own registered charity or other charitable body and is not for their own personal gain.

19.3 Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the Trust's own.

19.4 Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

19.5 Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

## 20 Strategic Decision-making groups

20.1 In common with other NHS bodies, the Trust uses different committees to make key strategic decisions about issues such as:

- Entering into (or renewing) large scale contracts;
- Awarding grants;
- Making procurement decisions;
- Selection of medicines, equipment and devices.

20.2 The interests of those who are involved in these committees should be well known so that they can be managed effectively. For this Trust, the committees are:

- The Board of Directors
- Appointments & Remuneration Committee
- Finance and Performance Committee
- Audit Committee
- Quality Committee
- People and Culture Committee
- Charitable Funds Committee
- Population Health and System Committee
- Trust Management Group

20.3 The above committees should adopt the following principles:

- Chairs should consider any known interests of members in advance and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's register(s)
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

20.4 If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason or the chosen action is documented in the minutes:

- Requiring the member to not attend the meeting
- Excluding the member from receiving meeting papers relating to their interest
- Excluding the member from all or part of the relevant discussion and decision
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
- Removing the member from the group or process altogether

## 21. Roles and Responsibilities

### Responsibility of the Trust/Public Service Values

21.1 Public service values must be at the heart of the National Health Service (NHS). High Standards of corporate and personal conduct, based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for effective use of taxpayers' money.

21.2 There are three crucial public sector values that must underpin the work of the Trust as a whole:

- ***Accountability*** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

- ***Probity*** – there should be an absolute standard of honesty in dealing with the assets of the NHS. Integrity should be at the heart of all personal conduct in decisions

affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

- ***Openness*** – there should be sufficient transparency about NHS activities to promote confidence between the Trust, its staff, service users and the public.

**Responsibilities of the Trust**

21.3 The Trust should ensure that it has clear processes in place and that these are communicated to staff and help staff understand what they need to do.

21.4 The Trust should maintain a register of interests and publish this at least once annually on its website.

21.5 In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individuals' name and/or other information may be redacted from the publicly available register(s). Where staff believe that substantial damage or distress may be caused to them or another person by the publication of information about them, then they should write to the Company Secretary to request that it not be published, explaining the reason for this. The Company Secretary may seek legal advice where required. A confidential, un-redacted version of the register will be held by the Company Secretary Team.

21.6 Staff should be aware that external organisations for example the Association of British Pharmaceutical Industries (ABPI) may also publish information relating to commercial sponsorship or other payments. External publications may be reviewed to ensure that appropriate internal declarations have been made in accordance with this policy.

21.6 The Trust should ensure that, at least annually, all decision-making staff are prompted to update their declarations of interest or provide confirmation that they have no interests to declare.

21.7 In line with the NHS Standard Contract 2021/22 General Conditions (Full Length) the Trust is required to publish the name and position of any decision-making staff that failed to complete a declaration of interest or a nil return within the contract year.

21.8 The Trust should audit the effectiveness of this policy and the associated processes and procedures at least once every three years.

**Responsibilities of Managers**

21.9 The Chief Executive is the Trust's designated "Accountable Officer" and has overall responsibility for ensuring the Trust operates efficiently, economically and with probity.

21.10 The Company Secretary is responsible for maintaining a register of interests and a register of gifts and hospitality (including sponsorship) for all staff and Board Members.

21.11 Trust Directors and Managers are responsible for assisting the Trust and its staff in complying with this policy by:

- Ensuring that the policy and its requirements are brought to the attention of staff for whom they are responsible including on initial appointment or when an individual moves to a new role;

- Ensuring that those staff are aware of its implications for their work;
- Ensuring that those staff have a thorough understanding of the Trust's governance arrangements;
- Ensuring that annual returns required by staff are completed in a timely manner;
- Reporting any cases of suspected bribery or fraud by abuse of position to the Local Counter Fraud Specialist for investigation.

**Responsibilities of Staff**

21.12 All NHS staff are expected to:

- Ensure that the interests of patients remain paramount at all times
- Be impartial and honest in the conduct of their official business
- Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.
- Not abuse their official position for personal gain or to benefit their family or friends.
- Not seek to advantage, or further, private business or other interests, in the course of their official duties.
- Declare any relevant interests, gifts, hospitality or sponsorship to the Company Secretary
- Understand it is both a serious criminal offence (Bribery Act 2010) and a disciplinary matter to allow themselves to be bribed or to bribe another person
- Understand that failure to follow this policy may damage the Trust and its work and so may be viewed as a disciplinary matter, to be dealt with under normal disciplinary procedures, and the penalty could include dismissal. Action may also be taken by the Trust under its Counter Fraud Policy
- Understand that any cases of suspected bribery or fraud by abuse of position will be referred to the Local Counter Fraud Specialist for investigation in accordance with the Trust's Anti-Fraud, Bribery and Corruption Policy
- All Trust staff must ensure that their private and personal interests to not influence their decisions, and that they do not use their positions to obtain personal gain of any sort, either for themselves directly, or their families, friends or associates. Guidance and codes of conduct issued by the Department of Health and Social Care, NHS England and professional bodies requires that these interests are declared by staff.

## 22. Association of British Pharmaceutical Industry (ABPI) Declarations

22.1 Staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These include payments relating to:

- Speaking at or chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the cost of accommodation and travel.
- Donations, grants and benefits in kind provided to healthcare organisations

22.2 It is a mandatory requirement to disclose any such payments to the Trust. Staff making a declaration to ABPI are also required to submit a declaration to the Trust. Failure to do so constitutes a breach of this policy.

## 23. Dealing with breaches

23.1 There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally or because of the deliberate actions of staff or other organisations. For the purposes of this policy, these situations are referred to as "breaches".

23.2 Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to their Line Manager and subsequently to the Local Counter Fraud Specialist in they remain concerned about the action being taken, for investigation in accordance with the Trust's Anti-Fraud, Bribery and Corruption Policy.

23.3 To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised, refer to the Trust's "Freedom to Speak Up" policy.

23.4 The Trust will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

23.5 Following the investigation, the Trust will:

- Decide if there has been or is a potential for a breach and if so the severity of the breach
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager as a minimum
- Consider who else inside and outside the Trust should be made aware
- Take appropriate action.

23.6 Action taken in response to breaches of this policy will be in accordance with the Trust's disciplinary procedures and could involve the Directorate of HR for staff support, the Local Counter Fraud Specialist, the Trust's auditors and senior managers/executive directors.

23.7 Inappropriate or ineffective management of interests can have serious implications for the Trust and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches. Sanctions should not be considered until the circumstances surrounding the breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the Trust can and will consider the range of possible sanctions available to it, in a manner which is proportionate to the breach.

23.8 Reports on breaches, the impact of these and action taken will be considered by the Audit Committee on a "by exception report" basis.

## 24. Training

24.1 A "Short Guide for Staff" is available on the Trust's Intranet.

## 25. Monitoring and Auditing

25.1 The Audit Committee will carry out an annual review of the register of interests including actions taken by management in response to interests declared and any breaches of this policy.

25.2 This policy/procedure will be reviewed by the Company Secretary on a three-yearly basis, unless there is a change in legislation or practice, or new guidelines are published which necessities an earlier review.

25.3 The implementation of this policy will be monitored by the Audit Committee as part of its formal arrangements.

25.4 The external auditors will review the register of interests to ensure that there are no relationships with third parties that could potentially damage the Trust.

## 26. References

- The Codes of Conduct and Accountability [July 2004]
- The Code of Conduct for NHS Managers [October 2002]
- NHS Foundation Trust Code of Governance [2014]
- The Bribery Act 2010
- Fraud Act 2006
- Fraud Response Plan
- Secondary Employment Procedure
- Procedure on the Quotations and Tendering Process
- Procedure for Study/Professional Leave for Senior Medical Staff
- Consultant Job Planning Guidance
- GMC Good Medical Practice – paragraphs 77 - 80
- British Medical Journal 2003: 326: 1115-16 – No More Free Lunches
- British Medical Journal 2003: 326: 1189-96 – Who pays for the Pizza
- British Medical Journal 2003: 326: 1196-93 – How to dance with porcupines: rules and guidelines on doctors' relations with drugs companies
- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2016)
- ABHI Code of Business Practice
- Care Quality Commission guidance on fit and proper persons requirements for directors [March 2015]
- NHS Standard Contract 2021/22 General Conditions (Full Length)
- NHS England: Managing Conflicts of Interest in the NHS

## 27. Supporting Documents

27.1 All of the following documents can be found on the Trust intranet

- Short guide to staff on interpreting the Managing Conflicts of Interest Policy
- Declaration of Interests Form

## 28. Review

28.1 The policy will be reviewed by the Company Secretary every three years and changes submitted to the Board of Directors for approval.

## 29. Equality Impact Assessment

29.1 Refer to Appendix 1

**EQUALITY IMPACT ASSESSMENT** **Appendix 1**

| | |
|---|---|
| Date of assessment: | February 2020 |
| Care Group or Directorate: | Company Secretariat |
| Author: | Yasmin Dossabhoy and Ewan Gauvin |
| Position: | Company Secretary and Corporate Governance Manager |
| Assessment Area:<br><br>(i.e. procedure/service/function) | Managing conflicts of interest |
| Purpose: | To outline the process and provide guidance on the procedures to be followed in regard to the acceptance of gifts and hospitality and recording interests. |
| Objectives: | To guide staff on what and how to record interests and to follow the principles of the Trust in regard to accountability, probity and openness. |
| Intended outcomes: | Ensuring a standardised approach is adopted throughout the Trust and all required documents submitted. |

What is the overall impact on those affected by the policy/function/service?

| Ethnic Groups | Gender groups | Religious Groups | Disabled Persons | Other |
|---|---|---|---|---|
| High/Medium/ Low | High/Medium/ Low | High/Medium /Low | High/Medium /Low | High/Medium/ Low |
| Low | Low | Low | Low | Low |

Available information: N/A

Assessment of overall impact:
Providing easy to use guidance and supporting documents for staff to provide assurance and documentation of any gifts, hospitality and interests.

Consultation:
Audit Committee

| Actions: None identified |
| --- |

University Hospitals Dorset
NHS Foundation Trust

# ANTI-FRAUD, BRIBERY & CORRUPTION POLICY

**If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version**

University Hospitals Dorset NHS Foundation Trust

| A) SUMMARY POINTS |
|---|
| • Policy and procedure for ensuring the Trust has a zero-tolerance approach to all fraud, bribery and corruption. |
| • Guidance to help staff understand what fraud, bribery and corruption is and how to identify and report it effectively. |
| **ASSOCIATED DOCUMENTS** |
| • Values and Aims of The Trust |
| • Managing Conflicts of Interest |
| • Declaration of Gifts, Hospitality and/or Sponsorship |
| • Staff Discipline Procedure |

| B) DOCUMENT DETAILS | |
|---|---|
| **Author:** | Heather Greenhowe |
| **Job title:** | Counter Fraud Specialist |
| **Directorate:** | Finance |
| **Version no:** | 1 |
| **Target audience:** | All Staff |
| | |
| **Approving committee / group:** | Board of Directors |
| **Chairperson:** | Rob Whiteman |
| **Review Date:** | TBC |

| C) CONSULTATION PROCESS | | | |
|---|---|---|---|
| **Version No.** | **Review Date** | **Author** | **Level of Consultation** |
| 1 | 10/09/2021 | Heather Greenhowe | Chief Finance Officer and Trust Secretary |
| 2 | 05/01/2023 | Heather Greenhowe | Audit Committee |
| | | | |
| | | | |

| D) VERSION CONTROL | | | | | | |
|---|---|---|---|---|---|---|
| **Date of Issue** | **Version No.** | **Date of Review** | **Nature of Change** | **Approval Date** | **Approval Committee** | **Author** |
| Oct 21 | 1 | | New policy for UHD | | Audit Committee | Heather Greenhowe. Local Counter Fraud Specialist - RSM |
| Jan 2023 | 2 | Jan 24 | Updated reference in 5.4 from Director of Finance to Chief Finance Officer | | Board of Directors | Heather Greenhowe Local Counter Fraud Specialist - RSM |

**Foreword by the Chief Finance Officer**

This Trust is committed to eliminating fraud, bribery and corruption within the NHS, freeing up public resources for better patient care.

To this end, the Trust employs a specialist counter-fraud service to undertake a comprehensive programme against fraud, bribery and corruption which is overseen by the Trust's Audit Committee.

We operate a zero-tolerance approach to fraud, bribery and corruption. Staff are reminded that it is a criminal offence to give, promise or offer a bribe, and to request, agree to receive, or accept a bribe. We expect this policy to be complied with by all staff, patients, contractors and suppliers.

Although the Bribery Act permits hospitality, all staff are required to consider, on an individual basis, whether accepting any hospitality offered is appropriate and should they then elect to take it, to record it within the Trust's Hospitality register (in line with the Receipt of Hospitality, Gifts and Inducements policy) so that it has been fully disclosed.

It is also important that all of our contractors and agents comply with our policies and procedures. When entering into contracts with organisations, the Trust follows the NHS standard terms and conditions of contract for the purchase of goods and supplies. For more information see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121260

We ask all who have dealings with the Trust, as employees, agents, trading partners, stakeholders and patients, to help us in our fight against fraud, bribery and corruption. If you have any concerns or suspicions we need to know about, the Trust's Local Counter Fraud Specialist can be contacted in confidence and their details can be found on the staff intranet counter fraud page. Any suspicions of fraud and corruption can also be reported to the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60, again in strict confidence.

Chief Finance Officer

# 1 Introduction

## 1.1 General

1.1.1 This policy has been produced in conjunction with the Local Counter Fraud Specialist (LCFS) and is intended as a guide for all employees on counter fraud work within the NHS.

1.1.2 One of the basic principles of public sector organisations is the proper use of public funds. Any fraud committed is wholly unacceptable and ultimately leads to a reduction in the resources available for patient care.

1.1.3 The Local Counter Fraud Service carries out work in accordance with guidance issued by the Government and NHS Counter Fraud Authority (CFA).

1.1.4 The Counter Fraud Authority has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the NHS. All instances where fraud is suspected are properly investigated until their conclusion by staff trained by the NHS CFA. Any investigations will be handled in accordance with the *NHS Counter Fraud and Corruption Manual*.

1.1.5 As a Trust we encourage anyone that has reasonable suspicions of fraud to report them. All employees, patients and contractors can be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes “reasonably held suspicions” shall mean any suspicions other than those which are raised maliciously and found to be groundless.

1.1.6 The Trust has a zero-tolerance approach to any fraud or corruption and will commit to investigate all concerns raised

## 1.2 Generic Areas of Action

1.2.1 The Trust is committed to taking all necessary steps to counter fraud and corruption. To meet its objectives, the LCFS ensures that the Trust complies with the Government Functional Standards 0:13, part of which involves an annual self-assessment and submission to NHS CFA. The assessment covers 13 requirements which include planning and governance, training and awareness, proactive detection and investigations.

## 1.3 Aims and Scope

1.3.1 This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud. It provides a framework for responding to suspicions of fraud, advice and

information on various aspects of fraud and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud and corruption. The overall aims of this policy are to:

- improve the knowledge and understanding of everyone in the Trust, irrespective of their position, about the risk of fraud, bribery and corruption and its unacceptability;
- assist in promoting a climate of openness and a culture and environment where staff feel able to raise concerns sensibly and responsibly;
- set out the Trust's responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, bribery and corruption; and
- ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
    - criminal prosecution
    - civil prosecution
    - internal/external disciplinary action.

This policy applies to all employees of the Trust, regardless of position held, as well as consultants, vendors, contractors, and/or any other parties who have a business relationship with the Trust; it will be brought to the attention of all employees and form part of the induction process for new staff.

# 2 Definitions

## 2.1 Fraud

2.1.1 There are three main offences under the Fraud Act 2006:

1) Fraud by false representation (s.2) – lying about something using any means, e.g. by words or actions

2) Fraud by failing to disclose (s.3) – not saying something when you have a legal duty to do so

3) Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

2.1.2 Within the Fraud Act it is not always necessary to prove that a person has been deceived. The focus is on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss.

2.1.3 It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. For

guidance on examples of types of fraud please refer to the Trust's Counter Fraud web pages.

2.1.4 The full Act can be viewed at https://www.legislation.gov.uk/ukpga/2006/35/contents

## 2.2 Corruption / Bribery

2.2.1 This can be broadly defined as the offering or acceptance of inducements, gifts, favours, and payment or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

2.2.2 Under the Bribery Act 2010 it is an offence to offer/ give / accept / agree to accept a financial of other benefit in return for performing an improper function.

2.2.3 Under section 7 of the Bribery Act 2010 it is an offence for organisations to fail to prevent persons associated with them from giving, offering, receiving or agreeing to receive bribes.

2.2.4 The Trust must be able to prove it has adequate procedures in place to prevent persons associated with it from bribing to have a defence to the section 7 offence.

2.2.5 To protect themselves from the risk of receiving a gift or hospitality that may be perceived as a bribe staff must ensure compliance with the Receipt of Hospitality, Gifts and Inducements policy.

## 2.3 Employees

2.3.1 For the purposes of this policy, 'employees' includes the Trust staff, as well as board, executive, non-executive members (including co-opted members), governors, third party providers and honorary members.

2.3.2 The Receipt of Hospitality, Gifts and Inducements policy extends also to anyone working in any capacity on behalf or representing the Trust, such as bank and agency staff or contractors.

# 3 Codes of Conduct

3.0.1 The codes of conduct for NHS boards and NHS managers set out the key public service values. They state that high standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. These values are summarised as:

- *Accountability* Everything done by those who work in the authority must be able to stand the tests of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- *Probity* Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.
- *Openness* The health body's activities should be sufficiently public and transparent to promote confidence between the authority and its staff and the public.

3.0.2 In addition, all those who work for, or are in contract with the Trust, should exercise the following 'Nolan Principles' when undertaking their duties:

| | |
|---|---|
| Selflessness | Should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends. |
| Integrity | Should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties. |
| Objectivity | Should, in carrying out public business, (including making public appointments, awarding contracts, or recommending individuals for rewards and benefits), make choices on merit. |
| Accountability | Are accountable for their decisions and actions to the public and must submit them to whatever scrutiny is appropriate to their office. |
| Openness | Should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest demands. |
| Honesty | Have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest. |
| Leadership | Should promote and support these principles by leadership and example. |

These standards are national benchmarks that inform local policies and procedures. The arrangements made in this policy have been designed to ensure compliance with the national standards.

3.0.3 All staff should be aware of and act in accordance with these values.

# 4 Fraud Strategy

4.0.1 Through our day-to-day work, we are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure that those risks – however large or small – are identified and eliminated. Where staff believe the opportunity for fraud exists, whether because of poor procedures or oversight, they should report it to the LCFS, Director of Finance or the NHS Fraud and Corruption Reporting phone line (see Appendix 1).

4.0.2 The Trust will take all necessary steps to counter fraud and corruption in accordance with this policy, the *NHS Counter Fraud and Corruption Manual*, the policy statement '*Applying Appropriate Sanctions Consistently'* and any other relevant guidance or advice issued by the NHS CFA, including the *Government Functional Standards*.

4.0.3 The Trust will implement the seven generic areas of counter fraud action outlined below. Adherence to these areas will assist with compliance against the 13 principles of the *Functional Standards under areas for* planning and governance, training and awareness, proactive detection and investigations.

## 4.1 The Creation of An Anti-Fraud Culture

4.1.1 The Trust will use Counter Fraud publicity material to persuade those who work in the Trust that fraud and corruption is serious and takes away resources from important services. Such activity will demonstrate that fraud and corruption is not acceptable and is being tackled.

4.1.2 The trust has a zero-tolerance approach to fraud and bribery. The Trust also has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff have concerns about any procedures or processes that they are asked to be involved in, the Trust has a duty to ensure that those concerns are listened to and addressed.

## 4.2 Maximum Deterrence of Fraud

4.2.1 Deterrence is about increasing the expectation that someone will be caught if they attempt to defraud – this is more than just tough sanctions. The Trust will

introduce such measures to minimise the occurrence of fraud, bribery and corruption.

### 4.3 Successful Prevention of Fraud That Cannot Be Deterred

4.3.1 The Trust has policies and procedures in place to reduce the likelihood of fraud, bribery and corruption occurring. These include a system of internal controls, Standing Financial Instructions and documented procedures, which involve physical and supervisory checks, financial reconciliations, segregation and rotation of duties, and clear statements of roles and responsibilities. Where fraud, bribery or/ and corruption has occurred, the Trust will ensure that any necessary changes to systems and procedures take place immediately to prevent similar incidents from happening in the future.

### 4.4 Prompt Detection of Fraud Which Cannot Be Prevented

4.4.1 The Trust will develop and maintain effective controls to prevent fraud, bribery and corruption and to ensure that if it does occur, it will be detected promptly and referred to the LCFS for investigation.

### 4.5 Professional Investigation of Detected Fraud

4.5.1 The LCFS is professionally trained and accredited to carry out investigations into suspicions of fraud, bribery and corruption to the highest standards. In liaison with NHS CFA, the LCFS will professionally investigate all suspicions of fraud and corruption to prove or disprove the allegation.

4.5.2 The Trust are committed to preventing and detecting fraud by all available means and so shall make available any Trust data as necessary to allow the LCFS to identify and evidence any frauds that have occurred.

### 4.6 Effective Sanctions

4.6.1 Following the conclusion of an investigation, if there is evidence of fraud, available sanctions will be considered in accordance with the guidance issued by NHS CFA – ‘Applying Appropriate Sanctions Consistently’. This may include criminal prosecution, civil proceedings and disciplinary action, as well as referral to a professional or regulatory body.

### 4.7 Effective Methods for Seeking Redress in Respect of Money Defrauded

4.7.1 Recovery of any losses incurred will also be sought through civil proceedings if appropriate, to ensure losses to the Trust and the NHS are returned for their proper use.

## 5 Roles, Responsibilities, Sanctions and Redress

5.0.1 All employees, contractors, providers and members of the public have a responsibility to protect the assets of the Trust, including all buildings, equipment and monies from fraud, theft, bribery or corruption. Any concerns should be reported to the LCFS, Chief Finance Officer , or to the NHS Counter Fraud Authority (NHSCFA) via the Fraud and Corruption Reporting Line or via their online form. Details of these reporting methods can be found in the Fraud and Bribery Policy and/ or the counter fraud pages of the intranet.

The following are those tasked with financial redress and sanctions at the Trust:

### 5.1 The Chief Finance Officer

5.1.1 The Trust's Executive Board has overall responsibility for the effective operation of all Trust activities and is liable to be called to account for specific failures in the Trust's control systems. The Chief Finance Officer will ensure adequate controls are implemented to safeguard the resources and operations of the Trust, staff receive training and support in the use of these resources and controls and adequate measures are employed to prevent, detect and deter fraud, bribery and corruption. The Chief Finance Officer will monitor and ensure compliance with this policy, monitor and record the progress of recoveries and report progress to the Audit Committee. In addition, the Chief Finance Officer will;

- Meet with the LCFS/NHSCFA and a legal advisor to seek appropriate advice and guidance before deciding on a course of action for recovery.
- Agree an appropriate course of action for recovery.
- Ensure that the Trust is effective in recovering any losses incurred to fraud, bribery and corruption.
- Ensure that civil redress is progressed effectively through the Finance department.

### 5.2 Audit Committee

5.2.1 The Audit Committee will support the Board of Directors to deliver the Trust's responsibilities for the conduct of public business and the stewardship of funds; to be responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust.

5.2.2 The Committee shall seek to ensure that business is conducted in accordance with the law and proper standards; public money is safeguarded and properly accounted for; Financial Statements are prepared in a timely manner and give a true and fair view of the financial position of the Trust for the period in question; services are managed so as to secure economic, efficient and effective use of resources; and that reasonable steps are taken to prevent and detect fraud and other irregularities.

5.2.3 The committee will authorise the proposed work plans of the internal audit and counter fraud teams, ensuring that the proposed work meets the Trust's strategy and aims in identifying and reducing fraud. The committee will meet regularly with auditors to receive updates on the progress of their plans. The committee will be apprised of all current fraud investigations, any losses identified, and the measures being implemented to safeguard against further occurrences.

**5.3 Managers**

5.3.1 Managers must be vigilant and ensure that procedures to guard against fraud and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud and corruption. If they have any doubts, they must seek advice from their nominated LCFS.

5.3.2 Managers must instil and encourage an anti-fraud and anti-corruption culture within their team and ensure that information on procedures is made available to all employees.

5.3.3 The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

5.3.4 All instances of actual or suspected fraud or corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, **managers must not attempt to investigate the allegation themselves**; they have the clear responsibility to refer the concerns to their nominated LCFS as soon as possible.

5.3.5 Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud and corruption therefore primarily rests with managers but requires the co-operation of all employees. As part of that responsibility, line managers need to:

- inform staff of the Trust 's code of business conduct and counter fraud and corruption policy as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms

- ensure that all employees for whom they are accountable are made aware of the requirements of the policy

- assess the types of risk involved in the operations for which they are responsible

- ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively

- ensure that any use of computers by employees is linked to the performance of their duties within the Trust

- be aware of the Trust 's Counter Fraud Policy and the rules and guidance covering the control of specific items of expenditure and receipts

- identify financially sensitive posts

- ensure that controls are being complied with

- contribute to their director's assessment of the risks and controls within their business area, which feeds into the Trust's and the Department of Health Accounting Officer's overall statements of accountability and internal control.

### 5.4 Employees

5.4.1 The Trust's Standing Orders, Standing Financial Instructions, policies and procedures place an obligation on all employees and non-executive directors to act in accordance with best practice. Employees are expected to act in accordance with the standards laid down by their professional institutes, where applicable, and have a personal responsibility to ensure that they are familiar with them.

5.4.2 Employees also have a duty to protect the assets of the Trust, including information, goodwill and property. In addition, all employees have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:

- avoid acting in any way that might cause others to allege or suspect them of dishonesty

- behave in a way that would not give cause for others to doubt that the Trust 's employees deal fairly and impartially with official matters

- be alert to the possibility that others might be attempting to deceive

5.4.3 All employees have a personal responsibility to protect the assets of the Trust, including all buildings, equipment and monies from fraud, theft, or bribery. All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, receipts or dealing with contractors or suppliers.

5.4.4 If an employee suspects that there has been fraud or corruption, or has seen any suspicious acts or events, they must report the matter. This can be done directly to the LCFS, or to the Chief Finance Officer or Freedom to Speak up Guardian.

### 5.5 Internal and External Audit

5.5.1 Any incident or suspicion that comes to internal or external audit's attention will be passed immediately to the nominated LCFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems.

### 5.6 The Local Counter Fraud Specialist (LCFS):

5.6.1 The LCFS Advises the Trust on the evidence available to be able to seek recovery of funds. Ensures that all records are of sufficient quality to be able to support the recovery process. Liaises with the NHS CFA to obtain guidance and advice as appropriate and inform the Trust. Seeks agreement with the Chief Finance Officer on the most appropriate course of action (or the CEO if the Chief Finance Officer is implicated). Liaises with the relevant line manager and payroll manager to facilitate any deductions from salaries. In addition the LCFS will;

- Liaise with the police and/or NHS CFA for cases being sent to CPS (either via the police or via the NHS CFA)
- Liaise with HR when parallel criminal (LCFS) and disciplinary (HR) investigations are being conducted to ensure one does not prejudice the other.
- Maintain decision logs on NHS CFA case management system regarding sanctions and redress. This will include reasons for and against the pursuance of such action.
- Upon the provision of details of sanctions/recoveries applied, this will be recorded on the NHS CFA case management system within 20 working days of such a decision.
- Where appropriate, publicise proven cases of fraud and bribery within the Trust with details of sanctions and redress.

**5.7 NHS Counter Fraud Authorities (NHS CFA)1:**

- Provide a centralised investigation capacity for complex economic crime matters in the NHS and investigate the most serious, complex and high-profile cases of fraud, and work closely with the LCFS, Chief Finance Officer, police and the Crown Prosecution Service to bring offenders to justice.
- Provide specialist financial investigators to recover NHS money lost to fraud.
- Approve submission of cases to the CPS where the LCFS has not conducted the investigation jointly with the police.
- Report progress back to the Trust where a case has been adopted.

**5.8 Human Resources**

The LCFS will seek an agreement with the Chief People Officer (or nominated deputy) to ensure that all potential investigations of fraud are reviewed as per the detailed flow chart in appendix 3.

- Reviews instances of staff conduct, behaviour, and incident to establish whether there has been a breach of policy, procedure, or legislation.
- Ensures that all records are of sufficient quality to be able to support the recovery process.
- Seeks agreement with the Chief People Officer on the most appropriate course of action (or the CEO if the Chief People Officer is implicated).
- Liaises with the relevant line manager and payroll manager to facilitate any deductions from salaries.
- Liaise with the LCFS when parallel criminal (LCFS) and disciplinary (HR) investigations are being conducted to ensure one does not prejudice the other.
- Provide details of any sanctions/recoveries applied to the LCFS within 20 working days for recording purposes.

**5.9 Payroll**

Liaise with HR, the relevant line manager and LCFS to facilitate any deductions from salaries. Implement agreements reached on the amount and timescale of any timescale of repayments.

[1] The NHS CFA is a specialist Health Authority tasked with leading the fight against fraud, bribery and corruption in the NHS

**5.10 Finance Team**

Where invoices need to be raised: Agree with the individual the amount and timescale of any repayments. Ensure that invoices are raised and followed up on a timely basis.

**5.11 Disciplinary Panels**

Provides a panel of staff that may consist of Directors, Managers and HR staff to establish what sanctions and/or redress may be applied from a disciplinary perspective. Ensures that all records are of sufficient quality to be able to support the disciplinary process and decision made. Provide details of any sanctions/recoveries applied to the LCFS within 20 working days for recording purposes.

# 6 Sanctions and Redress

6.0.1 The Trust will always seek to apply appropriate sanctions in response to financial crime perpetrated against the NHS. The range of available sanctions which may be pursued by the relevant decision makers includes:

- criminal prosecution (potentially resulting in fine, imprisonment, community penalty, confiscation and/or compensation order) or out-of-court disposal
- civil action, including action to preserve assets and recover losses
- disciplinary action by the Trust
- regulatory action by a relevant regulatory body (e.g. GMC, GDC, NMC).

Each case will be considered individually on its own facts and merits; however, applying a consistent and thorough approach in all cases will ensure that:

- the most effective investigations are undertaken, including the gathering and assessment of all relevant material which may form evidence of fraud, bribery, corruption, misconduct and/or unfitness to practise
- the most appropriate sanction or combination of sanctions is sought where fraud, bribery, corruption or related misconduct is identified.

**6.1 Financial Redress:**

6.1.1 The Trust has an obligation to safeguard public funds. As such, the Trust will seek financial redress wherever possible due to losses to fraud, bribery or corruption. Financial redress can take the form of:

- a confiscation and/or compensation orders in accordance with the Proceeds of Crime Act.
- a civil order for repayment
- a local agreement between the organisation and offender to repay any monies

Actions which may be taken when considering seeking redress include:

- no further action
- penalty charges (falsely claiming assistance with NHS Health Charges)
- criminal investigation
- civil recovery

- disciplinary action
- confiscation order under the Proceeds of Crime Act 2002
- provisions available under Anti-money laundering (AML) legislation
- recovery sought from ongoing salary payments or pensions.

**6.2 Criminal Sanctions:**

6.2.1 The LCFS and the NHS CFA may conduct a criminal investigation with a view to submitting a case to the Crown Prosecution Service for a decision regarding prosecution for any number of reasons, for example:

- The case is serious and/or extensive.
- If a prosecution took place it would help to challenge beliefs about fraud, bribery and corruption and how and when they can occur.
- If a prosecution took place it would help to prevent or deter financial crime.
- If a prosecution took place it would demonstrate to potential offenders and the public that those who commit crimes against the NHS will be held to account.

This list is non-exhaustive; the NHS CFA and health bodies reserve complete discretion to conduct a criminal investigation in any case and to carry out investigations across a range of offences.

Actions which may be taken when considering seeking a criminal sanction include:

- no further action
- fine
- suspended sentence
- custodial sentence
- community penalty
- confiscation and/or compensation orders

**6.3 Civil Sanctions:**

6.3.1 A civil claim with the objective of financial recovery can be brought where financial redress via the criminal route is not thought to be appropriate, or where a health body was not (fully) compensated following a criminal conviction. If successful the claimant is entitled to seek enforcement by various means, including the forced transfer of assets, the forced sale of property to realise capital, or insolvency proceedings.

**6.4 Disciplinary Sanctions:**

6.4.1 As per the Disciplinary Policy, there are a number of actions that may be taken when considering disciplinary sanctions, including:

- no further action
- verbal warning
- written warning
- dismissal
- recovery of any losses via payroll
- referral to regulatory body

### 6.5 Regulatory Body Sanctions:

6.5.1 In certain cases where the conduct of an individual contravenes their regulatory body's Code of Conduct, the Trust may refer the matter to the regulatory body, for example the GMC, GDC, and NMC. It is the responsibility of the Chief Finance Officer to make or direct such referrals.

Following an investigation by the regulatory body the following sanctions may include:

- no further action
- restrictions to licence
- being struck off by the regulatory body (i.e. no longer being able to practice profession)

In addition, NHS England may suspend or remove doctors, dentists, and ophthalmic medical practitioners from performers lists comprising those who may provide NHS services. Where clear evidence exists that a healthcare professional has been involved in fraud or corruption, there is likely to be a strong public interest in informing NHS England to enable it to undertake enquiries regarding the allegations and to take action where appropriate. In making its decision, NHS England may consider whether the instances of fraud in question, as well as any current or past investigations relating to the professional, justify such action. The duty to protect patients is a major factor in deciding what action is necessary.

## 7 Process

7.0.1 Once the loss has been identified and all investigations have been fully undertaken and reported to the Audit Committee, the Chief Finance Officer and LCFS will consider all recovery of losses options in line with the Fraud and Bribery Policy.

The Chief Finance Officer will authorise the appropriate recovery method considering the advice and guidance of the LCFS. The chosen method of recovery will be reported to the Audit Committee.

Appropriate action in relation to the recovery of the loss will be applied by the relevant staff of the Trust liaising with the LCFS.

7.0.2 The ongoing monitoring and recovery of the loss will be regularly reported to the Audit Committee within part 2 of the meeting. The reporting of the outstanding loss will be reported until full recovery has been accomplished or if the Audit Committee decide to write off the debt. The writing off of the debt will be in line with the Losses and Special Payments/Debt Recovery policy.

7.0.3 This process applies to:

- all employees and prospective employees of the Trust, regardless of position held;
- agency staff;
- consultants;
- vendors;
- contractors and subcontractors;
- service users;
- committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust) members of organisations funded by the Trust
- employees and principals of partner organisations; and/or
- any other parties who have a business relationship with the Trust.

## 8 Reporting Fraud, Bribery or Corruption

8.0.1 This section outlines the action to be taken if fraud, bribery or corruption is discovered or suspected.

8.0.2 If an employee has any of the concerns mentioned in this document, they must inform the nominated LCFS or the Trust's Chief Finance Officer immediately, unless the Chief Finance Officer or LCFS is implicated. If that is the case, they should report it to the Chair or Chief Executive, who will decide on the action to be taken. As stated in section 4.10.4 above, **managers must not attempt to investigate the allegation themselves**.

8.0.3 ***Appendix 1*** provides a reminder of the key contacts and a checklist of the actions to follow if fraud, bribery and corruption, or other illegal acts, are discovered or suspected. Managers are encouraged to copy this to staff and to place it on staff notice boards in their department.

8.0.4 An employee can contact any executive director of the Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the LCFS or Chief Finance Officer.

8.0.5 Employees can also call the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60. This provides an easily accessible route for the reporting of genuine suspicions of fraud within or affecting the NHS. It allows NHS staff that are unsure of internal reporting procedures to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

8.0.6 Anonymous letters, telephone calls, etc are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.

8.0.7 The LCFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

8.0.8 Staff should always be encouraged to report reasonably held suspicions directly to the LCFS. They can do this by filling in the NHS Fraud and Corruption Referral Form (***Appendix 2***) or by contacting the LCFS by telephone or email using the contact details supplied on the Trust's intranet site.

8.0.9 The Trust wants all employees to feel confident that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1998, The Trust has produced a whistleblowing policy. This procedure is intended to complement the Trust's Fraud, Bribery and Corruption Policy and code of business conduct and ensures there is full provision for staff to raise any concerns with others if they do not feel able to raise them with their line manager/management chain.

### 8.1 Disciplinary Action

8.1.1 The disciplinary procedures of the Trust must be followed if an employee is suspected of being involved in a fraudulent or otherwise illegal act.

8.1.2 It should be noted, however, that the duty to follow disciplinary procedures will not override the need for legal action to be taken (e.g. consideration of criminal action). In the event of doubt, legal statute will prevail.

### 8.2 Police Involvement

8.2.1 In accordance with the *NHS Counter Fraud and Corruption Manual*, the Chief Finance Officer, in conjunction with the LCFS, will decide whether or not a case should be referred to the police. Any referral to the police will not prohibit action being taken under the local disciplinary procedures of the Trust.

### 8.3 Managing the Investigation

8.3.1 The LCFS, in consultation with the Director of Finance will investigate an allegation in accordance with procedures documented in the *NHS Counter Fraud and Corruption Manual* issued by NHS Counter Fraud Authority.

8.3.2 Staff under investigation that could lead to disciplinary action have the right to be represented at all stages. In certain circumstances, evidence may best be protected by staff member is suspended from duty. The Trust will make a decision based on HR advice on the disciplinary options, which include suspension.

8.3.3 The Trust will follow its disciplinary procedure if there is evidence that an employee has committed an act of fraud or corruption.

### 8.4 Gathering Evidence

8.4.1 The LCFS will take control of any physical evidence, and record this in accordance with the procedures outlined in the *NHS Counter Fraud and Corruption Manual*.

8.4.2 The LCFS may speak to any staff member and will take written statements of evidence where necessary.

8.4.3 The LCFS may be provided any data collected or held by the Trust, which assists in proving or disproving the allegations made. This may, include but is not limited to, swipe card records, CCTV, system access reports, payslips, application forms, references, personnel documentation and rosters.

8.4.4 The LCFS may conduct interviews under caution of those suspected of committing frauds against the Trust in accordance with the Police and Criminal Evidence Act 1984 (PACE). Any staff member being interviewed will be informed in writing and invited to attend voluntarily. They will also be entitled to have legal representation present at the interview.

8.4.5 The application of the Counter Fraud and Corruption Policy will at all times be in tandem with all other appropriate Trust policies, e.g. Standing Financial Instructions (SFIs).

### 8.5 Parallel Sanctions

8.5.1 In line with NHS Counter Fraud Authority guidance, the conduct of a counter fraud investigation will not preclude either an internal or civil investigation, or disciplinary process from taking place.

### 8.6 Recovery of Losses Incurred to Fraud, Bribery and Corruption

8.6.1 The seeking of financial redress or recovery of losses will always be considered in cases of fraud, bribery or corruption that are investigated by either the LCFS or NHS Counter Fraud Authority where a loss is identified. As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case.

8.6.2 Redress allows resources that are lost to fraud and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

### 8.7 Reporting the Results of the Investigation

8.7.1 The investigation process requires the LCFS to review the systems in operation to determine whether there are any inherent weaknesses. Any such weaknesses identified should be corrected immediately.

8.7.2 If fraud, bribery or corruption is found to have occurred, the LCFS should prepare a report for the Chief Finance Officer and the next Trust Audit Committee meeting, setting out the following details:

- the circumstances
- the investigation process
- the estimated loss
- the steps taken to prevent a recurrence
- the steps taken to recover the loss.

This report should also be available to the Trust's board.

### 8.8 Action to be taken

8.8.1 Sections 10 and 11 of the *NHS Counter Fraud and Corruption Manual* provide in-depth details of how sanctions can be applied where fraud, bribery and corruption is proven and how redress can be sought. To summarise, local action can be taken to recover money by using the administrative procedures of the NHS Trust or the civil law.

8.8.2 In cases of serious fraud and corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s), and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate.

8.8.3 NHS Counter Fraud Authority can also apply to the courts to make a restraining order or confiscation order under the Proceeds of Crime Act 2002 (POCA). This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

8.8.4 Actions which may be taken when considering seeking redress include:

- no further action

- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under POCA
- recovery sought from ongoing salary payments.

8.8.5 In some cases (taking into consideration all the facts of a case), it may be that the Trust, under guidance from the LCFS and with the approval of the Chief Finance Officer, decides that no further recovery action is taken.

8.8.6 Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring this activity to the attention of the criminal courts (magistrates' court and Crown court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

8.8.7 The civil recovery route is also available to the Trust if this is cost effective and desirable for deterrence purposes. This could involve a number of options such as applying through the Small Claims Court and/or recovery through debt collection agencies.

8.8.8 Each case needs to be discussed with the Director of Finance to determine the most appropriate action.

8.8.9 The appropriate senior manager, in conjunction with the HR department, will be responsible for initiating any necessary disciplinary action. Arrangements may be made to recover losses via payroll if the subject is still employed by the Trust. In all cases, current legislation must be complied with.

### 8.9 Timescales

8.9.1 Action to recover losses should be commenced as soon as practicable after the loss has been identified. Given the various options open to the Trust, it may be necessary for various departments to liaise about the most appropriate option.

### 8.10 Recording

8.10.1 In order to provide assurance that policies were adhered to, the Chief Finance Officer will maintain a record highlighting when recovery action was required

and issued and when the action taken. This will be reviewed and updated on a regular basis.

## 9 Review of The Policy

9.1 This policy will be reviewed annually by the LCFS in conjunction the CFO and senior management and in accordance with relevant guidance, best practice and legislation.

### 10 Associated Internal Policies and Procedures

- Anti-Bribery Statement
- Disciplinary Policy
- Managing Conflicts of Interest in the NHS
- Secondary employment Policy
- Raising Concerns (Whistle-blowing) Policy
- Standing Financial Instructions
- Standing Orders
- Protocol for the Acceptance of Gifts, Hospitality, Sponsorship and Donations
- Code of Conduct (*If separate to any of the above policies)*
- Alcohol and Substance Misuse Policy

### 11 Associated External Policies and Procedures

- NHS Counter Fraud Authority guidance - *Parallel criminal and disciplinary investigations policy statement*.
- NHS Counter Fraud Authority guidance - *Parallel criminal and disciplinary investigations guidance for Local Counter Fraud Specialists*.
- Sanctions and Redress Guidance Note

University Hospitals Dorset
NHS Foundation Trust

# APPENDIX

## NHS FRAUD AND CORRUPTION: DOS AND DON'TS - A DESKTOP GUIDE

***FRAUD*** is the dishonest intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position.
***CORRUPTION*** is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

| ***DO*** | ***DO NOT*** |
|---|---|
| **Note your concerns**<br>Record details such as your concerns, names, dates, times, details of conversations and possible witnesses.<br>Time, date and save your notes<br><br>**Retain Evidence**<br>Retain any evidence that may be destroyed, or make a note and advise your LCFS<br><br>**Report your suspicions**<br>Confidentiality will be respected – delays may lead to further financial loss<br>Complete a fraud report and submit in a sealed envelope marked 'Restricted – Management' and 'Confidential' for the personal attention of the LCFS | **Confront the suspect or convey concerns to anyone other than those authorised, as listed below**<br><br>**Attempt to question a suspect yourself; this could alert a fraudster or accuse and innocent person**<br><br>**Try to investigate, or contact the police directly**<br><br>**Attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take in to account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in line with the legislation.**<br><br>**Be afraid of raising your concerns**<br>The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures. |

**If you suspect that fraud against the NHS has taken place, you must report it immediately, by:**

- directly contacting the Local Counter Fraud Specialists, contact details to be found on the staff intranet page.
- phoning the NHS Fraud and Corruption Reporting Line on 0800 028 40 60. (All calls will be treated in confidence and investigated by professionally trained staff), or
- contacting the Chief Finance Officer.

***Do you have concerns about a fraud taking place in the NHS?*** If so, any information can be passed to the NHS Fraud and Corruption Reporting Line:

University Hospitals Dorset
NHS Foundation Trust

# APPENDIX 2

## NHS FRAUD AND CORRUPTION REFERRAL FORM

*All referrals will be treated in confidence and investigated by professionally trained staff*

***Note: Referrals should only be made when you can substantiate your suspicions with one or more reliable pieces of information. Anonymous applications are accepted but may delay any investigation.***

***1. Date***

***2. Is this an anonymous referral? <Delete as appropriate>***
*Yes (If 'Yes' go to section 6) or No (If 'No' complete sections 3–5)*

***3. Your name***

***4. Your organisation/profession***

***5. Your contact details***

**6. *Suspicion***

***7. Please provide details including the name, address and date of birth (if known) of the person to whom the allegation relates.***

***8. Possible useful contacts***

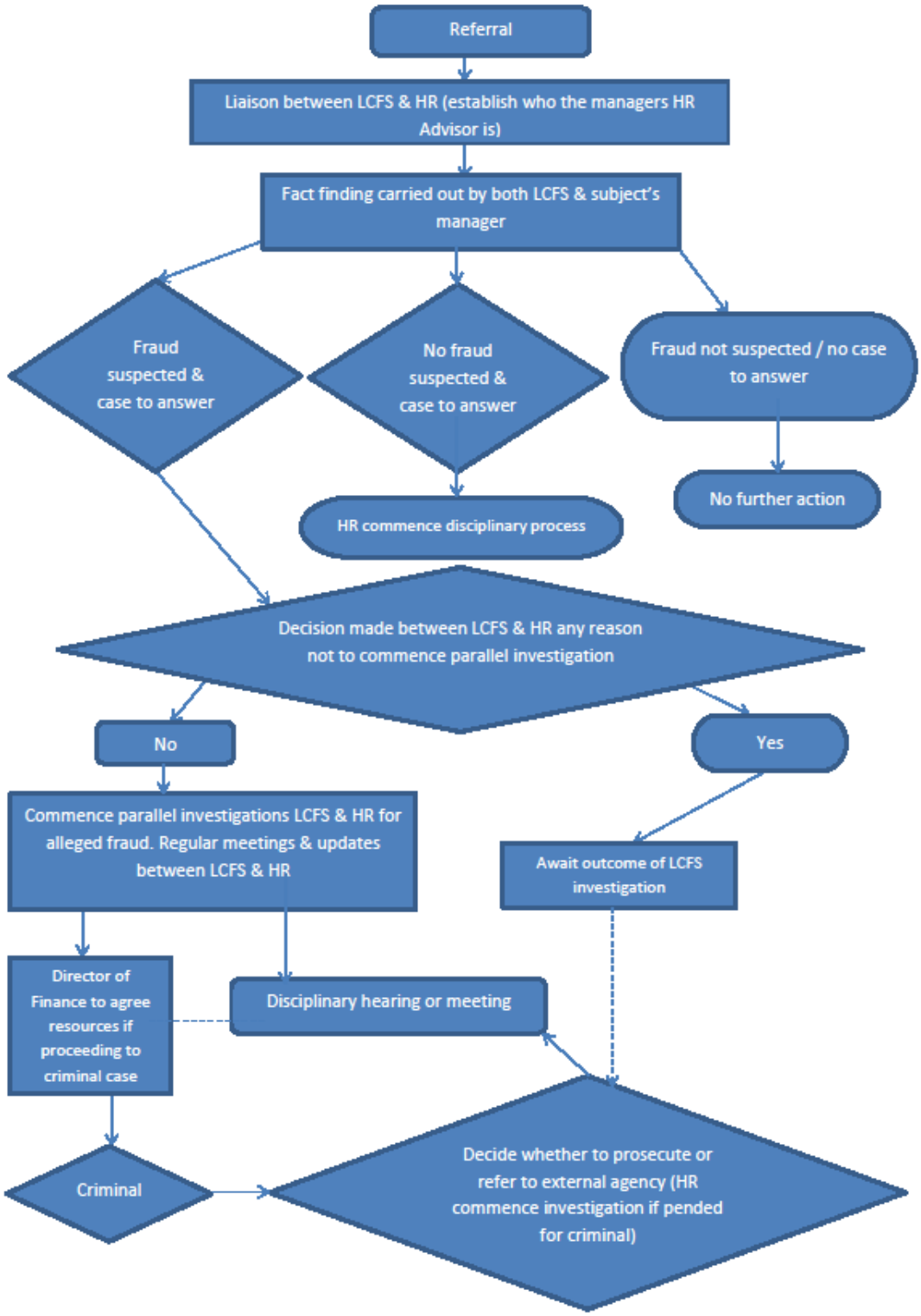
| |
|---|
| |

***9.*** **Please attach any available additional information**.

University Hospitals Dorset
NHS Foundation Trust

# APPENDIX 3

## LCFS REFERRAL / HR INVESTIGATION FLOW CHART



University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 25 January 2023**

**Agenda item: 10.5**

| | |
|---|---|
| **Subject:** | Catering - Charity Business Case December 2022 |
| **Prepared by:** | Emma Honnywill – Ops Transformation Manager |
| **Presented by:** | Richard Renaut<br>Chief Strategy & Transformation Officer |

| | |
|---|---|
| **Strategic Objectives that this item supports/impacts:** | Continually improve quality ☐<br>Be a great place to work ☒<br>Use resources efficiently ☒<br>Be a well led and effective partner ☐<br>Transform and improve ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | Staffing support and being a great place to work. |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | As part of the developing new catering services across the Trust linked to the reconfiguration there is an opportunity to go above and beyond the NHS funded offer. This would improve the service for patients, staff and visitors at the emergency hospital which will be a busy 24/7 site.<br><br>A review of recommendations of existing UHD groups looking at staff wellbeing including ISE (Improving staff Experience) and Hotfood@night campaign has highlighted out of hours food offering as something that will be beneficial.<br><br>In developing the brief and engaging with staff through the task & finish groups several items beyond the essential scope have been identified as an enhanced service offer within the Atrium scheme. These are:<br><br>• An out of hours hot food facility, with layout, equipment, security and servery hatch for quiet hours, that allows lower staffing levels and to still be secure. This makes the model more economically sustainable.<br><br>• "Grab and go" collection point for staff to get food and drink quickly, especially during busy times, by pre-ordering with an app. |

| | |
|---|---|
| | The total Interim build works project cost including the enhancements above is £1.596 million (inclusive of VAT).<br><br>£1.32 million of funding has been secured within the NHP Capital Plan specifically in relation to the Catering scheme and enabling works.<br><br>This is a request for charity funding of £250,000 top up for two specific elements that are "above and beyond" the NHS funding.<br><br>Without the top up to the NHS funded budget the two items above would need to be excluded from the scheme.<br><br>• The main benefit of these enhancements through charity funding is for staff, and especially those that work out of hours, at nights and weekends. The charity purposes include supporting staff.<br>• Easy access to healthy, affordable hot food, for staff often on 12-hour shifts is an important and highly visible way of supporting staff.<br>• Staff feedback shows there is current demand for hot food out of hours. However, it is not enough to justify keeping the main kitchens open without a very large, recurrent subsidy, at a level that would take funds from direct patient care.<br><br>The proposal resolves this through a building solution that allows a sustainable staffing and wide range of hot foods. |
| **Background:** | An NHS funded upgrade to the Atrium café at Bournemouth hospital is planned, as part of the NHP (New Hospital Programme) enabling works programme for catering.<br><br>At the core of this the CPK (Central Production Kitchen). This will be in the Stour ground floor and will allow fresh cook and short timescale freezing, which then allows more food choices, more personalized portion sizes while retaining locally produced, high quality ingredients and no additives.<br><br>This model was chosen following extensive engagement with patient representative, dietician, nursing and catering team expert input. It also fits well with the national policies around both patient food and the move to net zero carbon. |
| **Key Recommendations**: | The detailed business case has been considered by the Financial Planning Group and is recommended.<br><br>The Charity Committee chair supports the Board making the decision, and then for a more detailed scrutiny at the February Charity committee meeting. |

| | |
|---|---|
| | The recommendation is that the Board approves the use of charitable funding and this can be strongly supported because of the value added, better level of service supporting staff and patients/visitors through this enhanced Catering service offer. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality and Diversity ☐<br>Financial ☒<br>Operational Performance ☐<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☐<br>Regulatory ☐<br>Strategy/Transformation ☒<br>System ☐ |
| **CQC Reference:** | Safe ☐<br>Effective ☐<br>Caring ☒<br>Responsive ☒<br>Well Led ☐<br>Use of Resources ☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Charity Committee | 06/02/2023 | TBC |

| | |
|---|---|
| **Reason for submission to the Board in Private Only (where relevant)** | Commercial confidentiality ☐<br>Patient confidentiality ☐<br>Staff confidentiality ☐<br>Other exceptional reason ☐ |

University Hospitals Dorset
NHS Foundation Trust

# Business Case Concept Form

*Concept form to be completed for all expenditure not covered by budget, both capital and revenue. More complex business cases will also require full business case after receiving concept approval*

## Atrium catering "top up" for out of hours hot food offer

| | | | |
|---|---|---|---|
| **Care Group:** | Operations | **Directorate:** | Facilities |
| **Date:** | Dec 22 | **Category:** | Facilities - Catering |

**1.Exec Summary** *Exec summary should be limited to half page max, Please be clear about specifically what this proposal is requesting.*

An NHS funded upgrade to the Atrium café is planned, as part of the NHP enabling works programme. A £1.32 million source of funds has been identified within the current NHP Capital Plan specifically in relation to the Catering scheme and enabling works.

An Executive led Task & Finish group was established to review the provision of Hotfood@night and to provide recommendations and deliver a cost neutral out of hours offer.

In developing the brief and engaging with staff through the Task & Finish group several items beyond the essential scope have been identified as an enhanced service offer within the Atrium scheme. These are:

- 24/7 hot food facility, with layout, equipment, security and servery hatch for quiet hours, that allows lower staffing levels to still be secure. This makes the model more economically sustainable. (App based ordering)
- "Grab and go" collection point for staff to get food and drink quickly, especially during busy times, by pre-ordering with an app.

The App has been developed inhouse with the support of the IM&T directorate within existing resources.

The total project cost including the above enhancements, is £1.596 million (inclusive of VAT). To remain within the NHS funded budget the above two items would need to be excluded from the scheme.

The use of charitable funding can be strongly supported because of the value added, better level of service supporting staff and patients/visitors through this enhanced Catering service offer.

The main benefit of these enhancements through charity funding is for staff, and especially those that work out of hours, at nights and weekends. Easy access to healthy, affordable hot food, for staff often on 12-hour shifts is an important and highly visible way of supporting staff. Staff feedback shows there is current demand for hot food out of hours. However, it is not enough to justify keeping the main kitchens open without a very large, recurrent subsidy, at a level that would take funds from direct patient care.

Through the Task & Finish groups research all pointing to a staff need trials of alternative catering offers; smart vending with microwaves, external providers and delivery companies were trialled but proved to not be an economically sustainable solution through a value for money assessment.

This proposal looks to resolve this by having staff use an app for ordering and are able to get a quick collection from a secure central hospital location (the Atrium).

**2. Financial Headlines:** *Briefly outline investment required*

Capital costs, and fees £1.32 million (Appendix 1)

Shortfall of £250,000 against NHS funded element (NHP as main funding source).

Options are:

1) Charity committee supports funding to allow provision of the enhanced service through a modernised digitally enabled App based ordering and out of hours hot food, plus grab and go offer for staff.

2) Reduce scope to fit within identified NHS Capital funding envelope by removing these features from the design.

The build works enabling scheme has been competitively tendered and so the above prices are reasonably firm, but will only be held for several weeks, given the volatility in materials and labour supply and inflation.

The tender allows either option to be progressed. Charity Committee out of committee approval would allow the scheme to proceed in the best way and keep to timetable and tendered costs.

VAT treatment will be reviewed through specialist advice due to the complex nature of the scheme being both existing and new refurbishment.

**3. Estimate Resource Implications**

| **Recurrent Costs** | **£'000** | **Non-Recurrent Costs** | **£'000** |
|---|---|---|---|
| Staff Costs | | Staff Costs | |
| • Substantive | | • Substantive | |
| • Bank | | • Bank | |
| • Agency | | • Agency | |
| | | | |
| Non Pay Costs | | Non Pay Costs | |
| • Equipment | | • Equipment | |
| • Drugs | | • Drugs | |
| • Other | | • Other (capital) | £250,000 |
| | | | |
| Income | | Income | |
| • Other (specify) | | • Other (specify) | |
| | | | |
| **Total** | | **Total** | £250,000 |

NB. No revenue funding is required as model will be staffed internally from the current team as the methodology, opening hours etc are developed over the next 2 years.

**4. Whole Time Equivalent (WTE) Impact**

*Please detail the whole time equivalent (WTE) impact across staff category by 'recurring' and 'non-recurring' impact.*

Extra sales cost will need to cover food and staffing costs. Exact staffing levels will be refined over time as demand and supply adjust. The main step up is expected in spring 2025 as the BEACH building and extra beds open at RBH and the number of 24/7 staffing on site more than doubles. Until then the service will be developed and trialled to improve the offering.

**5. Activity Headlines/Impact on Performance Standards**

As part of the Catering Transformation work the ask was to provide a cost neutral 24/7 accessible food service for staff. For assurance in relation to the funding request this service is envisaged to be nett neutral, however there is a future opportunity as the service expands to move to a profit generating service for visitors supporting the trusts financial position.

**6. Impact on support services**:

**Is there any impact on support services?**

- Facilities for cleaning will be provided through existing catering staffing provision.
- Portering for security (with porter lodge next door this is ideal location) and no direct costs incurred.

**If Y, please provide details of support services agreed:**

n/a

University Hospitals Dorset NHS Charity

Registered Charity No.1057366

# CHARITABLE FUND APPLICATION FORM

| | | | |
|---|---|---|---|
| **Applicant Name:** | Emma Honnywill / Stuart Willes | **Date:** | 29.12.2022 |
| **Email address:** | stuart.willes@uhd.nhs.uk | **Extension Number:** | |

**Amount requested:** £250,000.00 *(inclusive of VAT and any installation/ estates costs)*

**Charity Fund and number:** 76109 - UHD General Fund

**Directorate to benefit:** Facilities

Please ensure you attach the quote - without we will not be able to progress your application.
If this is for Estates or IT work please attach any email correspondence in relation with the quote inclusive of VAT.

**Application for:**
Please give as much detail about what you are applying for and explain why this is above and beyond standard NHS provision. Please note the charity can not fund retrospective applications, and further checks may have to be made so please leave enough time from the application submission to the date the funding is needed (for larger requests >£25k, this can take up to three months).

An NHS funded upgrade to the Atrium café is planned, as part of the NHP enabling works programme. A £1.32 million source of funds has been identified within the current NHP Capital Plan specifically in relation to the Catering scheme and enabling works.
An Executive led Task & Finish group was established to review the provision of Hotfood@night and to provide recommendations and deliver a cost neutral out of hours offer.
In developing the brief and engaging with staff through the Task & Finish group several items beyond the essential scope have been identified as an enhanced service offer within the Atrium scheme. These are:
•24/7 hot food facility, with layout, equipment, security and servery hatch for quiet hours, that allows lower staffing levels to still be secure. This makes the model more economically sustainable. (App based ordering)
•"Grab and go" collection point for staff to get food and drink quickly, especially during busy times, by pre-ordering with an app.
The App has been developed inhouse with the support of the IM&T directorate within existing resources.
The total project cost including the above enhancements, is £1.596 million (inclusive of VAT). To remain within the NHS funded budget the above two items would need to be excluded from the scheme.
The use of charitable funding can be strongly supported because of the value added, better level of service supporting staff and patients/visitors through this enhanced Catering service offer.
The main benefit of these enhancements through charity funding is for staff, and especially those that work out of hours, at nights and weekends. Easy access to healthy, affordable hot food, for staff often on 12-hour shifts is an important and highly visible way of supporting staff. Staff

**Patient benefit:**
Please note that this must be above and beyond what the NHS can provide in order to be in line with charity guidelines and not essential to patient care.

With the reconfiguration of RBH to the major emergency hospital for Dorset, and the opening of the BEACH building with larger ED, Critical care, Maternity and Paediatrics there will be more patients and visitors, and more 24/7 services concentrated on site.
Having modernised catering facilities will meet a need, especially for visitors to patients which is important for patients to feel supported. Having the access to 24/7 hot food is above and beyond what is currently provided, or considered viable within the exiisting or NHS funded facilities.
From 2025 as the new services open on site, with this top up funding the catering offer can be expanded for patients/visitors.

**Staff benefit:**
The charity can fund support for staff relating to health, wellbeing, welfare and development. If applying for training please state the delegate names.

To offer an affordable hot meal out of hours, quickly and easily, requires catering staffing. The catering staff cost is minimised through design, and being able to use freshly frozen food from the new Central Production Kitchen (CPK) opening in later 2023. This will provide the best balance of quality food, affordable pricing, and easy access out of hours. The exact service model will develop over time as demand dictates, but the crucial decision is whether charity funding can be used now to construct the full designs.

| | | | |
|---|---|---|---|
| **Is this Medical Equipment:** | No | **If yes, directorate will cover ongoing maintenance costs:** | Yes |
| Please note that all equipment must be sourced via your Procurement lead. No charity application can be processed without this and an up to date quote. | | Please note that the charity can not fund ongoing costs such as maintenance and consumables. | |
| **Has the Trust used this before:** | No | **If no, has 'MD1' form been completed and attached?** | yes |

| | | | |
|---|---|---|---|
| **Name of Procurement lead:** | Alex Dean | **Please ensure quote is attached** | |
| **Estates lead** *(if appropriate)* **:** | Richard Callaghan | | |

| | **Approved by:** | **Declined by:** |
|---|---|---|
| **Print name:** *(Authorised Fund Signatory)* | | |
| **Signature:** *(Authorised Fund Signatory)* | | |

| | |
|---|---|
| **GDO approval for over £5k** *:*<br>*(GDO to sign)* | Richard Renaut (CSTO and Estates lead) |
| **Reason for refusal:** | |
| **Please submit by email to:** | UHD.charity@uhd.nhs.uk |