University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 26 July 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

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 26 July 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 26 July 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**
	4	Update from Council of Governors	**Verbal**	**Information**	**Lead Governor**
13:30	**5**	**MINUTES AND ACTIONS**			
	5.1	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 24 May 2023	**Paper**	**Approval**	**Chair**
	5.2	Matters Arising - Action List – (*none outstanding)*	**Verbal**		**Chair**
13:35	**6**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
	6.1	Trust Chair's Update	**Verbal**	**Information**	**Chair**
	6.2	Chief Executive Officer's Report • Update • ICB Minutes – 4 May 2023	**Paper**	**Information**	**CEO**
13:50	**7**	**INTEGRATED PERFORMANCE REPORT AND RISK**			
	7.1	Board Assurance Framework – Breakthrough Objectives and Strategic Initiatives	**Paper**	**Approval**	**CEO**
	7.2	Risk Register Report	**Paper**	**Approval**	**CNO**

	7.3	Integrated Quality, Performance, Workforce, Finance and Informatics Report *Questions to the Executive Team by exception*	**Paper**	**Assurance**	**Execs**
14:20	**8**	**STRATEGY AND PLANNING**			
	8.1	Improvement Strategy	**Paper**	**Approval**	**CSTO**
14:40	**9**	**COMMITTEE CHAIRS' REPORTS**			
	9.1	Finance and Performance Committee – Chair's Reports – June and July 2023	**Verbal**	**Assurance**	**Committee Chair**
	9.2	Quality Committee – Chair's Reports – June and July 2023 • Annual Statement of Commitment for Safeguarding *or approval)* • Annual Infection Prevention and Control Report – Board Assurance Statement *(for approval)* • Mixed Sex Accommodation Declaration *(for approval)* • Annual Complaints Report	**Verbal**	**Assurance**	**Committee Chair**
	9.3	Population Health and System Committee – Chair's Report – June 2023	**Verbal**	**Assurance**	**Committee Chair**
	9.4	Annual Review of Committees' Effectiveness	**Paper[R]**	**Assurance**	**Committee Chairs**
15:05	**10**	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 23 July 2023 to company.secretary-team@uhd.nhs.uk		**Receive**	**Chair**
	11	Any Other Business	**Verbal**	**Discussion**	**Chair**
	12	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 27 September 2023 at 13:15.			
	13	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
15:15	**14**	**Close**	**Verbal**		**Chair**

* Late paper

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

Items for Next Board Part 1 Agenda

Standing Reports

- Patient Story
- Trust Chair's Update
- Chief Executive Officer's Report
- Integrated Performance Report
- Risk Register Report
- Integrated Care Board Minutes (July 2023)

Quarterly Reports

- Guardian of Safe Working Hours Report

Bi-annual/Annual Reports

- Nursing Establishment Review
- Annual Safeguarding Report
- Quality Impact Assessment Report
- Freedom to Speak Up Guardian Report
- Quality Assurance for Responsible Officers and Revalidation
- Annual Health and Safety Report
- Annual Security Report
- Workforce Race Equality Standards Report
- Workforce Disability Equality Standards Report and Action Plan
- EPRR Assurance Report

Ad Hoc Reports

- Amendment to Population Health Terms of Reference

AGENDA – PART 2 PRIVATE MEETING

15:30 on Wednesday 26 July 2023

Time	Item		Method	Purpose	Lead
15:30	15	Welcome, Introductions, Apologies & Quorum	Verbal		Chair
	16	Declarations of Interest	Verbal		Chair
15:35	17	**MINUTES AND ACTIONS**			
	17.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 28 June 2023	Paper	Approval	Chair
	17.2	Matters Arising – Action List	Verbal	Review	Chair
15:40	18	**UPDATES**			
	18.1	Chief Executive Officer's Update • EPR	Verbal	Information	CEO
	18.2	Escalations from Committee Chairs (not already covered in Part 1)	Verbal	Information	Committee Chairs
	18.3	CQC Update	Verbal	Information	CNO
15:55	19	**QUALITY AND PEOPLE**			
	19.1	Serious Incident Report	Verbal [R]	Review	CMO
16:05	20	**STRATEGY, TRANSFORMATION AND FINANCE**			
	20.1	Endoscopy consumables	Paper	Approval	CFO
	20.2	Fire alarm maintenance	Paper	Approval	CFO
	20.3	Supply of Dragon Medical One and Speech Recognition Software	Paper	Approval	CFO
	20.4	Microsoft Licences	Paper	Approval	CFO
	20.5	Medium Term Financial Plan	Paper	Review	CFO
	20.6	New Hospitals Programme	Paper	Approval	CSTO
	21	Any Other Business	Verbal		Chair
	22	Reflections on the Board Meeting	Verbal		Chair

	23	**Date and Time of Next Standing Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 27 September 2023 at 15:30.			
17:00	**24**	**Close**	**Verbal**		**Chair**

* Late paper
R Associated item in Reading Room

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Items for Next Standing Board Part 2 Agenda

Standing Reports

- Trust Chair's Update
- Chief Executive's Update
- Serious Incident Report

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
IPR – Integrated Performance Report
ITU – Intensive Therapy Unit
MSG – Mortality Surveillance Group
NHSE/I – NHS England/Improvement
#NOF – Fractured neck of femur
NRTR – No reason to reside
OPEL – Operational Pressures Escalation Levels
RTT – Referral to Treatment
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 24 May 2023 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
	Sharath Ranjan	Non-Executive Director
	Richard Renaut	Chief Strategy & Transformation Officer
	Cliff Shearman	Non-Executive Director
	Paula Shobbrook	Chief Nursing Officer
	Peter Wilson	Chief Medical Officer
In attendance:	Robert Bufton	Public Governor
	Yasmin Dossabhoy	Associate Director of Corporate Governance
	James Donald	Associate Director of Communications
	Rob Flux	Staff Governor
	Ewan Gauvin	Corporate Governance Manager
	Marjorie Houghton	Public Governor
	Tiffany Joby	Care Quality Commission *(until end of item BoD 124/23)*
	Judith May	Associate Director of Operational Performance and Oversight
	Keith Mitchell	Public Governor
	Patricia Scott	Public Governor
	Jeremy Scrivens	Public Governor
	Gemma Short	Midwife
	Susanne Surman-Lee	Public Governor
	Joe Talora	Health Service Journal
	Caroline Tapster	Non-Executive Director
	Kani Trehorn	Staff Governor
	Michele Whitehurst	Deputy Lead Governor
	Sandy Wilson	Public Governor
Public attendees:	3 members of the public attended	

BoD 105/23	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting. Apologies were received from: • Judy Gillow, Non-Executive Director. • John Vinney, Associate Non-Executive Director. The meeting was declared quorate.

BoD 106/23	**Declarations of Interest** General declarations had been made: • By Judy Gillow who was a specialist adviser to the CQC, coach for overseas NHS fellows and a volunteer for the Milford-on-Sea community café. • By Sharath Ranjan who was an independent governor for Solent University. • By Mark Mould whose wife and daughter were co-owners of iskinsecrets Limited. • By John Vinney who in addition to being a director of Bournemouth University was a director of Bournemouth University Innovations. No existing interests in matters to be considered were declared. In addition, no further interests were declared.
BoD 107/23	**Patient Story** Rob Whiteman reported that uniquely there would be no Patient Story presented at the meeting as the patient was unable to attend on this occasion.
BoD 108/23	**For Accuracy and to Agree: Minutes of the Board of Directors Part 1 Meeting held on 27 March 2023** The minutes of the Board of Directors Part 1 meeting held on 27 March 2023 were APPROVED as an accurate record.
BoD 109/23	**Matters Arising – Action List** It was noted that there were no outstanding actions.
BoD 110/23	**Trust Chair's Update** Rob Whiteman provided the Trust Chair's Update highlighting: • Overall, inflation had reduced but food inflation was continuing. The Board was conscious of the challenges for its staff and patients. It was important that the Trust continued to help the less economically well off who used its services. • The Board was delighted with Judy Gillow and Sharath Ranjan having joined the Trust as Non-Executive Directors. • The topping out ceremony of the BEACH building that had taken place the previous week. It was commendable that this project was on budget and on time. • He had attended meetings with the Chief Executive of the South West Region, other Chairs within the Dorset system and the Chair of the Dorset Integrated Care Board (ICB). He had also met with the national Chief Finance Officer for the NHS. In addition, he had been pleased to carry out visits to some of the services at the Trust. • He and the Non-Executive Directors had discussed some of the Board meetings being held face to face. This would be arranged for the September 2023 meeting of the Board as well as during 2024. He had also asked the Board Committee Chairs to schedule a balance of face to face as well as virtual meetings. The Board NOTED the Trust Chair's Update.
BoD 111/23	**Chief Executive Officer's Report** Siobhan Harrington presented the Chief Executive's Report highlighting: • She would shortly reach her one-year anniversary as Chief Executive of the Trust. With the NHS having emerged from five rounds of Covid and recent industrial action, she and the Board continued to appreciate the care and commitment given by the Trust's staff.

- Most of the detail in the Board papers related to April 2023, but there had been a number of national updates referenced in her report. She highlighted that on 18 May 2023, NHS England had formally written to the Trust stepping down the Covid pandemic from a level three incident to level two.
- Within Dorset, there was considerable momentum in relation to development of the Integrated Care Strategy, the operational plan and the Dorset People Plan. The Dorset Provider Collaborative had been refreshed and she would be chairing it over the next 12 months; as providers, a smaller number of priorities would be delivered together.
- Green shoots were continuing to emerge:
    - In April 2023, for urgent and emergency care, the Trust had achieved 61.3% of people being seen within the four-hour target against a trajectory of 60%.
    - No criteria to reside numbers had decreased, attributable to work across the Trust and with system partners.
    - On elective and cancer care, there was positive news with the Trust's barn theatres opening to their first patients the following week. A video was available on Twitter showing the inside of the barn theatres.
    - Within the Trust's elective performance, the Trust had achieved no patients waiting for 104 weeks. By the end of June 2023, the Trust was striving to achieve no patients waiting more than 78 weeks, although this may be impacted by industrial action. The Trust also had an aim of no patients waiting more than 65 weeks by the end of the operational year.
    - In the performance report, there was a slide in relation to breast screening, which was showing good progress. When benchmarked nationally, the Trust's performance in this area was good.
- Following the CQC visit, work had been undertaken to strengthen the governance and risk management across the Trust. Within the accountability framework document in the meeting materials was a slimmed down internal governance structure that would continue to be refined.
- The internal financial position was challenging. A plan was in place, the issue being with delivering a recurrent position.
- Patient First, the quality improvement initiative across the Trust was progressing. This would be palpable during the summer with the Patient First improvement training. Clinical teams would be taken through Patient First during September to November 2023. 2023 would be a transitional year towards the Trust being driven by quality improvement.
- Workforce figures were showing improvement.
- The Trust had been informed of the latest junior doctor industrial action planned from 14 June to 17 June 2023. Plans for that week were being worked through. The Board respected the right to take industrial action but a resolution was needed across the NHS and would continue to support a resolution at a national level.
- She received in the region of 50-60 nominations each month for the staff excellence awards.
- Congratulations were extended to Lorraine Tonge, Director of Midwifery who had received a national Chief Midwifery Officer silver award.

	Rob Whiteman asked Siobhan Harrington whether it was expected that the Secretary of State would make announcements that week about the Trust's outline business case, which she confirmed was anticipated. The Board NOTED the Chief Executive Officer's Report.
BoD 112/23	**Board Assurance Framework Q4** Introducing the Board Assurance Framework Q4, Rob Whiteman outlined that there were a number of risks on the Trust's risk register and he was keen to see further development of the Board Assurance Framework. Considerable work was being undertaken to enhance this. Paula Shobbrook presented the Board Assurance Framework Q4 report, which had been presented through Committees. The report was a formal closure of the previous year's Board Assurance Framework. The Board NOTED the Board Assurance Framework Q4 report and the closure of the previous year's framework.
BoD 113/23	**Board Assurance Framework 2023/24** Richard Renaut presented the Board Assurance Framework 2023/24. He explained that the Trust's well embedded risk register would continue to remain in place. The Board Assurance Framework would be a tool to support focus on delivery of and risks to strategic objectives. Rob Whiteman commented that Board members considered it to be good progress, with Richard Renaut adding that the document would continue to evolve. The Board APPROVED the Board Assurance Framework 2023/24.
BoD 114/23	**Risk Register Report** Rob Whiteman introduced the Risk Register Report reiterating that there were a high number of risks, many of which had been in existence for some time. With the Board Assurance Framework 2023/24 having been approved, an area that would need to be focused upon was whether the relevant controls were in place, which he considered would drive the risks remaining on the register for a shorter period of time. Paula Shobbrook presented the Risk Register Report. It was important that positive engagement continued with teams across the organisation to ensure that risks identified were put onto the register, with the Board having oversight of the aggregation of risks. The four new risks for the register had been reviewed at the Finance and Performance and Quality Committees, respectively, with a recommendation having been for the Board to approve. In relation to risk 1881, Pete Papworth summarised that this was the opening of the new year financial control total risk and the risk of non-delivery of the Trust's regulatory financial position. Karen Allman outlined the progress being made on the theatre staffing vacancies. This included 13 offers having been made to new staff to join the Trust in the preceding two weeks. There was a national shortage, but it was expected that there would be positive movement on the Trust's position by the next meeting of the People and Culture Committee. It was important that the Trust made the most of promoting the fantastic theatres that it had. Peter Wilson provided additional context in relation to risk 1697, relating to the Trust's ability to produce and deliver chemotherapy in a timely manner. One of the key issues was in relation to the shortage of pharmacists. There was a disconnect between the increasing chemotherapy requirements and the availability of qualified staff. Locums had been appointed who were being trained. Work was in progress as well with haematology and oncology

	colleagues in relation to their processes. By changing some of their processes, it would be possible to ensure that the pharmacy received the requests in a more timely manner, giving additional time to carry out the required work. He explained that the reason that the rating was 15 was that notwithstanding both of such mitigations being in place, the Trust was not yet delivering completely to the levels it would want to, although was in a position of safety. The risk rating would be retained at 15 for at least the next two months until the processes were in place and people had been fully trained. In relation to risk 1840 the outlier patients were predominantly older people services patients, who were not able to go to an older people services ward within the Trust, driven by capacity issues. This posed issues with patients not being seen as early in the day as the Trust would want them to be seen, which potentially led to worsening outcomes. The team of doctors walked around the wards to ensure patients were seen, but the issue for these particular patients was with timeliness. There was therefore an element of reducing length of stay leading to fewer outliers. Clinicians had undertaken considerable work in this area, which had resulted the previous week in the Trust having the least number of outliers it had seen in the past year. There was a short-term mitigation with staff working together and a longer-term IT solution. Referencing risks that had been closed, Paula Shobbrook highlighted that in relation to risk 1744 relating to triage, as at the date of the meeting, 97% of women were being seen by a midwife within 15 minutes. An increase in timeliness of being seen by obstetricians was also reported. From the data, this was being sustained and continuously improving. Paula Shobbrook added that across the organisation, work was being carried out to ensure that risks were reviewed in a timely manner and with ongoing focus upon controls and mitigations. More detailed conversations in relation to the risks were also taking place at the Quality Committee with changes in reporting having also been made. Caroline Tapster agreed that the reporting of risk was moving in an appropriate direction. She raised a question in relation to the role of the Committees when considering risks and the role of the Board, in response to which Paula Shobbrook reminded the Board of the relevant provisions in the Trust's Risk Management Strategy. In relation to risk 1493, Karen Allman highlighted that the original risk related to, among other aspects, Covid and was being refreshed and reviewed. Adding to Caroline Tapster's comment, Stephen Mount reminded the Board of the four lines of defence model and its application to the Trust. He concurred that through the work that was being undertaken the governance and risk management was being enhanced. Siobhan Harrington commented upon the importance of triangulation of data, observation and what was being said. The highest risks related to the hospitals building program, the urgent and emergency care pathway and the elective care backlog. This was followed by risks such as financial and workforce related. In response to a question from Rob Whiteman about the risk related to fractured neck of femur not having changed, Mark Mould confirmed that there had been a slight dip during the month, impacted by industrial action and a significant increase in volume. It was important that there was a sustained position over a period of at least three to four months before the risk rating was reduced. Cliff Shearman supported this, cautioning against responding to blips in the trending; it was important to see sustained decreases and to have an understanding behind those.

	The Board APPROVED the Risk Register Report.
BoD 115/23	**Integrated Quality, Performance, Workforce, Finance and Informatics Report (IPR)** Presenting the operational performance aspects of the IPR, Mark Mould added that good news was anticipated in relation to endoscopy. The Trust had received support for its bid for £20m investment for this at the Poole hospital site. The Trust would become a training centre for endoscopy in the south west. Richard Renaut commented also upon the endoscopy research elements and the positive partnership working with Bournemouth University. In response to a question about the national standards from Pankaj Davé and the expectations upon staff, Mark Mould summarised the staged approach to this. These improvements would not only deliver a better experience for patients but would support keeping staff motivated. Cliff Shearman commented positively upon the use of statistical process control charts (SPC), which supported a more forward-looking approach being taken. He observed that in common with other trusts, in relation to reduction in waiting lists and actions taken to reduce those lists such as theatre utilisation, it appeared that more than ever would need to be done. Mark Mould agreed with this and outlined: • The Trust's aspirations of increasing the current theatre utilisation of approximately 76% to 85%. This would increase the number of patients treated by approximately 3% which would contribute to waiting list reductions. However, currently there were spare theatre sessions and estate that could not currently be staffed. If the Trust were able to recruit and retain, noting also the forthcoming incentive scheme, this would enable 7% more work to be undertaken. • There was a challenge with the overall waiting list size. It was envisaged that a point would arise where there was insufficient capacity to meet the demand. He reminded the Board of actions being taken such as validation of the waiting list and understanding as to whether individuals required treatment. Different approaches to provide clinical input to patients on the waiting list was also being considered. A further factor was the relationship with GPs. Currently, how to address the waiting list size was work in progress. • The Executive Team were visiting a progressive organisation the following week and would be seeking to understand more about their capacity and theatre utilisation. Rob Whiteman added that the Board could use seminar and development sessions to learn from what has worked well in taking a forward-looking approach, as referenced by Cliff Shearman. Reflecting on the progress made towards an enhanced data driven approach, Siobhan Harrington added that increasingly SPC charts would be seen in clinical areas. Quality care would continue to be offered but in a different way to more quickly reduce waiting lists. Peter Wilson highlighted that there were significant opportunities in outpatients, which was recognised by the consultant body, including through digital means. Presenting the aspects of the IPR under the quality heading, Paula Shobbrook added that: • No lapses in care had been identified from the MRSA case referenced in the IPR. In line with usual processes, this would be reviewed with ICB colleagues.

- Referencing the fundamentals of care, falls and pressure damage, there were some staffing vacancies which were being mitigated with link nurses. Positive assessments were being conducted: patients being admitted with pressure damage was a predominant feature that would continue to be worked upon. Discussions were taking place with the integrated care system professional practice team to seek to have a joined-up approach with work in the community.
- Complaints response times had not been seen to be improving Additional resource had been implemented, with the impact starting to be demonstrated from this.
- There had been three stillbirths which were being reviewed through the perinatal maternity review tool, with the local maternity system and would be reviewed at the Quality Committee.

Peter Wilson presented the mortality section of the report, adding that there was an awareness that different metrics were being used in different places. This would form part of the review going forward. From a patient safety incidence perspective, there was an awareness of the top five areas of the deteriorating patient, falls, pressure ulcers, medication and signing off of reports. A working group had been recently established in relation to the last of these which had IT involvement. A group would be set up in relation to deteriorating patient.

In relation to the number of stillbirths and this showing in the reporting as red, Caroline Tapster enquired about the timescale for completion of the review. Paula Shobbrook confirmed that these had been reviewed in early May 2023 and the detail would be reported through the Quality Committee. Cliff Shearman added that there were other red areas including the APGAR seven in five minutes: considerable focus was being placed upon this at the Committee.

Presenting the workforce sections of the IPR, Karen Allman added that

- Since July 2022, the Trust's joining rate had been higher than its turnover rate. There had been very positive progress with recruiting and retaining staff.
- The sickness rate in April 2023 was the lowest it had been since pre-Covid. Considerable focus had been placed on staff wellbeing.
- Since the paper had been written, the notice of the ballot for consultant medical staff had been issued.
- A newly qualified open day had been held which had been supported by two of the Trust's senior matrons and colleagues across the Trust. Over 70 offers had been made on that day.

Pete Papworth presented the Trust's financial position from the IPR, adding:

- In addition to the unfunded escalation beds, there had been a higher prevalence of mental health conditions which often required one to one nursing care at a premium cost.
- Considerable additional expenditure relating to urgent estates maintenance had been seen following some specific in-month issues. However, this had been offset by underspends against capital charge budgets, additional bank interest and reduced clinical supply costs with reduced activity during the period of industrial action.
- There was a risk in relation to income with elective activity having been cancelled during the industrial action. Further national guidance on how that would be managed was expected to be issued.
- A dedicated program management office and associated governance and accountability were being established to support the

	identification of and delivery of the remaining cost improvement requirements. Responding to Pete Papworth's update in relation to the use of agency spend, Rob Whiteman enquired whether the Trust was currently doing enough to assuage such costs. Pete Papworth confirmed that agency had reduced in April 2023 compared to March 2023 although not as much as would have been desirable. Support from an external company had been received both in relation to temporary staffing office and e-roster governance and controls. A significant proportion of agency was linked to beds being opened for which the Trust was unfunded. Those beds were generally being opened at short notice with the Trust being reliant upon bank staff in such circumstances. He also reiterated the cost of additional support for patients with mental health needs. Paula Shobbrook provided an update on discussions with Dorset Healthcare on working more closely in partnership. From a medical perspective, Peter Wilson added that through the Medical Staffing Transformation Group and across the system, consideration was being given to certain consultancy costs. A job planning program had also commenced. Peter Gill provided an overview of the informatics section of the IPR: • There were currently 72 projects in escalation within informatics. A review of those would be undertaken in light of the agreed Trust objectives. • He drew the Board's attention to there currently being only 30% of the Trust's assets which were compliant to the national expectations and the end of June 2023 deadline. • He had visited the outpatients clinic at Beales, where 15 specialties now using the location. One of the rules of using Beales was that it was paperless. The Board NOTED the Integrated Performance Report.
BoD 116/23	**Annual Operational Plan** Richard Renaut presented the Annual Operational Plan, highlighting two substantive changes: • The text in the financial section would be updated as the Trust now had a break-even plan. • The strategy triangle would also be updated. It was a point in time document. The Board would be asked to continue the focused efforts - with there being a smaller number of priorities - and making a larger difference. There needed to be a balance between ambition and achievability. Sharath Ranjan queried the metrics that would be used to measure supporting inequalities in outcome and access. Mark Mould reported that he had shared his A3 with the leads of the inequalities group and had asked them to identify what needed to be the priority in relation to the emergency and elective care objective. Richard Renaut also made reference to measuring and focusing upon the Core 20 plus 5 and associated metrics in the longer term. The Board APPROVED the Annual Operational Plan.
BoD 117/23	**Mortality Report** Peter Wilson presented the Mortality Report adding that: • A new medical director for Governance and Risk had been appointed who would be working with him, the Mortality Lead and the Executive team to consider connecting mortality with Patient First. • Mortality was a late indicator of safety.

	• The initial approach of using the business intelligence support deep dive had commenced. • The biggest areas of mortality were cardiovascular, respiratory and neoplasm. • It was not only about the clinical position but also length of stay. • Through Patient First there was an ambition to be significantly better than expected, which translated into two standard deviations from the current position. • Reporting of data would be changed through the Patient Safety Incident Reporting Framework. A meeting had taken place with Cliff Shearman and the proposed approach would be presented at Quality Committee, including how investigations would be conducted to decrease mortality. Cliff Shearman commented positively upon the proposed approach which echoed discussions earlier in the meeting about a forward-looking approach. John Lelliott asked for clarification in relation to the data difference when adding the Poole and Bournemouth sites together. Peter Wilson confirmed that this was an area that would be considered further. In other organisations in which he had worked, it had been as a result of other areas not having been included in sites, for example hospices. The Board NOTED the Mortality Report.
BoD 118/23	**Guardian of Safe Working Hours Report** Peter Wilson presented the Guardian of Safe Working Hours Report in the absence of the Guardians, who had been working with the Trust's junior doctors. With the number of exception reports declining, Philip Green enquired whether junior doctors considered the system was working. Responding to this, Peter Wilson outlined that there were a multitude of facets: • He considered that there were good processes in place where investigation reports were being investigated and fed back; • It was likely that junior doctors considered that what they reported may not be taken into account. Creating more staff was an ongoing struggle. All three patient safety incidents were attributable to junior doctors' perception that a ward was unsafe because of staffing levels. • He was meeting regularly with junior doctors on both sites and medical education colleagues. He would like to work with the two Guardians of Safe Working Hours to go through the mitigations and action plans. He recognised that it was important that the Guardians were seen to be independent. Within the junior doctors' forum, discussions would take place about what was within the Trust's gift to make a difference and how that could be taken forward. Cliff Shearman expressed concern that notwithstanding the numbers having dropped, they still remained high and significant change was not being seen, although the steps that Peter Wilson was proposing to take were noted. The Board NOTED the Guardian of Safe Working Hours Report.
BoD 119/23	**Finance and Performance Committee – Chair's Reports – April and May 2023** Rob Whiteman outlined that there was not much time between the meetings of the Committees and the Board to produce both full minutes of the meetings as well as assurance reports to the Board. He was proposing that for the next Board meeting, the Committee chairs would produce their own assurance

	reports. He expected that the Board would receive crisp assurance reports from each Chair. Referencing the Finance and Performance Committee's Chair's Reports, Philip Green highlighted that an important discussion had taken place in relation to financial risk mitigation in the operational revenue budget and also the work being undertaken with the support of external advisers. At the April 2023 meeting of the Committee, the information governance report had been received. Philip Green referred to an update previously provided to the Board about the notice from the Information Commissioner, with Peter Gill confirming that he was comfortable that the Board was apprised of what it needed to be. The Board NOTED the Finance and Performance Committee – Chair's Reports for April and May 2023.
BoD 120/23	**Quality Committee – Chair's Reports – April and May 2023** Cliff Shearman referred the Board to the reports, upon which no questions were raised. The Board NOTED the Quality Committee – Chair's Reports for April and May 2023.
BoD 121/23	**People and Culture Committee – Chair's Report – May 2023** Pankaj Davé referenced the headline good news areas presented by Karen Allman earlier in the meeting. He reported that the Trust was facing the same risks as previously in relation to capacity, morale, recruitment and retention and space for people to undertake transformation related activities. Updates at the meeting had been provided by the Care Groups, which had invested time in analysing their people survey reports and developing plans and debrief sessions for teams. The Gender Pay Report data had been considered at the meeting of the People and Culture Committee and was being presented to the Board for approval. In addition, reports had been considered from the Freedom to Speak Up Guardian, the Guardians of Safe Working Hours and the education and training report. He emphasised the importance of people having the opportunity to participate in creating a new future for the Trust, particularly with the transition to two site working and the clinical services reconfiguration. Referencing that the timing of the meetings of the People and Culture Committee had been changed to quarterly, he added that a conclusion had been reached that more frequent meetings would be needed. He proposed to work with Karen Allman on a new cadence to meet every two months and a refocus of the agenda items to have appropriate coverage on more strategic areas. Rob Whiteman agreed that it was important that if there were extra meetings that a plan was in place to be forward-looking on strategy. The Board NOTED the People and Culture Committee's Chair's Report – May 2023 and APPROVED the Gender Pay Report for publication on the Trust's external website.
BoD 122/23	**Population Health and System Committee: Chair's Report – April 2023** Caroline Tapster provided an update on the first meeting of the Population Health and System Committee, which was NOTED by the Board.
BoD 123/23	**Audit Committee – Chair's Report – May 2023** Providing an update on the May 2023 meeting of the Audit Committee, Stephen Mount highlighted:

	• Constructive and positive developments in relation to the governance and risk management frameworks. • One of the key roles of the Audit Committee being to oversee the degree of assurance received. • The update from KPMG, external auditors, on the external audit process, which had almost concluded. • The final report from BDO, outsourced internal audit providers, which he considered provided a greater degree of independent assurance than if they were in-house. They were reporting the organisation overall moderate in terms of the design of risk mitigation and operational effectiveness. He had queried the moderate rating and according to the BDO partner, only one organisation (a CCG) had received substantial assurance in recent times. On that basis, he considered that the Trust was receiving a reasonable degree of assurance in relation to its own governance and control systems. In summary, their conclusions were that there were appropriate procedures and controls in place to mitigate the key risks reviewed and generally a sound system of internal control designed to achieve system objectives with some exceptions. Pete Papworth further outlined that internal auditors had explained that while it was possible to achieve substantial assurance, the Trust had a maturity in its use of internal audit. Rather than steering internal auditors to areas where substantial assurance was likely to be received, the Trust pointed them to review areas of weakness or perceived weakness. • The Committee had reviewed for endorsement the draft annual governance statement. This was included in the meeting materials and was APPROVED by the Board. • In relation to the quarterly report on losses and special payments, Stephen Mount commented upon the increase in the number of payments for lost hearing aids, and the need to improve controls in that area. In this context, Peter Gill commented upon the pioneering work by the Pro-Ability Staff Network in the creation of high visibility red boxes for hearing aids which was being rolled out. In addition, Pete Papworth outlined that the Patients' Property policy had recently been updated with training being provided to ward teams. The Board NOTED the Audit Committee – Chair's Report – May 2023.
BoD 124/23	**Charitable Funds Committee – Chair's Report – May 2023** John Lelliott highlighted that the charity was in a strong position. The position could be even further enhanced with legacies, which were a good source of income. This gave opportunities to look at investment opportunities for patients and staff, for example, in wellbeing or equipment. The National Health Covid fund had specifically been considered which was looking for opportunities to spend in relation to staff welfare. The annual report had been reviewed. Eight business cases had been considered and recommended for approval, either actual or in principle. The Board NOTED the Charitable Funds Committee – Chair's Report – May 2023.
BoD 125/23	**Training of Governors** The Board APPROVED the annual certificate in relation to the training of Governors.

BoD 126/23	**Terms of Reference and Committee Membership** The Board APPROVED the changes to the Terms of Reference and Committee Membership.
BoD 127/23	**Seal of Documents Register** The Board NOTED the Seal of Documents Register.
BoD 128/23	**Enabling Accountability Framework** Mark Mould presented the Enabling Accountability Framework, sharing slides with the Board providing an overview of key messages. Siobhan Harrington highlighted the structure chart at the back of the document, which had been significantly streamlined from the previous version. This would be an iterative process of further rationalisation going forward. External assurance and review would be sought from the Good Governance Institute and also working with certain regional colleagues. Stephen Mount considered it would be beneficial to reflect upon the amount of time spent by senior management in meetings compared to other trusts and whether within the Trust they were over-burdened in that way. Mark Mould stated that he could not immediately comment upon how the Trust benchmarked; however, the intention of Patient First was upon observing, listening and being curious. Rob Whiteman observed that the Board structure was not overly burdensome but it struck him that there were issues with papers being generated on time. In addition, papers were lengthy and could get into operational issues. He considered that the root cause was because of the Executive groups and the Executive Team needing to work through whether there was duplication among their groups, whether each had a clear purpose and clear terms of reference. He considered that while it was not directly a Board issue, the weight of such Executive group meetings was having a knock-on effect on the Board papers. He commented that he found it re-assuring that Siobhan Harrington would continue to work on receiving external advice in this area. The Board APPROVED the Enabling Accountability Framework.
BoD 129/23	**Freedom to Speak Up Annual Report 2022/23 and Policy** Helen Martin presented the Freedom to Speak Up Annual Report 2022/23. John Lelliott enquired whether there was a feedback loop about staff that had raised grievances considering that there had been satisfactory resolution. Helen Martin outlined the complexity of feedback and outlined different approaches to making the outcome feel better for the particular individual. Noting the cross-referencing with BAME as one of the nine protected characteristics and the results of the staff survey in terms of fairness to people with protected characteristics, Peter Gill enquired whether there was anything that the Board should note in this regard. Helen Martin responded that protected characteristics were a deep national problem; she would work with him and the staff networks on how this could be approached meaningfully. Having observed media headlines the previous day in relation to crime on NHS property and how that fit with staff sentiment and triangulation with complaints data, Sharath Ranjan questioned how assurance was gained on the position within the Trust. Helen Martin confirmed that she did not view data in isolation; there was a wealth of data as well as feedback from colleagues that was taken into account within the report. Rob Whiteman enquired what the two to three key short term asks of the Board ahead of the next meeting would be. Helen Martin summarised that these would be acknowledgment, checking in and appreciating staff. These

	small observations would support staff in knowing that individuals were looking and wanted to look. The Freedom to Speak Up e-module completion rate also needed to increase. Calling out poor behaviour when it was seen was also important. The Board APPROVED the Freedom to Speak Up Annual Report 2022/23.
BoD 130/23	**Questions from the Council of Governors and Public** No questions had been received from the Council of Governors or members of the public.
BoD 131/23	**Any Other Business** There being no further business, following the passing of the resolution below, the meeting was closed.
BoD 132/23	**Resolution Regarding Press, Public and Others** 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 26 July 2023 at 13:15 via Microsoft Teams.

CHIEF EXECUTIVE'S REPORT
JULY 2023

It's been a hot June with record temperatures not seen since 1884 which has challenged and delighted us all in equal measure. At the time of writing this report we are again preparing for another round of junior doctors' industrial action and for the first-time consultants' industrial action. This is a bigger challenge than previously experienced but again I thank you all for your positive approach and flexibility to ensure the safety of our patients and staff. I will also remind all of our dedicated staff to ensure they look after their health and wellbeing and use the support services we have in place.

Activity continued to be high in June with 45,453 patients seen in our outpatient departments and an additional 8,981 virtually. We carried out 1,145 day-case procedures, supported the birth of 296 babies, attended 13,318 patients in our emergency departments, and cared for 215 people at the end of their lives.

1 NATIONAL UPDATES

1.1 NHS @ 75

5 July 2023 marked the 75th anniversary of the NHS. It's humbling to reflect on the huge strides the NHS has made during that period and to recognise the ongoing demands the service faces. Despite the challenges, nine in 10 people agree that healthcare should be free of charge and more than four in five people agree that care should be available to everyone. It's gratifying to know that the NHS makes most people proud to be British.

Locally we celebrated our birthday sharing personal stories of an NHS family medical dynasty and a rheumatology practitioner's history of her parents meeting whilst nurse training at Poole hospital in the 1960s. Caroline Boyd, one of our sisters in Poole maternity, was featured in the Daily Echo and online taking newborn baby Lydia to the car in 1997 and also taking Lydia's own baby to her car, 26 years later. These stories show the commitment and dedication many of our staff demonstrate day in and day out. We are rightly proud of our staff who show this level of commitment and dedication. The story has received a huge response online with 13,000 responses.

We also had four nominated staff attend the national service at Westminster Abbey in London. They were Monica Chigborogu, trainee clinical physiologist; Mike Tiller, scientist; Dr Matt Thomas, deputy medical director and Robert Sawdy, Consultant Obstetrician and Gynaecologist. Unfortunately, our volunteer representative was unable to attend at very short notice. All who attended said that the experience was very enjoyable. Dr. Matt Thomas had commented that it was lovely to be surrounded by people who care.

Lastly Local BBC news hosted their evening news segment at the Royal Bournemouth site where the work of UHD was highlighted through patient and staff interviews. The segment is available via our website: HERE.

1.2 NHS Long Term Workforce Plan

The first in depth and funded workforce plan for the NHS has been published by NHS England. The plan recognises that NHS staff are hardworking and the bedrock of the

NHS. It identifies that previously our workforce has not been planned in a co-ordinated way across the whole NHS. The plan models NHS workforce demand and supply over a 15-year period and details the actions to be taken to address identified shortfalls in addition to existing programmes. The plan includes three areas of focus: Train, Retain and Reform.

We will be reviewing the plan and working with the Integrated Care Board (ICB) on how this will be met locally.

1.3 Patient Safety Incident Response Framework (PSIRF)

The PSIRF has replaced the Serious Incident Framework (2015) and changes significantly the way in which the NHS responds to safety incidents for the purpose of learning and improving patient safety.

The change is being overseen by our Clinical Governance Group and currently a training needs analysis is being undertaken. Timescales are relatively short and we will need to give priority to the work to ensure the safety of our patients and support for our staff. It will be aligned with our Patient First work.

2 OUR OBJECTIVES FOR 2023-24

We now have agreed our seven objectives for 2023-24. The objectives identify to the public and particularly our staff what we wish to achieve. They will help to engage and empower our staff as we make changes to the way in which we work through our QI approach Patient First. The objectives will also be used within all appraisals ensuring that all staff know what their part is in delivering the objectives.

3 PERFORMANCE

There was a reduction in overall attendances to our Emergency Departments in June of approximately 50 per day, unfortunately our performance did not reflect this. As a Trust we reported 61.7% achievement against the four-hour safety standard against a plan to achieve 63%.

The Trust moved to a new Patient Administration System (PAS) called Agyle within our Emergency Departments (ED) in June at the Poole site, which impacted on performance as there had been some initial teething issues. The system was introduced at the Bournemouth site on 10 July, meaning that the Trust now has a single ED PAS across the Trust. The system will support more efficient patient management within the department and give a broader understanding why we breach the four-hour safety standard, helping us to make changes to see our patients sooner.

In June, Elective recovery improved across a range of specialties however industrial action and workforce challenges continue to impact on the Trust's ability to fully meet its planned procedures. Nevertheless, patients waiting for procedures over 78 weeks and 65 weeks reduced and the total number of patients on a referral to treatment

waiting list also fell.

In June we also continued to make progress on delivery of cancer improvements. Whilst the impact of the industrial action in April showed in the faster diagnostic standard performance in May, which was below the planned trajectory, improvement has been recorded in June and we have maintained performance above 70% throughout.

The number of patients on the over 62 day Patient Treatment List similarly increased to above 300 in May but recovery of the increased position has been achieved in June and July to date.

4 FINANCE

The Trust's financial position continues to be very challenging, exacerbated by further industrial action. At the end of the first quarter the Trust is reporting an adverse variance of £2.9m driven by the cost of industrial action, energy costs above the level budgeted due to inflationary pressures, and a requirement to open additional ward capacity. Positively however, June saw an improved position compared to April and May, following a reduction in the number of unfunded escalation beds required, a reduction in energy costs, and additional bank interest due to a higher than planned cash balance and increases in the Bank of England base rate. Further work is underway to identify efficiency opportunities to ensure the full year plan can be achieved.

5 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.

Phase 2: Strategy Development will be completed at the end of August 2023. Our annual corporate objectives for 2023/4 are now part of this year's appraisal process and have been shaped by our five strategic themes.

In September 2023 we will commence Phase 3: Strategy Deployment. This will involve a full cascade of UHD's strategic priorities through our care groups and corporate directorates. This 'golden thread' will ensure everyone is pulling in the same direction, as part of #TeamUHD.

In September 2023 we will run the first cohort of our new Patient First for Leaders programme to ensure all our senior leadership team and their directly reporting staff have the right improvement tools and coaching skills to support our frontline teams. Enrolment onto the modules has been really encouraging so far. We are also working on our roadmap for:

a) A further cascade to all managers and supervisors who have line management responsibilities for staff.

and

b) Team training for all our wards and departments to develop standard systems for

managing improvement across the organisation.

We continue our regular round of face-to- face briefings with staff, to encourage informal conversations about Patient First and confirm how teams can get involved in problem solving and continuous improvement. I continue to be encouraged by the feedback so far and the ideas we are sharing together at these events.

6 CARE QUALITY COMMISSION INSPECTIONS

The CQC undertook service inspections on 27 and 28 June of our outpatients departments (OPD) at Poole hospital and the outpatients assessment clinic situated in Beales. They also inspected the emergency departments (ED) at Poole hospital and Royal Bournemouth hospital. Interviews and focus groups were held with staff and information requests sent to the CQC as part of this process, which is still in progress. Initial high-level feedback has been provided to the Trust. There were positive findings related to team working and feedback from patients regarding their care. There were observations regarding some estates works, documentation and care within ED which is being addressed with executive support. OPD feedback was predominantly positive with some helpful observations regarding some of the estate.

UHD is also getting ready for the first CQC Well-led inspection following merger. The CQC team have supported postponing the initial planned date in July, given the impact of junior doctor and consultant industrial action, and this has been rescheduled for the 8 – 9 August 2023. It has been confirmed that NHSE will not be undertaking the financial governance review as part of the well led inspection, as the Trust is currently considered as low risk. It is however acknowledged that the Trust is in a challenging financial position this year.

7 WORKFORCE

A further round of industrial action by post-graduate doctors in training took place from 13 July until 18 July 2023. Consultant medical staff are due to take industrial action for the first time on the 20 and 21 July 2023. A Christmas day level of service is being planned.

In month sickness absence has risen slightly to 3.9% from 3.7% within May. However, the rolling 12-month sickness rate has again decreased and stands at 4.9%.

Significant recruitment activity has taken place and 25 Registered Nurse Degree Apprentices and seven Trainee Nurse Apprentices are due to commence work in September 2023.

7.1 Cultural Celebrations

On Friday 7 July, we held our first UHD Cultural Celebration. We danced, shared stories and came together to celebrate all of the wonderful cultures that make up #TeamUHD. The special cross-site event showcased how important it is to continue to educate ourselves about each other and our unique experiences.

7.2 See Me First

In 2022 the NHS Staff Survey results identified that black, Asian and minority ethnic staff experienced more inappropriate behaviours and had a less positive experience overall while working at UHD compared to white staff.

In response to those results we have officially launched “See ME First” a staff-led initiative to promote equality, diversity and inclusivity. It requires colleagues to challenge and work together towards ending racism and discrimination in the workplace. The aim is to make real change to our culture, creating a more inclusive, open, and non-judgemental work environment in which all staff are treated with dignity and respect. As part of the scheme, staff are asked to pledge to encourage colleagues to speak up and safely challenge discriminatory behaviour through appropriate channels. Staff who have made a pledge receive a See Me First badge to signify their support for the programme.

7.3 Anti-racism

Following the launch of See Me First it is timely to consider the publication of a commitment from the Board to be an anti-racist organisation. I would like to ask us at this time to agree the following:

> “As the Trust Board of University Hospitals Dorset, we affirm that the Trust is an open, non-judgemental and inclusive organisation that will not tolerate racism or discrimination. We celebrate the diversity of our staff and community. We will treat all our staff equitably, with dignity and respect, whatever their race, gender, religion, age, disability or sexual orientation."

This statement once approved will be placed on our website and shared with staff widely across the Trust and we will engage colleagues to consider what this means for them and what more we need to do to ensure we live this in all areas of our Trust..

7.4 Staff Travel

We are undertaking lots of work around staff travel:

- We will be offering bigger staff discounts for bus travel an announcement will be made shortly.
- Making space for patients and visitors in Poole multi-storey car park (by better use of the Stadium car park for staff). Letters to staff affected will be sent soon;
- Opening of the RBH bus bike hub;
- Incentives for car shares;
- Car parking permit costs will rise by 32-39p per week for most staff, and 50p for the highest paid staff – all of which is being re-invested into staff travel support.

If you’d like to help shape our travel plans, and be part of the two-way communication about how we can make travel to and from work better, would you want to be one of our travel champions? To find out more email travelwise@uhd.nhs.uk or Elliot Prescott

7.5 People Pulse Survey

The July People Pulse survey is now live and all I would ask all staff to complete the survey. I had been asked at a recent briefing why staff should complete the survey. I was so pleased to be able to answer that not only do the results allow us to benchmark ourselves against other Trusts but it also gives valuable insights into the morale of staff. I always ensure that I have seen the free-text comments staff are making about working at UHD.

The survey results also form part of our work to meet our newly agreed objectives to make UHD “a great place to work”. I would like to see the response rates rise to

thousands of our staff.

7.6 Staff Monthly Excellence Awards

The following staff were awarded gold pins for excellence and a certificate of thanks following nominations by staff, patients and volunteers:

- BEAT Clinical Educators: Stu Richardson, Maggie Chan, Giuseppe Dell'Avvocato and Deepthi Vijayan Kamala
- Portering Team - Poole
- Barn Theatres Delivery team: Andrew Ward, Steve Harris, Jacqueline Bardner, Sean Bartlett, Stuart Mondon, John Heppell, James Meachin, Kirsty Duncan, Jacqui Hayfield, Louise Campbell, Andrew Ward.
- Dementia and Delirium Support Worker: Tristan Saunders-Moses –
- Ward 2: Sister Amy and staff
- Likitha Lai, Radiology

8 OUR BUILDINGS

We held the official opening of the Barn Theatres, in Poole Hospital on 18 July. The new building is at the centre of our plans to create the major planned care hospital for our region. This will help to shorten waiting times, provide easier access to planned care and deliver better outcomes for patients. The ceremony was attended by key personnel from UHD with special guests Mrs Jacqueline Swift, Deputy Lord Lieutenant of Dorset, Deputy Mayor of Poole, Cllr Tony Trent and Deputy Mayoress, Mrs Anne Trent,

Mrs Julie Hills the first patient to be operated on in the Barn Theatres was accompanied by her husband Simon Hills

Due to a very strong team effort the project was completed on time and on budget. We look forward to the positive impact the facility will have in the future.

9 INTEGRATED CARE BOARD (ICB)

I attended the ICB meeting which took place on 4 May 2023. The approved minutes of the meeting are included in the reading room.

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 4 May 2023 at 10am
Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG
and via MS Team

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	John Beswick (JB) (virtual)	ICB Non-Executive Member (virtual)
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member
	Jonathon Carr-Brown (JCB)	ICB Non-Executive 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
	Patricia Miller (PM)	ICB Chief Executive
	Rob Morgan (RM)	ICB Chief Finance Officer
	Debbie Simmons (DSi)	ICB Chief Nursing Officer
	Kay Taylor (KT)	ICB Non-Executive Member
	Forbes Watson (FW)	GP Alliance Chair, Primary Care Partner Member
	Dan Worsley (DW)	ICB Non-Executive Member
Invited Participants Present:		
	Neil Bacon (NB) (virtual)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Cecilia Bufton (CB)	Integrated Care Partnership Chair
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Leesa Harwood (LH)	ICB Associate Non-Executive Member
	Matt Prosser (MP)	Chief Executive, Dorset Council
	Jon Sloper (JS)	Chief Executive, Help and Kindness
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Dean Spencer (DSp)	ICB Chief Operating Officer
In attendance:		
	Liz Beardsall (LBe) (minutes)	ICB Head of Corporate Governance
	Emma Elliott (EE) (virtual)	ICB Business Manager to the CEO
	Kirsty Hillier (for item ICBB23/088) (KH)	ICB Deputy Director of Communications and Engagement
Observing:		
	Rhiannon Beaumont-Wood (RBW)	ICB Non- Executive Member (starting 1 June 2023) (virtual)
Public:		
	One member of the public was present in the room.	

Apologies:		
	Philip Broadhead	Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East) (member)
	Sam Crowe	Director of Public Health Dorset (participant)
	Graham Farrant	Chief Executive, Bournemouth, Christchurch and Poole Council (participant)
	Andrew Rosser	Chief Finance Officer, SWASFT (participant)
	Manish Tayal	Interim Non-Executive Member (member)

ICBB23/074 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from: Philip Broadhead, Sam Crowe, Graham Farrant, Andrew Rosser and Manish Tayal.

ICBB23/075 Conflicts of Interest

There were no conflicts of interest declared in the business to be transacted on the agenda.

ICBB23/076 Minutes of the Part One Meeting held on 2 March 2023

The minutes of the Part One meeting held on 2 March 2023 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 2 March 2023 were approved.

ICBB23/077 Action Log

The action log was considered and approval was given for the removal of completed items. It was noted that all items were complete.

Resolved: the action log was received, updates noted and approval was given for the removal of completed actions.

ICBB23/078 Patient Story: Manni and Reuben Coe 'Brother do you love me'

The ICB Chief Nursing Officer introduced the patient story regarding the book which brothers Manni and Reuben Coe had written regarding Reuben's experience as an adult with learning difficulties. The brothers were unable to attend in person, but had been interviewed via Teams, a recording of which was presented to the Board. It was noted that the names of care establishments had been changed in the book and video.

The brothers told the story of Reuben's experience in care and the impact on his wellbeing and mental health, including the isolation he faced especially during the pandemic, the difference between 'looking after' and 'caring for' someone, the lack of communication and family involvement in decisions regarding Reuben's care, and the role of pride in Reuben's recovery. Reuben's mission for the book was "to make everyone in the world emotional" and the brothers aimed to give hope to others in similar situations.

The Board discussed the powerful video, noting the positive outcome for Reuben who was now in an assisted living flat with support from People First Dorset. Much had been done in social care to address the lessons in the video including the challenges faced during Covid, the lack of suitable placements, and social care recruitment and retention. Isolation remained a challenge for those in social care, and the role of the voluntary and community sector in supporting this was discussed.

The Board also discussed the role of the ICB in providing environments where the workforce are supported to provide the best care, the need to support people to navigate their way through care pathways, the importance of communication with families and service users to better understand their needs, and the need to challenge stereotypical views regarding those with learning difficulties.

It was requested that People First Dorset be invited to talk to the ICB Board about their work.

ACTION: LB

ICBB23/079 Chief Executive Officer's Report

The ICB Chief Executive Officer (CEO) introduced the previously circulated CEO's Report covering national and local updates, and latest news from the health provider and local authority partners, which was taken as read. Highlights included:

- The Hewitt Review, noting the government response to recommendations was awaited
- Industrial Action, noting that a significant number of unions had accepted the proposed pay deal, but negotiations continued.
- The NHS Dorset Operational Plan had been submitted, noting that there remained some challenges in delivery, especially in relation to finance.
- NHS Staff Survey 2022 had been published on 9 March, with NHS Dorset coming second in the national league table for ICBs and good results for NHS partners. It had previously been agreed that the Integrated Care System would move forward with a single approach to equality, diversity and inclusion and work on this would commence shortly.
- Portland Asylum Seeker Accommodation, noting conversations were underway around funding and health service provision.
- Work was underway on the Integrated Care System Operating Model
- Following work on the discharge process there had been a reduction in No Criteria to Reside patients. Partners were thanked for their hard work in achieving this reduction.

The Board discussed how the Joint Five Year Forward Plan had been developed with partners, including through the ICB Board. There would be further engagement with the Health and Wellbeing Board Chairs, and it would be reviewed again by the ICB Board prior to submission. Delivery of the plan would be monitored by the Integrated Care Partnership.

The role of Place regarding investment in out-of-hospital services and the work that would be led by the ICB Chief Finance Officer on 'one public estate' were noted.

The Chair thanked the CEO and partners for their contributions to the report, and thanked the ICB leadership for their role in the positive Staff Survey outcomes for the organisation.

Resolved: the Board noted the Chief Executive Officer's Report.

<u>Items for Decision</u>

ICBB23/080 Business Conduct

(a) Standards of Business Conduct Policy

The Head of Corporate Governance introduced the previously circulated ICB Standards of Business Conduct (incorporating Conflicts of Interest) Policy. The revised policy was presented to the Board for approval, following approval and recommendation to the Board by the Risk and Audit Committee. The policy had been updated into the new ICB policy

format and had been reviewed in light of NHS guidance and best practice. There were minor changes to the policy content and these were detailed in the report.

The Board approved the policy.

Resolved: the Board approved the Standards of Business Conduct Policy.

(b) Annual Review of Declarations of Interest, Gifts, Hospitality and Sponsorship
The Head of Corporate Governance introduced the previously circulated Annual Review of Declaration of Interest, Gifts, Hospitality and Sponsorship report, for the Board to note following presentation at the Risk and Audit Committee. Only 13 out of 600 declarations remained outstanding at year end. No declarations of concern had been received during the year and internal audit had provided a substantial opinion of the organisation's process. Revised training for ICBs was expected shortly from NHS England to replace the previously stood-down training modules for Clinical Commissioning Groups. This training would be rolled out to staff once available.

Resolved: the Board noted the Annual Review of Declarations of Interest, Gifts, Hospitality and Sponsorship Report.

Items for Noting/Assurance/Discussion

ICBB23/081 Committee Escalation Reports
The Board Committee Chairs presented the Committee Escalation Reports from the April meeting. All issues discussed were included in the previously circulated reports and key issues included:

- Clinical Commissioning Committee – interconnection, tackling demand and the prevention agenda.
- Finance and Performance Committee – the committee's discussion about 'what does a good committee look like', Personal Healthcare Commissioning, and thanks to the teams for the operational and financial performance.
- People and Culture Committee – staff survey results, and the work required relating to equality, diversity and inclusion.
- Primary Care Commissioning Committee – the general practice model and sustainability, and pharmacy, optometry and dental services delegation.
- Quality and Safety Committee – medicines optimisation and safeguarding governance architecture. The committee escalated to the Board the increase in c-difficile infections, noting that this was in line with a national increase and a tool had been developed to better understand what was driving the increase.
- Risk and Audit Committee – key management judgements on year end, annual plans for internal and external audit and the Mental Health Investment Scheme audit which had been completed and would be discussed further in the Part Two Board meeting.

The Board thanked the corporate governance team for the quality of the escalation reports, and for their support of the Board Committees.

Resolved: the Board noted the Committee Escalation Reports.

ICBB23/082 Quality Report
The ICB Chief Nursing Officer introduced the previously circulated Quality Report. Highlights included:

- The Care Quality Commission (CQC) had published its findings on services at University Hospitals Dorset. There had been detailed discussion of the report at Quality and Safety Committee. All immediate actions were complete and a remedial

action plan had been sent to CQC. Pilots under the new CQC framework would start shortly, with inspections under the framework commencing in September.

- In relation to patient safety, the report detailed the outcomes of the Annual Patient Safety Audit and provided an overview of the national Learning from Patient Safety Events (LFPSE) online recording service and the local pilot which was underway.
- The use of the 'my mhealth' app and the positive impact this was having for users.

In relation to adverse events, the Board asked the Chief Nursing Officer if there were any identifiable reasons for the increase in 'care delivery' related incidents. Also it was queried why Royal Bournemouth Hospital was not listed in the Incidents by Site table (p101/210).

Post meeting note: in the Part Two Board meeting the Chief Nursing Officer provided updates on the two questions above. Firstly, 'care delivery' as a cause 1 had been increasing over the last 2-3 years, and was consistent with regional trends. There had been no change to how these incidents are logged, however there had been a focus on potential harm from patient delays as part of care delivery and therefore an increased awareness of reporting. Secondly, the STEIS system from which the report was pulled does not recognise University Hospitals Dorset as an entity so all incidents for that trust are logged under Poole Hospital but the figure includes Bournemouth data.

Resolved: the Board noted the Quality Report.

ICBB23/083 Performance Report

The ICB Chief Operating Officer introduced the previously circulated Performance Report, which demonstrated continual improvement in almost all areas. Highlights, as detailed in the report, included the progress being made on reducing long waits, meeting the 28 day cancer standard, diagnostic performance, the reduction in No Criteria to Reside patients and the positive impact of the Multi Agency Discharge Events (MADE).

The Board discussed MADE events for mental health service providers, the rise in 52 week waits and how this was being monitored, the need to sustain improvements especially in relation to discharges and how this would be underpinned by prevention work and managing demands, the inequity of dermatology provision in Dorset, and healthcare worker vaccination rates.

The Board welcomed inclusion in the report of measures relating to primary care but requested additional narrative to better understand what the data was showing. It was noted that this would be addressed once the strategic objectives were in place. The need for the introduction of reporting on health inequalities and prevention was also discussed, and this would form part of the discussion on the committee structure at the Board Development Session in June.

Resolved: the Board noted the Performance Report.

ICBB23/084 Dorset ICS Finance Update 2022/23

The ICB Chief Finance Officer introduced the previously circulated Dorset ICS Finance Update for 2022/23 covering the financial position of both the ICB and Integrated Care System NHS providers for the financial year ending 31 March 2023, in addition to an update on the Operational Plan.

The ICS reported a pre-audit surplus of £0.4m for 2022/23 against a breakeven plan; with surplus positions solely attributable to NHS providers and a balanced position reported by NHS Dorset ICB.

The ICB reported a breakeven position against plans for the financial year 2022/23. Several risks had needed to be managed in order to achieve a breakeven position including above contract activity levels with Independent Sector Providers (ISPs), staffing, prescribing and Personal Health Commissioning (PHC).

There was a commitment to have a medium term financial plan submitted by the end of September 2023.

The Board discussed in detail the depiction of ICB spend as cogs (p147/210 in the meeting pack). There was interest in mapping this information against in year reporting and patient volumes. It was noted that some sectors were more expensive than others, and therefore it was important to understand the right place for people to be managed mapped against where they were being managed. This would then demonstrate where resources should be focused and the most efficient use of these resources.

The challenges relating to recurrent/non-recurrent funding and agency spend were discussed. The need for messages relating to a 'value' culture was noted. It was anticipated that this would form part of the Dorset Value Improvement Programme work, which was currently in development.

Resolved: the Board noted the Finance Report.

ICBB23/085 Hewitt Review

The ICB Chief Executive Officer introduced the previously circulated Hewitt Report. The Hewitt Review, reported on 4 April 2023 on the findings of the independent review to consider how the oversight and governance of Integrated Care Systems in England could best support them to succeed. The review encompassed five workstreams, and aimed to produce short term actions around operational challenges and long term priorities for Integrated Care Systems for the next 10-15 years.

The key principle resulting from the review was a reduction in the number of national indicators, which would be grounded in things important to public, with the remainder of the agenda being set locally. This would allow Integrated Care Systems more freedom and space to deliver, within an accountability framework. There was also a recommendation for an increase in funding for prevention.

The Board welcomed the sentiments of the report, especially regarding increased funding for prevention.

The Chief Executive Officer suggested that there was a need for a change in the narrative to explain the movement towards creating healthier communities, and the public's role in supporting this. An approach would be to connect the launch of the Five Year Forward Plan with the NHS's 75th Birthday and to link the narrative to this.

Resolved: the Board noted the Hewitt Review.

ICBB23/086 Urgent and Emergency Care Operations and Recovery Delivery Plan

The ICB Chief Operating Officer presented the previously circulated Urgent and Emergency Care (UEC) Operations and Recovery Delivery Plan which was discussed in detail at the Finance and Performance Committee in April. The plan aligned with the national recovery

plan and provided a clear indication of the system commitment to drive change and deliver in 2023/24.

The plan was built on the successful approach adopted over winter, focusing on covering the today position, the weekly position, and the longer-term commissioning and strategic position.

Delivery of the plan would be monitored through the Performance Report.

Resolved: the Board noted the Urgent and Emergency Care Operations and Recovery Delivery Plan.

ICBB23/087 Infection Prevention and Control Annual Report

The ICB Chief Nursing Officer introduced the previously circulated Infection Prevention and Control Annual report, which provided assurance that the infection prevention and control regime for NHS Dorset remained compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (updated 2022). Highlights included the key role of the Dorset Integrated Care System Infection Prevention and Control meetings and the proactive work around hydration. It was noted that the increase in c-difficile rates had been escalated to the Board (ICBB23/081).

It was noted that the Quality and Safety Committee had taken significant assurance from the report and commended the Infection Prevention and Control Lead Specialist Nurse.

Resolved: the Board noted the Infection Prevention and Control Annual Report.

ICBB23/088 Integrated Care System Brand and Identity

The ICB Deputy Director of Communications and Engagement joined the meeting and introduced the previously circulated Integrated Care System Brand and Identity update, which laid out the approach being taken to develop a refreshed brand and identity for the Dorset Integrated Care System and Integrated Care Partnership.

Stakeholder engagement work on the concept was ongoing, and the final version would be taken to the Integrated Care Partnership for approval. Work to date indicated there was strong identification with 'Our Dorset' and there was little appetite to move away from this. It had been suggested that 'One Dorset' currently formed part of Bournemouth, Christchurch and Poole Council's branding, although this was to be confirmed, and therefore should not be used for the Integrated Care System.

The Board discussed the need for a strapline, noting that this should be broader than 'health and care' to reflect all partners in the Integrated Care System.

The Board thanked the team for their work on the Integrated Care System brand.

Resolved: the Board noted the Integrated Care System Brand and Identity Report.

Items for Consent

The following items were taken without discussion.

ICBB23/089 Integrated Care System People Plan

It was noted that this item had come to the Board as a consent item as it had been discussed in detail at the Board Development Session and by the People and Culture Committee. The ICB Chief People Officer reassured the non-executives that the measures for success for the plan would not be solely based on quantitative or 'hard' measures. The

delivery plan would include qualitative and quantitative measures, and delivery would be monitored by the People and Culture Committee.

Resolved: the Board noted the System People Plan.

ICBB23/090 Questions from the Public

No questions were received in advance of the meeting from members of the public.

ICBB23/091 Any Other Business

It was noted that representatives from both local authorities would be unable to attend the next Board meeting as they would be attending the Local Government Association Conference. The Chair offered to look into this outside the meeting and noted that the timing of the conference would be taken into account when planning the meeting dates for next year.

ACTION: JDT/LB

ICBB23/092 Key Messages from the Meeting

The Chair summarised the key messages from the meeting as:

- The learning from the powerful Reuben and Manni Coe video, especially in relation to isolation of those in social care, supporting staff to provide the best care and family involvement in treatment decisions.
- The increasingly central role of prevention and health inequalities, and how this would link to the development of system performance data, the depiction of trajectories around prevention and to the functions of the ICB's Board Committee.
- Thanks to all the teams involved in delivering the year end performance and finance positions, especially in reducing the number of No Criteria to Reside patients and the positive impact this has for patients and their families.
- Support for the 'Our Dorset' branding for the Integrated Care System as inclusive and outward facing.

ICBB23/093 Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 6 July 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

ICBB23/094 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.

Signed by: 

Jenni Douglas-Todd, ICB Chair

Date: 06/07/2023

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 7.1

Subject:	Board Assurance Framework (BAF)
Prepared by:	Jo Sims, Catherine Hurst
Presented by:	Richard Renaut, Mark Mould, Pete Papworth

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	See BAF plan on a page attached for each BAF and risk register links
Purpose of paper:	Assurance
Executive Summary:	The Board have agreed seven trust objectives for 2023/24, which fit within our strategic themes and progress to our "True North." Assessing the risks and controls to achieving these then informs the content of our Board Assurance Framework (BAF). Nine specific BAF risks have been identified. The "BAF risk on a page" format set these out and are included in the attached. These link to our risk register entries, and the "ref" reference numbers, and the risk scoring of the likelihood and consequence of the main risk are listed. The Board committee tasked with the lead role is identified. The nine BAFs are allocated as follows: **Finance & Performance:** No more than 65 weeks wait; 4 hour emergency standard; sustainable finances; integration then reconfiguration **People & Culture:** Great place to work; Patient First programme **Quality**: Mortality; Moderate/Severe harms; Patient feedback

Background:	The BAF updated process is developmental and will continue to evolve. Additional BAF risks can also be added, especially for strategic and system risks. The risk register remains active and has both frontline identified risks, and strategy/Board identified risks.
Key Recommendations:	The Boards is asked to review the updated BAF, the controls, and gaps in controls and assurance. Suggestions on improvements to both the content and presentation are invited as part of our always improving approach. The Board is asked to scrutinize the progress being made and the forward looking plans to move towards the target level of risk for each BAF.
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**
Drafts have been shared at Committees and the February and June Board Development sessions.	Various	The agreement of the strategic themes, annual objectives and Annual Operating Plan, has now allowed the BAF to be updated, using the agreed format.

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

Board Assurance Framework - Plan on a Page 2023/24

NHS
University Hospitals Dorset
NHS Foundation Trust

Team UHD
Our 7 objectives
2023-24

- See our patients sooner
- Be a great place to work
- Improve patient experience, listen and act
- Save lives, improve patient safety
- Use every NHS pound wisely
- Start on our 'Patient First' journey
- Work as one team, fit for future changes

Themes	Vision	Objectives 2023/4 - Break through levels of improvement
Population health and system working (FPC)	To meet the patient national constitutional standards for Planned and Emergency care, reducing inequalities in outcome and access and improving productivity and value.	**See our patients sooner** Over 76% of patients treated within the 4 hours safety standard; To have no patients waiting in excess of 65 weeks on an RTT pathway.
Our people (PCC)	To be a great place to work attracting and retaining the best talent. NHS Staff Survey results in top 20% within three years.	**Be a great place to work** Improve our NHS Staff Survey Results for: "I would recommend my organisation as a great place to work" > 62%; Staff Engagement Score >7/10, both by March 2024
Patient experience (QC)	All patients at UHD receive quality care, which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.	**Improve patient experience, listen and act** A 5% improvement in employees who see patient care as a top priority for UHD; to increase the FFT (Friends & Family Test) and HYS (Have Your Say) feedback rates by 30%
Quality (Outcome and safety) (QC)	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios - SMR) and Patient Safety Incidents (PSIs)	**Save lives, improve patient safety** 1. HSMR <100, 2. Reduce PSI by 5%, 3. Improve staff survey safety culture questions by 5%
Sustainable services (FPC)	To maximise value for money enabling further investment in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.	**Use every NHS pound wisely** To develop and fully deliver recurrent financial efficiencies of £33m (4.4%) consistent with the 2023/24 budgeted Cost Improvement Programme target.
Patient First Programme (PCC)	To successfully and sustainably adopt the Patient First approach	**Start on our 'Patient First' journey** To deliver year one, of transitioning to the Patient First programme.
One Team: Patient ready reconfiguration (FPC)	To integrate teams and services, then to reconfigure, and so create the planned and emergency hospitals.	**Work as one team, fit for future changes** For every service to agreed their plan to integrate and start delivery to be "move in" and "patient ready" for the future.

TITLE	BAF Risk 1 - Risk of not meeting the patient national constitutional standards for Planned Care (No patients waiting more than 65 weeks on RTT pathway by March 2024)													
Ref	1074	Timely access to Planned Care - If we do not deliver on effective improvement plans to meet access standards then we will create patient safety risk, widen inequalities and be subject to regulatory action.												
Strategic Priority	Population and System Working	Risk Score 2023/24												
Review Date	20/6/23	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Operating Officer	20	20	20										6
Lead Committee	Finance & Performance Committee													
Risk Rating		Likelihood			5	Consequence			4	Gaps in Controls			Moderate	

Context	Controls	Gaps in Controls or Assurances
The NHS commits to provide convenient, easy access to services within the waiting times set out in the handbook to the NHS Constitution. NHSE 2023/24 operational planning priorities for planned (elective) care require Trusts to: • Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) • Deliver the system- specific activity targets UHD has set the following strategic target and stretch target for 2023/24: • To have no patients waiting in excess of 65 weeks on an RTT pathway to be seen and treated by March 2024 • Stretch Target: To have 0 non admitted patients above 52 weeks by Mar 2024	• Annual Operational plans in place and recovery planning trajectories for planned and cancer care. • Planned Care Improvement programme established. 5 elements: Outpatients, data optimisation, theatres, Diagnostics and Cancer. • Trust Access policy and SOPs for waiting list management. • Validation (clinical, admin and technical) competency framework • Clinical prioritisation/risk stratification of waiting lists following national guidelines. • Weekly Patient Treatment List (PTL) meetings with each speciality (RTT/cancer) • Appointed Clinical Leads for key performance areas and GP Clinical Lead • Planned Care Improvement Group and Operational Delivery Group monitor delivery against trajectories and review controls and mitigations monthly. • Care group/Directorate monthly Directorate performance meetings reporting into Care Group Board and Quarterly Care Group Performance reviews with Execs. • Governance and controls in place to access ERF to support recovery. • RTT staff training programme. • Single PAS and single waiting lists to enable equitable and timely access. • Productivity and efficiency programmes for outpatients and theatres in place • IPR and BI performance tracking tools against performance and activity targets, with deep dive analysis of data where required. • Harm review process in place for patients waiting beyond indicated dates.	Moderate gaps: *Capacity across the organisation to respond to the issues and take necessary action, including change management capacity.* *Key service/people gaps - Continued reliance on temporary staffing and independent sector providers to provide necessary capacity.* *Validation resources reduced post end of SW validation pilot.* *Professional development and capacity of medical and operational leaders to deliver transformation to support performance standards.* *Equipment gaps e.g. Nickel-free joint implants (national shortage)* *Reliance on non-recurrent funding streams including ERF.* *UEC growth, MRTL numbers and industrial action could expose the Trust to demand exceeding capacity.* *IT and BI capacity to deliver on digital and data improvement actions.*

PROGRESS

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
[16/06/2023] Improvement seen across a range of metrics including Cancer FDS and 62d performance and 104 week waits eliminated. A3 summary for elective care as part of the Patient First programme are in development. • Continue to deliver priority actions within the PCI Programme • Embed utilisation of BI tools at service level • Create visibility of level of activity delivered against plan/ forward view • Develop approaches to High Intensity Theatre sessions • Continue delivery against the theatres/outpatients value programmes • Implement enhanced bank rate scheme for theatres, prioritising Orthopaedics and Colorectal Surgery • Progress delivery of digital transformation for outpatients and MyPreop	Industrial action in June and potential for further IA related to Consultants, Radiographers and Nurses following ballots in June 2023. Current national equipment shortages e.g. Nickel-free joint implants. Bed occupancy remains high and continues at times to impact on elective capacity. Cancer demand may increase due to national awareness campaigns e.g. melanoma campaign Maintaining service provision at 109% rate during summer holiday period	5 transforming elective care programmes established to deliver improvements in elective care performance: Outpatients, Cancer, data and validation optimisation, diagnostics and theatres. Monitoring group – Operational Delivery Group

Record here any recent risk score changes and why

TITLE	BAF RISK 2: Risk of not meeting the patient national constitutional standards for Emergency Care												
Ref	1460	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation.											
Strategic Priority	Population and System Working	Risk Score 2023/24											
Review Date	30/6/23	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Operating Officer	20	20	20										6
Lead Committee	FPC													
Risk Rating		Likelihood	5	Consequence	4	Gaps in Controls			Moderate					

Context – Free text	Controls	Gaps in Controls or Assurances
UHD was one of 14 national pilot sites for a revised suite of Clinically Reviewed Emergency Care metrics from spring 2019. The Delivery plan for Recovering Urgent and Emergency Care Services published January 2023 by NHSE set out the requirement for "*Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25*". UHD received a contract change notice terminating the pilot metrics and confirming the requirement to return to 4-hour reporting from mid May 2023. UHD Trajectory developed to achieve 76% against the 4-hour standard.	• National Standards • Daily Performance reporting against metrics • Daily operational meetings to support UEC flow and challenges 7 days a week • Efficient patient pathways and streaming process to SDEC's and UTC • Timed Admissions Process evoked (Push model) • Compliance with Trust and ED Escalation plans/SOPs • Fully recruited to template • IPS optimisation • Diagnostic delays standards (blood tests/x-ray and CT) • 'Surge Management' criteria and plan • Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy. • 4 hour performance metrics linked to ED escalation • Escalation email/text process along with ED shift report template improvement • MIU and UTC Type 3 ED attendances being reported	• Gaps in assurance for sustainable delivery of 4-hour standard. • SDEC pathways not in place 12 hours a day 7 days a week across all services. • Revised Escalation processes (ED and wider organisation) not yet embedded. • Gaps in recruitment remain a key challenge. • Capacity across the organisation to respond to the issues and take necessary action, including change management capacity, noting deployment of new ED IT System in June 2023 requiring priority. • UEC growth, MRTL numbers and industrial action could expose the Trust to reduced patient flow and performance • Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards

PROGRESS

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
• (14/6/23) Achieved May 2023 Trajectory – performance 65.9% against a trajectory of 63%. • New IT system in place in Poole ED (AGYLE). Benefits in terms of patient pathways, reduced clinician time on computer and enhanced accuracy and range of reporting (acute and retrospective) • Weekly performance meetings in place with a focus on areas identified in thematic Root Cause Analysis. • Block booking of agency activity to reduce spend and improve staffing levels to better facilitate performance against trajectory. • Work on system flow progressing with improvement in performance, particularly non admitted flow since April 1st. Breach analysis in place daily with weekly thematic analysis and monitored via wider system 4-hour group.	UHD reporting to the National Monthly Trust Situation Reports (MsitAE) data collection will commence based on June data. Thematic RCA analysis attributes drops in performance overnight and at weekends to: • Reduced SDEC availability • Reduced senior decision makers in ED. Type 3 data from MIU and UTC remains a manual process.	• Continue to develop ECDS feed for reporting. • Surgical SDEC now 7 days (May 2023). Medical plans for weekend service from November 2023. • ED medical staff template funded in budget setting 23/24 – recruiting, ongoing gaps in middle grade tier. • Work with Dorset Health Care to deliver automated reporting • Governance through daily hot debrief, with actions tracked through the ED performance meeting feeding through to Work Stream 1 of the Hospital Flow improvement programme/OPG

TITLE	BAF Risk 3 – Risk of not significantly improving staff experience and retention over the next 3 years (and not being in the NHS staff survey results top 20% of comparator trusts).														
Ref	1493	Absence, Burnout and PTSD													
Associated significant risks	1492 1811	Resourcing Pressures – Staffing (12) Staff Vacancies and skill mix deficit – Theatres (12)													
Review Date	30/6/23		Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CPO	1493	12	12	12										4
Lead Committee	PCC														
Risk Rating		Likelihood	3	Consequence	4	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The NHS relies on its workforce to deliver patient centred care and services. There is evidence that staff working within the NHS are tired, feeling burnt out and also demoralised by national pay concerns which has led to industrial action across the NHS and has further impacted on staff morale, satisfaction and retention. UHD also has a major programme which requires some staff to move sites. Risk 1492 – vacancy rates have fallen across the organisation and the joining rate has been higher than turnover rate for 12 months many staff are not feeling the benefit of this in their areas. There is a significant focus on reducing vacancies, improving rostering and staff planning/utilisation, and eliminating high cost agency. Staff are our biggest asset and key to the success of our services and organisation and in achieving our aim of being a great place to work. Risk 1811 theatres – recruitment on going.	Health and wellbeing service standards, policies and procedures Access to proactive and preventative services (performance standards) Covid risk assessments Accessible ICS resource Staff survey (local and national) action plans Return to work and Annual Leave procedures Flexible working policy Delivery plan (aligned to national drivers). Staff sickness absence policy Recruitment and retention policy C&C well led KLOE Staff survey standards	Moderate gaps Development of the recruitment and retention policy, better exit information that is reviewed locally and triangulated with other data. Medical staffing processes and rostering ongoing. Data cleansing process – due to complete September and making steady progress with ward template review process continuing. Workforce dashboard in development
PROGRESS		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
Risk 1493 reviewed at WODG 17/5/23. Comparison of the levels of sickness now vs. previously to be undertaken prior to any decision around downgrading the risk – further review at the PCC in August. New actions added to the action plan. Risk description updated to remove the reference to Covid. Sickness absence levels reduced including short and long term. UHD received a highly commended for our Health and Wellbeing support in April 2023 in the Making a Difference awards. Progress with rostering in particular post graduate doctors in training. Strong staff networks support staff engagement Risk 1811 – Vacancy reduced PH no reg vacancies. 6.55 WTE un reg RBH, 5.78 WTE Band 6, 5.17 WTE Band 5, 15 WTE band 2/3 HCA recruitment open day in June with positive applications being processed.	Attracting recruiting and retaining staff who feel supported and optimistic about the changes in buildings, services and sites. Managing the scale of the changes including staff consultations that arise as a result. Pressure on HR operational staff in needed to support organisational change consultations.	The roll-out of sickness absence training for leaders across the organisation by August 2023. Demonstrating the return on investment for health and well being support and reviewing regularly the services provided and communicating these effectively

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

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

PROGRESS		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
1. Initial scoping of the patient experience strategy 2. Implementation of the roll out of Have Your Say Survey across all teams and directorates/care groups 3. Increasing number of different methods to undertaking FFT 4. Increase volunteers wishing to gather patient feedback 5. Introduction of UHD text message service for FFY/HYS 6. QR Code for FFY on leaflets Building and capturing data / dashboard with BI Team	1.Volume of Feedback being received is low compared to number of contacts with patients. 2. Teams do not all feel empowered or have the right skills to make QI changes 3.QI projects not always been directed based on patient experience insights. 4. No single platform currently for all patient experience metrics	1. Development of the SMS FFT and HYS 2/3. A3 training to be rolled out across specific services from Sept 23 4. BI team working with patient experience/quality governance team to develop metrics 5. Developing quality boards and the development of ward platform to test.

	5. Development of ward level data available and the awareness among colleagues.	

TITLE	BAF Risk 5 – Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next 3 years													
Ref	1922	If the Trust does not fully implement and embed an effective Trust wide learning from deaths process, then there is a risk that patient safety and patient care will be sub-optimal increasing the risk of avoidable deaths and an above expected HSMR.												
Strategic Priority	Quality	Risk Score												
Review Date	30/6/23	New	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CMO	L=2 S=5 RR=10	10	10	10										
Lead Committee	QC														
Risk Rating	10	Likelihood	2	Consequence	5	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
HSMR has been steady rising over the last 3 years There is variation across our sites	NHS I Implementing the Learning from Deaths framework: key requirements for trust boards NQB National Guidance on Learning from Deaths for Trusts Care Quality Commission report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England UHD Learning from Deaths Policy UHD Medical Examiners Policy Mortality Surveillance Group ToR Learning Disabilities Mortality Review (LeDeR) programme, RCP National Early Warning Score (NEWS) 2 NICE NG51 Sepsis: recognition, diagnosis and early management CG50 Acutely ill adults in hospital: recognising and responding to deterioration HSMR reporting to MSG and Trust Board Integrated Performance Reporting (HSMR and SHMI) LERN policy and toolkit	Audit of M&M meetings (2022/23) identified inconsistent approach to mortality governance across UHD No current data available from eLearning from deaths system Compliance with mortality case note reviews not currently linked to consultant appraisal No audit process or data for NG51 or NG50 Compliance data available from eOBs but no current systematic review of data Gaps in data capture via Datix. Datix is unable to produce figures by theme e.g., incidents relating to managing the deteriorating patient or sepsis are not available. Ultimately a new software system will be needed in order to report in a way that supports A3 thinking.

PROGRESS		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
New UHD Mortality lead appointed May 2023 MSG ToR and membership being reviewed Mortality dashboard in production New HSMR reporting included in June IPR	eLearning from deaths process rolled out across UHD (but not currently embedded) Inconsistent approach to mortality governance across UHD	

TITLE	BAF Risk 6 – Risk of not reducing moderate/severe harm patient safety events through development of an outstanding learning culture													
Ref	1923	There is a risk that implementation of the new Learning from Patient safety Events (LFPSE) system will have a significant negative impact on reporting numbers with staff reporting less near miss and minor harm events due to the data burden for reporting. This will result in an increase in the % of moderate and severe harm events.												
Strategic Priority	Quality	Risk Score												
Review Date	30/6/23	new	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CMO	L=4 S=2 RR=8	8	8	8										
Lead Committee	QC														
Risk Rating	8	Likelihood	4	Consequence	2	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The definitions for reportable patient safety incidents will change with the introduction of LFPSE. Reportable incidents will not include external incidents, IG incidents, medical device incidents that do not result in patient harm, infection control breaches that do not result in patient harm, medication incidents that do not result in patient harm e.g., incorrect storage, incorrect CD counts etc. Decreasing the overall number of typically near miss or no harm events will impact on the Trust reporting profile. The change in the national definitions of levels of harm will also impact on baseline figures.	Patient Safety Incident Response Framework Serious Incident Framework National Patient Safety Strategy LERN Policy Datix National Reporting and Learning System CQC KLOE Safe National Staff Survey UHD Risk management strategy (and Governance structure) Just Culture principles (ICB and UHD HR policies) NHS England Policy guidance on recording patient safety events and levels of harm (April 23) NRLS data – Trust and National	Gaps in data capture via Datix. Datix is unable to produce figures by theme e.g., incidents relating to managing the deteriorating patient or sepsis are not available. Ultimately a new software system will be needed to report in a way that supports A3 thinking. NRLS data will not be available after Sept 23 and no alternative national benchmark date will be able after this date. Data uploaded to LFPSE will be unvalidated when sent. Currently there is no information available on how Trust will be able to amend any incorrect records sent. I.e. staff can code incidents as moderate, severe harm without internal checks or validation.

PROGRESS		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
Datix dashboards for baseline	Lack of resources to implement the training and patient safety incident investigation requirements of PSIRF (Patient Safety Investigation Response Framework) Lack of time and resource to support implementation of LFPSE (Learning from Patient Safety Events)	

	Risk that implementation of LFPSE will impact on reporting culture across UHD as time to complete a LERN report will significantly increase. The additional mandatory questions required under LFPSE add at least 10 mins onto the time currently taken to report a LERN Risk that implementation of PSIRF will change the current definitions of a patient safety incident and the levels of harm. Impact that baseline will change, and any reduction will not therefore be realised.	

TITLE	BAF Risk 7 – Risk of not returning to recurrent financial surplus from 2026/27														
Ref	1595	Medium Term Financial Sustainability													
Strategic Priority	Sustainable services	Risk Score													
Review Date	30/6/23		Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CFO	1881	16	16	16										6
Lead Committee	FPC														
Risk Rating		Likelihood	4	Consequence	4	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The Trust has set a balanced revenue budget for 2023/24, which if delivered in full recurrently would leave a recurrent underlying deficit of £33m. However, the Trusts operational revenue budget for the year contains considerable financial risk, including a material shortfall in recurrent cost improvement savings plans. A range of mitigations have been identified and budgets continue to be actively managed to safeguard the financial performance of the Trust. At the end of Month 2, the Trust is reporting an adverse variance of £2.4m.	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders • Dedicated financial support in place including additional variance analysis and reporting • Scheme of delegation, Standing Financial Instructions, Financial management accountability framework and other financial policies and procedures • Monthly reporting to TMB, FPC and Board highlighting and mitigating actions • Care group and Corporate directorate quarterly performance reviews.	• Weaknesses in temporary staffing controls, *Mitigation: External review of TSO commissioned to inform improvement plan (Led = CPO)* • Alignment of approved nursing templates, e-roster templates and budgeted establishment. *Mitigation; Full safe staffing review including realignment of approved templates, rosters and budgets underway (led =CNO)* • Incomplete medical job plans and inconsistent premium medical rates. *Mitigation: refreshed job planning policy, use of electronic systems, review of premium rates (Lead=CMO)* • Inconsistent approach to the opening of unfunded escalation capacity. *Mitigation: New SOP to inform consistent escalation process (*Lead = COO)

PROGRESS

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

TITLE	BAF Risk 8 – Risk of not successfully and sustainably adopting the patient first approach across UHD														
Ref	1924	Risk that benefits of transformation, improvement and innovation are not realised													
Strategic Priority	Patient First Programme	Risk Score													
Review Date	30/6/23	new	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CEO	2992	9	9	9										6
Lead Committee	PCC														
Risk Rating		Likelihood	3	Consequence	3	Gaps in Controls	Moderate								

Context	Controls	Gaps in Controls or Assurances
Trust has made good progress in delivery of early phases of programme: **Phase 1:** Organisational Readiness Assessment Complete [Jan 23] **Phase 2:** Strategy Development On Track [July 23] **Phase 3:** Strategy Deployment Underway **Phase 4:** Organisational Improvement System In Preparation **Phase 5:** Leadership Behaviours and Development Underway **Phase 6:** Governance To be confirmed	PID (to ensure clarity on the scope of the programme) Programme pillars Steering board ToR Patient First methodology A3 thinking methodology Corporate objectives and Annual plan	Moderate gaps in controls A full benefits realisation plan is required to align directly with strategic themes and corporate projects following completion of Phase 2

PROGRESS		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
Programme team established to include current QI and OD resource and skillset. Significant work to establish the programme, refresh of strategy – development of strategic themes including analysis of current state plus alignment of current work programmes Executive Leads assigned for key programme pillars UHD senior leadership team workshops (circa 40 staff) trained in A3 strategic problem solving [June 23] Our first phase of Patient First for Leaders [Modules 1-4] curriculum is in design and will commence in September 2023, involving circa 200 senior leaders and Executives. Invites to go out 23/6/23 Our first cohort of the senior medical leadership course [2 days] will take place in July 2023 Regular Patient First: Let's have a Conversation' sessions facilitated each month by our executive team to encourage engagement and involvement of all staff Ongoing development of programme deliverables / product descriptions Bi-monthly briefing session for NEDS to ensure non-executive directors are a) adequately briefed on progress and b) identify opportunities to engage in a number of continuous improvement activities with UHD staff	Operational delivery competing for time with *Patient First* rollout resulting in programme scope reduced or timescale extended Lack of support from internal stakeholders within the organisation and poor clinical involvement and engagement Failure to gain support ('air cover' and 'strategic patience') from regulators resulting in uncertainty and potentially additional work pressures on staff Lack of on-going programme management resource and appropriate budget to drive implementation and roll out Full coverage of PFIS to 10000 frontline staff planned over circa 3 - 4 years may result in teams identified within later phases feeling undervalued Full roll out of the Patient First management system will require revision of current approach	Alignment of improvement projects to ameliorate operational pressures *True North, Breakthrough Objectives, Strategic Initiatives, Corporate Projects* Continue early work with key stakeholders to elicit support for reset proposal Effective communication plan for stakeholder engagement. Attention to programme design philosophy - ongoing activities to support ownership amongst frontline staff In parallel to delivering PFIS rollout training, ensure staff are not prevented from making local improvements. This will need to be reviewed to ensure appropriate content and 'board to floor' alignment with True North

TITLE	BAF Risk 9 – Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals														
Ref	1784	Critical Path Management													
Strategic Priority	One Team	Risk Score													
Review Date	30/6/23		Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CSTO	1784	20	20	20										12
Lead Committee	FPC														
Risk Rating		Likelihood	5	Consequence	4	Gaps in Controls	Moderate								

Context	Controls	Gaps in Controls or Assurances
Taking lessons from previous relocations, such as the one in Bristol, we have recognized the importance of integrating and operating services as a unified entity at least 6 to 9 months prior to any move. As our build programs become more defined, our efforts need to shift towards the integration of teams. Therefore, as we approach the integration phase, our governance structure will be aligned with the four phases of reconfiguration, with a greater emphasis on preparing services for reconfiguration rather than solely focusing on the build program. The Acute Reconfiguration Capital Group will be renamed the Build Ready Group and ensure delivery of the buildings and manage risks. The Reconfiguration Oversight Group will be transformed into the Service Ready and Move Group and manage the critical path to being ready for treating patients in our reconfigured services.	**Prevention** Evidence of effective governance: • meeting structure, attendance, escalation and resolution from speciality steering groups into CG and then ROG. • Service Reviews to assess readiness for moves. • Robust critical path timeline that clearly articulates deliverables and interdependencies between specific deliverables • Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration) **Detection:** Internal Audit and NHP scrutiny of programme; external review of Gateway process **Contingency:** Programme contingency, including timeline for service review, and build slippage. Robust gateway review process (including Go/No Go Checklists)	Moderate gaps: Development of the integration dashboard Regular updating & dissemination of build critical path

PROGRESS		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
• Transition to new governance in June/July • Testing of Service review process with Pathology in June 23	(05/06/23) Risk score updated to 20. Issue remains the same and still awaiting full approval from NHP Team. The programme/timelines are now being monitored closely to manage delays and potential impacts	Monthly meetings (ROG) that reviews and escalated any barrier and delays. Detailed progress timeline is updated and any variance or off-track issues are highlighted to ROG. Internal Audit Review of Reconfiguration Programme

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 7.2

Subject:	Risk Register
Prepared by:	Joanne Sims, Associate Director of Quality Governance & Risk Natasha Sage, Head of Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic themes that this item supports/ impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/ Corporate Risk Register: (if applicable)	Risk Register
Purpose of paper:	Decision/Approval
Executive Summary:	

Current risks rated at 12 and above on the risk register	41
Potential new risks for Approval	0 June 1 May
12+ Risks that have changed score	3
Reduced, closed or suspended risk(s) no longer 12+ to note	0
Risks scoring 20+	5

To note – Risking Scoring 20+			
Risk no:	Title	Risk Owner	Exec Lead
1872	Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding	Jordan, Sophie	Mark Mould
1784	Critical Path Management	Killen, Stephen	Richard Renaut
1604	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds	Killen, Stephen	Richard Renaut

1429	Ambulance handover delays - risk to patient harm, performance and organisational reputation	Higgins, Michelle	Mark Mould
1460	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation.	Rathbone, Leanna	Mark Mould

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
41	41	100%	⇧ 2%

The 12+ risks have been realigned to map to the UHD A3 Patient First objectives:
-Patient Experience
-Sustainable services
-Partnership and Population Health
-People
-Quality

Background:

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

New and existing risks graded at 12+ will reflect acceptance (or not) on the current (live) Trust Risk register. Acceptance is predicated on evidence that:

- *The risk has been reviewed and agreed at Care Group Governance*
- *The risk has been reviewed and agreed by Care Group Directors*
- *Formal confirmation that an Executive Lead has been identified, briefed and agrees to sponsor the risk*
- *A current action plan is evidenced within the Risk record*

Actions identified in relation to current risks to be communicated and facilitated by Risk Owners.
Acceptance of closure and downgrade of risks to be reflected on the current (live) Trust Risk Register.

Key Recommendation

To consider and if thought fit approve the new 12+ risks..

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	13/07/2023	Meeting not taken place at time of submission of report.
Quality Committee	18/07/2023	Meeting not yet taken place at time of submission of report.

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

University Hospitals Dorset
NHS Foundation Trust

Risk Register Report

The Board of Directors will review the Trust's significant risks at each meeting, generating actions appropriate following each review.

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

For the period to end June 2023 (as on 05/07/2023)

Risk Register Report

Risk Register

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

Current risks rated at 12 and above on the risk register	41
Potential new risks for Approval	0
12+ Risks that have changed score	3
Reduced, closed or suspended risk(s) no longer 12+ to note	0

DEFINITIONS
Movement in month - Key:

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

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

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

Risk Rating Status

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

Risk Matrix and Risk Scores
See Appendix B and C

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

Risk Register Report

1. **There are 187 approved risks on UHDs Risk register, of which 41 are rated as 12 and above**
2. **There are 0 risks rated as 12 and above that has not been reviewed in the last month.**
3. **There are 0 new risk rated as 12 and above in the last month**
4. **There is 1 new risk rated as 12 and above to be approved at Trust Board- Part 1 (discussed at QC in June 23 and reviewed)**

<table>
<tr><td>Risk Ref</td><td>1876</td></tr>
<tr><td>Risk Rating</td><td>12</td></tr>
<tr><td>Risk Title</td><td>Inability to provide a dedicated 24/7 medical practitioner independent of other obstetric duties to maternity triage</td></tr>
<tr><td>Risk Description</td><td>If patients with maternity emergency complications are not seen appropriately by the correct staff, there is a risk to patient safety.</td></tr>
<tr><td>Risk Background</td><td>The latest CQC report identified that the service did not always have enough medical staff in maternity triage and supported plans for medical cover for triage 24/7. There is currently dedicated medical cover for Maternity Triage from 0800-1700 Monday - Friday. Outside of these times, the on call team will review triage patients .
In addition there is also medical cover as below: provided
1.24/7 resident obstetric medical cover provided at SHO and registrar level.
2.Resident obstetric consultant from 0800-2000 Monday to Thursday, 0800-1800 on Friday, 0800-1300 on Saturday and Sunday.
3.Gynaecology medical cover at SHO level between 0800-1700 seven days a week and at registrar level between 0800-2000 seven days a week.
When the obstetric SHO or registrar are unable to review maternity triage patients in a timely fashion (because of other obstetric workload), there is a clear escalation plan in place to call either the obstetric consultant or the gynaecology junior doctors.
A business case has been approved in line with the Safer Staffing Model for additional recruitment in order to provide 24/7 dedicated medical cover for Maternity Triage. Dedicated medical cover means that the medical cover is for maternity triage only and independent of any other obstetric or gynaecology workload</td></tr>
<tr><td>Leads</td><td>Rumani, Genc - Interim Associate Director for Women's and Children's Health
Taylor, Mr Alexander - Clinical Director Women's Health</td></tr>
<tr><td>Controls</td><td>Staffing rotas and monitoring
Maternity dashboard
Standard Operating procedure in place
Maternity triage standards (BSOTS)
Ongoing data collection for compliance with BSOTS in Maternity Triage
Learning through Incidents, Complaints and Claims</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Responsibility ('To')</th><th>Specialty</th><th>Title of Action</th><th>Description of action to be taken</th><th>Evidence of Effective Implementation</th><th>Start date</th><th>Due date</th><th>Action Status (type)</th></tr>
<tr><td>Mr Alexander Taylor</td><td>Maternity (Obstetrics)</td><td>To recruit additional Obstetric Registrars to cover 2 tier Registrar cover out of hours</td><td>To provide substantive medical cover on weekends and from 20:00-08:00 weekdays to support obstetric review of Maternity Triage patients in a timely manner as per BSOTS</td><td></td><td>26/04/2023</td><td>30/06/2023</td><td>Open</td></tr>
</table>
</td></tr>
</table>

Risk Register Report

5. There are 3 risks that have changed risk rating, but remain 12 or above, in month.

Ref	New Risk Rating	Description	Update	Risk Owner	Lead Executive	Last review date	Risk trend
1393	12	If demand continues to outweigh capacity in Endoscopy services then there is a risk of harm to patients due to delayed diagnosis or treatment	Continuing CDC work which will increase capacity. Revised drawings for endoscopy agreed (26.06.23). WTE nurse staffing will be added to TRAC. WLI work in progress and seeing improvement performance in DM01. JAG standards met at Poole - a/w RBH inspection. All controls reviewed and the risk reduced from 16 to 12 based on some improvements	Leanna Rathbone	Chief Operating Officer - Mark Mould	28/06/2023	Decrease from 16 to 12
1843	12	If we do not cover the shortfall in the acute paediatric medical rota children will receive delayed and inadequate assessment, diagnosis and treatment.	Risk score reduced from 16 to 12 (likely to possible) given improvement in PGDIT (post grad doctors in training) numbers and reduction in number of acting down shifts.	Mark Tighe	Deputy Chief Medical Officer UHD - Ruth Williamson	26/06/2023	Decrease from 16 to 12
1692	12	There is a patient safety and staff wellbeing risk associated with the absence of a framework for Safe Medical staffing across UHD clinical services	Risk discussed at BRAG 05/07/2023. Some reduction in additional shifts but not fully recruited yet. Given plans in place, suggest risk score reduced from 15 to 12.	Peter Wilson	Chief Medical Officer - Peter Wilson	06/07/2023	Decrease from 15 to 12

6. There are 0 risks closed, reduced or suspended in month that were previously rated at 12 and above

7. Risk updates

Risk Number	Title	Rating (current)	Last review date	Review for Board	Handler	Executive lead
Partnerships and Population Health						
1872	Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding	20	05/07/2023	The Trust has been reporting a OPEL 3 pressure status for the majority of June and still maintains a high bed occupancy (94.4%). This continues to provide challenges for timely placement and transfer of patients and impacts the delivery of the 4 hour safety standard. There has been a dependency on using planned and surge escalation capacity in Quarter 1 above the plan which has provided operational and financial pressures on the staff and Care Groups. An average of 38 escalation beds were open each day throughout June. There as been a concerted effort to reduce the dependency on unfunded escalation	Wersby, Stuart	Chief Operating Officer - Mark Mould

Risk Register Report

				capacity and to decrease the overall escalation beds opened in Month 3. A draft escalation policy has been co-created with the Care Groups to support decision making on a daily basis and to provide a prioritised list of areas to open if required. The challenge remains that the escalation capacity is often not in the most appropriate clinical area or on the most pressured site. The Care Groups are reviewing bed stock to consider a balancing of capacity. This will be included in the Capacity Plan to support winter pressures. The Medically Ready for Discharge position continues to improve with an average of 166 patients delayed in June which is the lowest it has been since August 2021 (164). The trial of the Care Traffic Control model has provided 24/7 improved focus on clinical placement of patients and has provided learning to develop current processes across the Trust, this will be managed and monitored via the Hospital Flow Improvement Group (Workstream 3). The system continue to work collaboratively through the WIG and focus is on enabling the agreed schemes to provide capacity and flow going into Winter. There remains a concern that UHD may require further escalation capacity and external funding in Q3 & Q4 as the occupancy levels on both sites have not improved to the required 92% system modelling and there remains a clear capacity gap.		
1074	Risks associated with breaches of 18 week Referral to Treatment and long waiter standards.	20	03/07/2023	Reduction in long waiters reported at end of June 2023 to 32 78week waits. Working to eliminate 78 week waits by end of July except for 1 patient requiring nickel free joint implant in trauma and orthopaedics due to national supply issues. 65 'at risk' March 2024 cohort continues to reduce. Recently announced industrial action in July may add further risk in the delivery of this plan and the details of the expected impact are currently being worked through alongside mitigating actions.	May, Judith	Chief Operating Officer - Mark Mould
1460	Ability to meet UEC 4 hour safety standard and related impact on patient safety, statutory compliance and reputation.	20	26/06/2023	26/6/23 May performance >60% and on trajectory. Improvement actions focused on Breach themes, non admitted flow and actions to improve TTFA and EPIC role in dept. Delivered against trajectory for May 2023 61.2% Delivered against trajectory for April 23 of 61.3% against 60%. Focus on 60 minute patient review within 4 hour window to support improvement against non-admitted performance. Block booking of agency activity to reduce spend and improve staffing levels to better facilitate performance against trajectory.	Higgins, Michelle	Chief Operating Officer - Mark Mould

Risk Register Report

1429	Ambulance handover delays - risk to patient harm, performance and organisational reputation	20	28/06/2023	No changes since previous update	Lister, Alex	Chief Operating Officer - Mark Mould
1053	Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NRTR patients	16	06/07/2023	Reduction in No CTR numbers remains consistent around an average of 175 progressing toward the required 30% reduction overall Continued roll-out to improve compliance of EDR recording on HOTW / and early referral for complex discharge planning System T&F groups are progressing the system priorities of reviewing the discharge pathways to deliver the Dorset D2A model Electronic referral development work continues Awaiting Central funding decision confirmation to invest in discharge team 7/7 working learning actions from MADE and review of adverse incident relating to discharge are been implemented Care Group action to support regular review of patients with LLOS implemented with the support of the Medical Director	Horn, Val	Chief Operating Officer - Mark Mould
1697	Increased waiting list for SACT treatment/ Capacity on Day units	15	15/05/2023	Discussion with operational manager in Cancer Care in relation to targets and number of patients the delay effects. Currently this is monitored manually based on the target date of planned treatment. To be reviewed at next directorate quality and risk meeting to understand if there is the ability to record this electronically and facilitate a weekly report.	Miller, Marie	Chief Medical Officer - Peter Wilson
1502	Mental Health Care in a Physical Health environment	15	27/06/2023	Key stakeholders meeting established and held on the 20th June. DDON, Liaison psychiatry, AMU and Medicine present. Need to include Alcohol Liaison, Clinical site and OPS in future meetings.	Aggas, Leanne	Chief Nursing Officer & Deputy COO - Paula Shobbrook
1393	Endoscopy capacity & Demand	12	28/06/2023	Continuing CDC work which will increase capacity. Revised drawings for endoscopy agreed (26.06.23). WTE nurse staffing will be added to TRAC. WLI work in progress and seeing improvement performance in DM01. JAG standards met at Poole - a/w RBH inspection. All controls reviewed and the risk reduced from 16 to 12 based on some improvements	Lloyd-Hatchard, Kate	Chief Operating Officer - Mark Mould
1386	National Cancer Waiting Times Standards	12	06/06/2023	Agreement to monitor every other month through the Cancer Strategy Group. No risk rating change this month due to improvements and remaining out of any regional and national intervention. Mitigations in place with WLI activity for further industrial action. Recovery plan in place as well as weekly escalation meetings.	Lake, Katie	Chief Operating Officer - Mark Mould
1300	Provision of 24hr specialist care for children (under 18 years) who have mental health needs.	12	26/06/2023	CAMHS and UHD working on a 8PA acute paediatric consultant covering eating disorders and in-reach to paediatric wards. UHD are participating in co-production of the new CAMHS service design (business case being submitted in August). MoU in place.	Lourence, Lynne	Chief Nursing Officer & Deputy COO - Paula Shobbrook

Risk Register Report

				Ligature light estates work is completed. De-escalation training undertaken by senior nursing staff. Improved visibility of CAMHS liaison team		
1292	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	12	25/06/2023	FU task & finish group in situ by the Associate Director of Operations. Various strategies worked through via clinical and administrative validation. Next steps to look at logic algorithms with clinicians to understand how this could be applied by BI to cohort patients for discharging to PIFU. eOutcome form development required to support PIFU at clinic appointments and improve data capture. Overdue follow ups >52 weeks reducing, Dr Dr pilot successful, summary attached. Progress continues.	Jose, Darren	Chief Operating Officer - Mark Mould
1840	OPS Outlying patients	12	12/06/2023	Action for creating outlier list has been closed, there is now a list but there is ongoing work to align processes across both sites. The other actions are in progress and work is ongoing with CST. In terms of controls, staffing has improved in terms of tier 1 staffing but not WTE Consultant staffing. We are still not able to provide Consultant cover as per the RCP safe staffing guidance. Outlier numbers have reduced but outliers persist on both sites. We will discuss the risk at the next Governance meeting on 28/6/2023	Pigott, Lisa	Chief Medical Officer - Peter Wilson
People						
1811	Staff Vacancies and Skill mix deficit - Theatres	15	08/06/2023	Recruitment on going as at May 2023 vacancy reduced PH no reg vacancies, 6.55 WTE un reg RBH 5.78 WTE Band 6, 5.17 band 5, 15 WTE band 2/3 HCA recruitment weekend in June request to over-recruit into core areas with candidates ahead of establishment review funding Bank incentives due to commence mid-June	Bone, Clare	Chief People Officer - Karen Allman
1483	Pharmacy vacancies are affecting patient care	16	22/06/2023	Shortage of pharmacists both regionally and nationally impacting on vacancies. Poole Hospital particularly challenged with pharmacists covering 4-5 wards daily each (would usually be 1-2 wards max) and lack of resilience for Poole site weekend service. Frequently only a weekend level service in operation at Poole during weekdays. Nos of pharmacist vacancies May 23 14 WTE In May we took on 3 x temporary locum pharmacists) Of 5 pharmacist vacancies advertised only 2 have been appointed to Almost all vacancies at the junior pharmacist level	Bleakley, Stephen	Deputy Chief Medical Officer UHD - Ruth Williamson
1397	Provision of 24/7 Haematology/ Transfusion Laboratory Service	16	12/06/2023	RBH: interviewing taking place for a B6 post and are likely getting a B6 resignation (currently on Mat leave). Seeking permission to offer for two posts. Poole: in the process of getting a locum who has confirmed they are able to come down. Arrangements need to be firmed up.	Macklin, Sarah	Chief Nursing Officer & Deputy COO -

Risk Register Report

						Paula Shobbrook
1202	Medical Staffing Women's Health	15	26/06/2023	Risk remains at 15.2x substantive obstetric consultants to be interviewed in august. clinical fellow jobs have been advertised and shortlisting is occurring. Predicted 20% middle grade rota gaps for July and august. mitigating this risk with employing locum registrars and a plan for consultants acting down.	Taylor, Mr Alexander	Deputy Chief Medical Officer UHD - Ruth Williamson
1758	Chemotherapy production in pharmacy now at capacity and limiting patients accessing treatment	12	20/06/2023	2 locums started 2.5.23 not fully trained on all aspects of clinical screening yet. Some screening signed off, impact on service (improvement) still to be seen. Additional concerns with one rotational Band 6 leaving the Trust soon. Increased by 2 on each site per day, additional nurse screeners for 2 specific medications. 2 Locums ready to start to relieve pressure. Incidents related to delays linked.	Bleakley, Stephen	Deputy Chief Medical Officer UHD - Ruth Williamson
1493	Absence, Burnout and PTSD	12	06/07/2023	Risk reviewed; previous comments remain applicable with new actions having been added which are in hand.	Mardon, Irene	Chief People Officer - Karen Allman
1492	Resourcing Pressures - Staffing	12	06/07/2023	International Nurse recruitment remains on track, with 8 arrivals in May and 10 in June. Ongoing focus on our HCSW WTE vacancy rate which remains at 22% this month, despite a good number of new starters each month, and leavers averaging 1 WTE per week. Next Direct Support meeting 27/7. Expected target is a 50% reduction in our vacancy rate. Open Day event on 10/6 resulted in over 70 offers; next event scheduled for 29/7/23. The 10/6 cohort are being closely tracked to see if offering candidates and carrying out employment checks on the day shortens our time to hire. Managers will have the option to risk assess candidates where there are delays in checks being completed, and low risk involved in starting them whilst they are completed. The launch of the Stay Questionnaires is delayed as the Image Now team is needed to work on forms related to changes in the NHS pension scheme, and retire and return. A draft report of the exit questionnaire data from the last 6 months has been reviewed and will be shared at Exec this month (July) for feedback and follow up proposals. [TGP]	Gill Parker, Tracy	Chief People Officer - Karen Allman
1692	Safe Staffing - Medical	12	06/07/2023	Risk discussed at BRAG 05/07/2023. Some reduction in additional shifts but not fully recruited yet. Given plans in place, suggest risk score reduced from 15 to 12.	Williamson, Ruth	Chief Medical Officer - Peter Wilson
1395	Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting.	12	22/06/2023	Agency staff have been recruited to support the admin processes at UHD and with the additional agency staff we are managing to hold the line. The department is still outsourcing wax blocks and there has been a number of quality issues associated with the outsourcing. The Cytology team at Poole are back up to establishment. Digital Pathology project runs at a linear pace, validation underway with Pathology engagement. Offsite reporting solution in place although IT limitations are a significant issue.	Massey, Paul	Deputy Chief Medical Officer UHD - Ruth Williamson

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				Recruitment of a new consultant through DPP for gynae workstream – encountering IT issues so uncertain as to how long this arrangement may continue		
1221	Medical Staffing Shortages - Medicine and Older Persons Medicine	12	26/06/2023	Continues at 12. Consultant template remains the same with escalated beds and outliers on both sites. Will be discussed again at Governance in July 2023 School of Medicine visited again this week and await report from this and GMC training survey. Continue to run under WTE Consultant template. We have recruited to tier 1 and 2. We continue to have ward 22, Kimmeridge and Lilliput escalated beds. Outliers on both sites continue although at reduced rates. The risk continues at 12 and will be reviewed in our Governance meeting in June.	Pigott, Lisa	Deputy Chief Medical Officer UHD - Ruth Williamson
1843	Paediatric acute medical staffing	12	26/06/2023	June Update: Risk score reduced from 16 to 12 (likely to possible) given improvement in PGDIT (post grad doctors in training) numbers and reduction in number of acting down shifts.	Tighe, Mark	Deputy Chief Medical Officer UHD - Ruth Williamson
1498	Medical Registrar Out of Hours Cover (RBH)	12	04/07/2023	Risk reviewed and understood rating cannot change currently but will reduce as more staff start in post. To be reviewed at next review date. Recruitment continues, and posts are starting to be filled. Whilst this will impact the risk rating it remains at the same level currently	Whitney, Sue	Deputy Chief Medical Officer UHD - Ruth Williamson
1771	Radiology Service Demands/ Radiologist staffing	12	06/07/2023	Reviewed at Radiology Q+R Meeting: GI post not recruited to; Shortlisting underway for IR post; job descriptions completed for MSK posts; Paediatric post interview in August. No change to risk, for review at next Q+R meeting. June outsourcing figures: Hexarad (PH) 534 and 510 (RBH); 4-ways 909. Total 1953 examinations in June (decreased by 269 since May)	Knowles, James	Deputy Chief Medical Officer PH - Matt Thomas
1642	Midwifery Staffing	12	26/06/2023	Risk grading to remain the same: 2x International Recruitment Midwives have commenced their orientation process at UHD. Further IRM interviews have taken place in June. Workforce action plan continues.	Taylor, Kerry	Chief Nursing Officer & Deputy COO - Paula Shobbrook
1283	Radiotherapy radiographer staffing	12	12/06/2023	Recruitment underway - seeking approval to appoint over advertised vacancies	Tanner, Mandy	Chief Nursing Officer & Deputy COO - Paula Shobbrook
1303	Therapy Staffing	12	04/07/2023	Discussed at quality and risk group, 6 band 5 OTs recruited as well as 1 overseas OT with a Band 6 advert out. Workstream looking at recruitment ongoing. Progress with the therapy workforce dashboard. Risk remains at present.	Godden, Rebekah	Chief Nursing Officer & Deputy COO - Paula Shobbrook

Risk Register Report

Quality (Safety and Outcomes)						
1214	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices.	16	04/07/2023	Update from CGG: KT confirmed that Spike Briggs/John Pickett will be the chairs for the Medical Devices Group, point of care testing/imaging will sit under this as a sub group. Names for reps from ED received for T&F group.	Massey, Paul	Deputy Chief Medical Officer UHD - Ruth Williamson
1378	Lack of Electronic results acknowledgement system	15	09/06/2023	Matt Thomas has agreed to set up a task and finish group to lead an evaluation of the options and the implementation of a solution to mitigate this risk	Hill, Sarah	Chief Information & IT Officer - Peter Gill
1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients	15	23/06/2023	No change to risk, CQC action plan populated	West, John	Chief Operating Officer - Mark Mould
1647	Ineffective and inconsistent patient handover processes	12	05/07/2023	Risk score to remain the same. CMO meeting with ED/AMU on 20.07.23 to progress.	Wilson, Peter	Chief Medical Officer - Peter Wilson
Sustainable Services						
1784	Critical Path Management	20	29/06/2023	29/06/2023: Risk increased from 16 to 20 due to delays in SoS OBC approval and also the likely delays of the new ward building. The timeline for Reconfiguration Move 1 has been delayed by 5-6 months so now looking at autumn 2025. NHP scheme and beds required for RBH site will not be ready until late 2025. Review proposed to move some services when BEACH building is ready (March 2025). A small T&F Group will be set up during July and August to understand risks and mitigations on Maternity, Critical Care and RBH ED moving in March 2025.	Killen, Stephen	Chief Strategy and Transformation Officer - Richard Renaut
1604	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds	20	29/06/2023	29/06/2023: NHP OBC was approved at JIC. However, confirmation of funding from DHSC/SoS has not yet been provided. Once approval received, will reduce to 16. The schemes are to be retained within the £262.7m, and TMB have agreed a Trust wide approach to attracting future funding for the £30m shortfall of schemes. A task and finish group will be set up to review the deferred list and agree the priority order to attract investment for the shortfall. S&T team will continue to lobby NHP National Team and others to secure the funding elsewhere.	Killen, Stephen	Chief Strategy and Transformation Officer - Richard Renaut
1881	Financial control total 2023/24	16	04/07/2023	The finance and performance committee agreed the current risk rating.	Papworth, Pete	Chief Finance Officer - Pete Papworth

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1416	GIRFT and Model Hospital	16	04/07/2023	Reviewed, no change	Rushforth, Helen	Chief Finance Officer - Pete Papworth
1595	Medium Term Financial Sustainability	16	04/07/2023	The finance and performance committee agreed the current risk rating.	Papworth, Pete	Chief Finance Officer - Pete Papworth
1355	Lack of integration between the Electronic Referral System (eRS) & Electronic Patient Record (ePR)	15	26/06/2023	Ongoing board meetings taking place to keep this project moving forward. Still working to the August pilot date.	Roberts, Michele	Deputy Chief Medical Officer UHD - Ruth Williamson
1805	EPR Stability Issues	12	26/06/2023	A root cause has been found that affected the data feeds which is one of the issues that made the ERP unstable. This was a legacy data feed from the old eCAMIS system at Poole, which has now been turned off. There are still other instability issues without a known root cause and hence the risk remains as is	Hill, Sarah	Chief Information & IT Officer - Peter Gill
1594	Capital Programme Affordability (CDEL)	12	04/07/2023	The finance and performance committee agreed the current risk rating.	Papworth, Pete	Chief Finance Officer - Pete Papworth
1260	Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling	12	29/06/2023	Risk score to remain the same however there is a huge resource pressure due to commitment to the capital plan, recruitment and sickness. This will impact the ability to adhere to the action plan. Currently there is Fire officer, compliance manager and mechanical trade staff out to advert. There continues to be significant concerns regarding succession planning and the number of people coming up to/are at retirement age.	Bhukal, Bernard	Chief Strategy and Transformatio n Officer - Richard Renaut

8. Risk Heat Map- UHD

Current Risk Grading		Likelihood				
		No Harm (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Severity	Almost Certain (5)	1	9	8	6	
	Likely (4)	1	26	14	7	
	Possible (3)	3	37	31	7	
	Unlikely (2)		7	17	7	5
	Rare (1)			1		

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

Current Risk Score– UHD total	June 22	July 22	August 22	Sept 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23	May 23	Jun 23
Very Low (1-3)	2	1	1	2	2	2	3	2	4	5	5	**4**
Low (4-6)	81	73	71	67	67	68	69	71	70	67	63	**63**
Moderate (8-10)	97	89	92	91	85	78	80	82	75	73	78	**78**
Moderate (12)	16	17	17	17	17	17	19	19	19	18	20	**21**
High (15 -25)	21	21	22	22	22	23	23	25	24	21	24	**21**
Total number of risks under review	217	201	203	199	193	188	194	199	192	184	190	**187**

9. Compliance and Risk Appetite

Summary of compliance UHD overall:

Current Risk Grading	*No: of risks under review*	*Number of Risks compliant with Risk Appetite timescales*	*% of Risks Compliant with Risk Appetite timescales*	*Month on month position*
12 and above	41	41	100%	↑ 2%
8 to11	78	72	92%	↑ 6%
4 to 7	64	56	90%	↓ 2%
1 to 3	4	4	100%	↔
Total	**187**	**173**	**93%**	↑ **3%**

10. Recommendations

The BoD is asked to:

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

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Appendix A: Model risk Matrix for Patient Safety Risk – Risk Level descriptors

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

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10	2	5	May occur annually but less than monthly and impacts on a large number of patients, increased probability of death or irreversible health effects occurring
	5	2	Evidence of daily occurrence that overall treatment or service is suboptimal with minor implications for patient safety
12	4	3	Evidence of weekly occurrence that a treatment/service has significantly reduced resulting in significant harm to more than 50% of the patient cohort
	3	4	Every month there is evidence of major injury leading to long-term incapacity/disability
15	5	3	Evidence of daily occurrence that a treatment/service has significantly reduced with resulting harm to more than 50% of patient cohort
	3	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced monthly
16	4	4	Weekly evidence of major injury leading to long-term incapacity/disability
20	5	4	Daily evidence of major injury leading to long-term incapacity/disability
	4	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced weekly
25	5	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced daily

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Appendix B: Matrix for Risk Register Assessment

Table 1 Consequence scores

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

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

Table 2 Likelihood score (L)

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

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

University Hospitals Dorset
NHS Foundation Trust

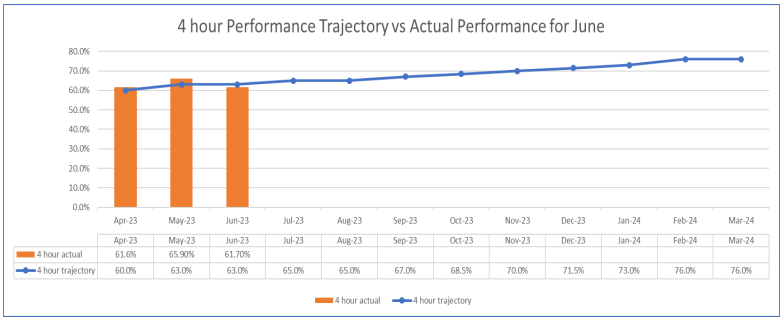
BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 7.3

Subject:	Integrated Performance Report
Prepared by:	Executive Directors, Alex Lister, Leanna Rathbone, Sophie Jordan, Judith May, David Mills, Fiona Hoskins, Matthew Hodson, Carla Jones, Irene Mardon, Jo Sims, Andrew Goodwin
Presented by:	UHD Chief Officers

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	Trust Integrated Performance report June 2023 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	There was a reduction in overall attendances to our Emergency Departments in June 2023 of approximately 50 per day, however performance did not reflect this. As a Trust we reported 61.7% achievement against the 4 hour standard against a plan to achieve 63%. The Trust moved to a new Patient Administration System (Agyle) for ED in June 2023 at the Poole site, which impacted on performance as the system is bedded into clinical practice. Ambulance handover improvement plateaued with just over 1000 hours being lost at UHD. A reduction in the number of patients with 'No Criteria to Reside' (NCtR) was also maintained, however escalation bed capacity remains in place with a number of unfunded beds being used. This carries associated risk and costs related to maintaining an unplanned bed base. Elective recovery demonstrates improvement across a range of metrics however industrial action and workforce challenges continue to impact on the Trust's ability to fully meet its operational planning trajectories. The cost of the recent industrial action, energy cost inflation and unfunded escalation capacity drive the challenging financial position, with a year-to-date adverse variance of £2.9 million. Consistent with national reporting guidance; elective income is

	assumed to be received in full, however this has yet to be confirmed. Mitigating actions continue to be identified and progressed to recover this position.
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by: • Extending best practice use of Statistical Process Control (SPC) Charts • Greater focus on key indicators as part of our Patient First Roll out programme • Providing SPC training to operational leads who compile the narrative against the data included within the report scheduled in June/July 2023. • Linking the structure of the report to the delivery of our strategic objectives
Urgent & Emergency Care (1 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** ***Advise (1): The Trust commenced national reporting against the 4-Hour Organisational safety standard in June 2023 at 61.7% against a trajectory of 63%*** • The Trust is planning for further BMA Industrial Action in July 2023 which will continue to impact on access to care for our patients. • The Trust met its trajectory for both April and May 2023, however June has proved to be a challenging month. • Attendances have dropped for the first time since January 2023, and there has been a sustained performance improvement for the number of patients in the department longer than 12 hours as well 12 hours from DTA. • In terms of Ambulance Handover, there were 599 hours at PH and 540 hours at RBH totalling 1139 hours lost in June 2023 vs 1039 in May and 2284 hours reported as lost at UHD sites in April. • Regionally however there was an improvement against handover delays with SWAST experiencing 18,180 lost hours vs 20,159 in May 2023 across the South-West. 

	The IPR provides detailed performance against the national Urgent & Emergency Care standards. A weekly High Intensity Support meeting led by the CMO, COO and CNO has been established to work with ED and the wider UEC pathway to support improving the position against the 4-hour standard, in addition to the existing governance arrangements.
Occupancy, Flow & Discharge (1 Assure)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** ***Assure (1): Medically Ready to Leave (MRTL) - reduction delivered in June although the Trust continues to have unfunded escalation beds open.*** • Both sites continued to maintain escalation beds open in June. Occupancy remains at an average of 94.4% across UHD. The Trust has de-escalated to declare OPEL level 3 (Operational Pressures Escalation Levels) throughout June 2023, with brief OPEL 2 periods. While we continue to use planned escalation beds the Trust continues to have unfunded escalation beds to maintain flow. • There was an average of 166 patients MRFD occupying beds across both sites in June 2023, which is 78 fewer than February. This is a positive and significant impact has been seen on the reduction of the number of people waiting for beds in the A&E department and the marked reduction in ambulance waiting times. • The ICB ambition is for a 30% reduction in no criteria to reside (NCTR) bed days by end Q1 and 50% reduction in NCTR bed days by end Q2. This has not been achieved for Q1 at an ICB level, or individually in any of the partner Trusts. • Discharge to Assess (D2A) continues to have a positive impact on discharge rates. The ICB ambition is that at least 95% of supported discharges are under a D2A approach, however this has not been achieved.
Surge, Escalation and Ops Planning	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** In June 2023 we continued the 8-week pilot of a centralised bed management with dedicated oversight of flow across both acute sites, with expected improvements in oversight, coordination and reduced transfer time.
Referral to Treatment (RTT) (2 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Advise (1): A reduction in 78 weeks waits was achieved at the end of June but the plan to virtually eliminate 78 week waits**

was not achieved. 65 week breaches are above plan, however the variance to plan has reduced in June.

- Both 78 week waits and 65-week waits were above plan in June 2023 but lower than the end of May position. Industrial action continues to impact on the Trust's capacity for routine elective treatments and appointments. Capacity in the School Age Neurodevelopment Service was also not able to meet the demand for first appointments for patients waiting over 78 weeks in June. The service has experienced an increase in referrals above 40% compared to 2019.
- 65 week waits at the end of June 2023 were 30 above plan, however the variance to plan has reduced this month by 63. Consistent progress is being made on reducing the 65 week 'at risk' March 2024 cohort, with this group reducing by 6,311 this month to 22,489.
- Additional waiting list initiatives are in place in July 2023 for both elective and cancer waits, but these will not fully mitigate against lost capacity due to IA in July.

Planning requirement	May 23	June 23	
Referral to treatment 18-week performance	54.30%	55.06% ▲	National Target 92%
Eliminate > 104 week waits	0	0	Plan Trajectory 0 by February 23
Eliminate >78 week waits	97	32 ▼	Plan Trajectory 0 by 31 March 2023
Eliminate >65 week waits	1,242	1,053 ▼	Plan trajectory 1,023 June 2023
Hold or reduce >52+ weeks	4,813	4,574 ▼	Plan Trajectory 4,042 by June 2023
Stabilise Waiting List size	74,500	74,483 ▼	Plan trajectory 75,261 June 2023

- All efficiency markers for theatre utilisation showed improvement in June and the intended (booked) theatre utilisation rate also increased to 73.4% (plan 87%). Further improvement however is required to achieve this target and an improvement programme is in place. Actions are detailed in the IPR.
- Staff vacancies across theatres remains a barrier to providing a full template for all surgical specialties. The workforce pipeline is improving with the trajectory showing a reduction of c.17wte by September 2023 and an enhanced bank rate for existing theatre staff is expected to increase the number of sessions run in July.

Advise (2): Trauma #NOF performance improved during June but did not achieve the standards.

	• 50% of the monthly activity was admitted during a 6 day period and there was a higher than average presentation of paediatric trauma cases. • Access to the newly opened Barn theatres nevertheless resulted in a rapid de-escalation of the position and recovery of the backlog of #NOF cases during the month. • The ability to flex into the 4th theatre at times of increased demand has provided the ability to manage this patient cohort in a safe and effective way. • A new pre-hospital #NOF 'pre-alert' from SWAST and admission pathway went live on 6 July 2023. • Implementation of the e-Trauma tool has commenced with a dedicated T&O Lead in post; and technical scoping is complete.
Cancer Standards (1 Assure)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Assure (1) Performance against the national Cancer Waiting Times standards in May was below the operational planning trajectories for Cancer 62D and the 28D Faster Diagnosis standard. The Trust is on track, however, to demonstrate improvement against the FDS standard in June.** • FDS performance in May 2023 was below the Trust's operational plan trajectory of 72%. • Treatment numbers in May 2023 were 17.2% lower compared to May 2022 due to an additional bank holiday and industrial action in the month. This negatively impacted on 62-day performance. • The number of patients on the over 62d PTL increased to above 300 in May 2023 but recovery of the increased position has been achieved in June and July to date.

KPI	Target	Q4 22/23 FINAL	Apr 23 FINAL	May 23 FINAL
Faster Diagnosis	75%	70.4%	71.2%	70.2%
31 Day First Treatment (Tumour)	96%	96.0%	96.1%	96.3%
Cancer Plan 62 Day Standard (Tumour)	85%	63.8%	67.0%	62.7%
62 Day Screening Standard (Tumour)	90%	75.3%	69.7%	75.0%

• There is continued evidence of progress against the recovery plans in place for Gynaecology, Urology and Colorectal tumour pathways. Additional waiting list initiatives are also planned to commence in July 2023 in Dermatology and Breast services.
• Weekly clinical reviews of patients on the over 62D PTL also continue.

Looking forward

• 28 Day - provisional performance for June 2023 is currently 71.9% (trajectory 73.5%). This is expected to improve by month end as records are validated.
• 62 Day - provisional performance for June 2023 is currently 60.2%, however, this is expected to increase as treatments are reported by month end.

DM01 (Diagnostics report)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** The DM01 standard has achieved 92.3% of all patients being seen within 6 weeks of referral, 7.7% of diagnostic patients seen >6weeks in June 2023. ***1% of patients should wait more than 6 weeks for a diagnostic test*** **June** / **Total Waiting List** / **< 6weeks** / **> 6 weeks** / **Performance** UHD / 12,584 / 11,609 / 975 / **7.7%** **<u>UHD remains the top performing Trust for diagnostics in the south-west region and an area we are very proud of as a team</u>**
Health Inequalities	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** The Dorset Intelligence & Insight Service (DiiS) Health Inequalities dashboard enables analysis waiting times disaggregated by ethnicity, age band and deprivation (Dorset Patients only). An analysis at Trust level of the average (median) weeks waiting by ethnicity grouping and Index of Multiple Deprivation (IMD) identifies no variation between patients within community minority groups and White British populations, and between the 20% most deprived and the rest of the population treated in Q1. This is an improved position compared to last month. Variation between age and length of wait on the waiting list is noted within the report with the greatest variation between 0-19yrs and 20+ age bands. However, this variation has reduced in Q1 to date compared to 2022/23. Variation in waits does exist at specialty level and specialties have access to this information. A health inequalities improvement programme is supporting action on health inequalities in the Trust.
Infection Prevention and Control: (1 Alert , 1 Assure)	**Quality, Safety, & Patient Experience Key Points** **Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)** **To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture** **Alert (1) Cdiff Cases** • In June 2023 we have noted a significant increase in the number of C. difficile cases reported, both identified – in the community and trust associated. IPC Team working to understand trends.

	• This trend has been reported nationally and within the SW too. IPC teams reviewing. **Advise: Hospital Associated cases trend** 2022/2023 Organism | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 Cdiff | 9 | 10 | 9 | 9 | 11 | 9 | 2 | 4 | 5 | 6 | 4 | 5 | 5 | 8 | 19 eColi | 6 | 1 | 7 | 4 | 7 | 9 | 6 | 7 | 5 | 10 | 7 | 14 | 5 | 8 | 17 MRSA | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 MSSA | 4 | 4 | 2 | 3 | 3 | 3 | 7 | 2 | 3 | 3 | 1 | 1 | 4 | 6 | 8 • June 2023 saw reduction in ward closures as seasonal viral infections declined. • New guidance for COVID screening appears to be largely adopted across UHD with some local exceptions e.g. Haematology • New A-Z pathogens out for consultation, as is IC Principles Policy • E. coli increase seen June an but seasonally increased - thought to be due to weather, increase in UTI as source. • IPC nurse consultant interview process in progress
Clinical Practice Team ***(4 Advise)***	**Clinical Practice Team** **Advise (1) Moving and Handling - Essential Core Skills** The ability to meet the face-to-face level two training requirements for clinical staff continues. The risk register entry remains at 10 (moderate). The development of an eLearning Level 2 package is being developed. **Advise (2) Moving & Handling:** Active recruitment into the following posts Associate Practitioner Falls and Moving and Handling and Moving and Handling Risk Advisor successful. Currently we have support from Dorset Healthcare and an external provider to support all new starters with practice and Level 2 face to face training. **Falls prevention & management** : The Lead falls and moving and handling lead is currently vacant and after successful recruitment due to start in September 2023. **Advise (3)** Six fall incidents reported in month, one moderate harm, and five severe including fractured NOF and head injury. Scoping and investigation process' are in place for all moderate and above incidents with support from the falls team. **Tissue Viability:** The ability of the service to meet the increased demand remains on the risk register entry 1821 and rated as 9 (moderate), an action plan has been completed and is updated. The number of complex patients being referred to the service remains high. • The team have successfully recruited an additional band 6 advert for a six-month secondment to support increased activity. **Advise (4)** In month has seen a reduced number of reported incidents with a total of five newly acquired category three ulcers. These were a combination of deterioration of existing, medical

	devices and newly acquired tissue damage. The appropriate scoping and level of investigation is in place.
Patient Experience ***(1 Advise, 1 Alert)***	**Strategic goal: Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.** **PALS and Complaints Team** **Advise (1) FFT Response rates: FFT response rates have returned to levels expected and reported at 91% in June 2023.** In June there were 456 PALS concerns raised, 76 new formal complaints and 13 Early Resolution complaints (ERC) processed. The number of complaints that were responded to and closed in June 2023 was 75. Regular meetings with the care groups continue to focus on closing of complaints. Key themes from PALS and complaints: • Quality – clinical standards • Safety – errors, incidents and staff competencies • Communication – absent or incorrect • Respect – caring and patient rights **Alert (1) Complaint response times are exceeding the 55-day response time.** The number of complaints that were responded to and closed remains low with a higher number of complaints exceeding 55-day response time, which remains a risk. Additional resource has been sourced and a new corporate complaints process initiated. Despite not seeing a rapid decline in overdue complaint responses the overall average time to respond has reduced meaning that new complaints being processed through the new complaint model is more timely. **Mixed Sex Accommodation Breaches** There were no reported MSA incidents in June 2023
Nurse Staffing: ***(3 Advise, 1 Alert)***	**Care Hours per Patient Day (CHPPD)** **Advise (1)** June 2023's CHPPD for registered nurses and midwives remained static at 4.8. **Healthcare Support Workers (HCSW)** **Advise (2):** HCSW vacancies remain high; however, June 2023's recruitment event saw high numbers of attendees progressing to job offer.

	Alert (1) The Trust is meeting monthly with the NHS SW Direct support team, to help improve the recruitment and retention of HCSWs. **Red Flag Reporting** **Advise (3)** There were 25 red flags reported across UHD in June 2023. No critical staffing incidents were reported with all flags mitigated at the time.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement and retention**
CPO Headlines:	
People Operations: (2 Advise, 1 Alert)	**Industrial Action** **Alert (1)** National disputes around pay continue with Post Graduate Doctors in Training and Consultant staff. Pension regulations are changing as from 1 October 2023 **Advise (1)** The British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA) are due to take part in official strike action for any shift starting after 06:59 on Thursday 13 July 2023 and before 06:59 on Tuesday 18 July 2023. The BMA also has a mandate for Consultant members to strike. They will be taking 48 hours action starting at 7am on Thursday 20 July 2023. Derogations will be in place to provide staffing cover at Christmas Day levels within UHD and nationally. Following the ballot for industrial action within the Society of Radiographers (SoR) and the Royal College of Nursing (RCN), these did not meet the required threshold to take strike action within UHD. **Advise (2)** NHS Pensions regulations are changing from 1 October 2023. A partial retirement option is available (subject to criteria). This releases benefits for members and retains continuity of employment. Additionally, local changes have been made to the retirement and return provisions within UHD. The employment break period for employees on substantive contracts (excluding bank workers), will reduce from a minimum of 2 weeks to a minimum of 24hrs. This change provides greater choice for staff and supports retention and financial wellbeing.
Blended Education & Training (1 Advise, 1 Alert, 3 Assure)	**Alert (1)** Mandatory Training has improved slightly to 89.4% as at end of June 2023 but is still under the 90% across all sites. **Advise (1)** Moving and Handling: Third party supporting whilst MH Team recruiting. E-Learning for Level 2 progressing – programme being actively built. Provisional launch expected December 2023 Oliver McGowan, Patient Safety training – need to be completed asap for all patient facing employees to meet national requirements BEAT Education Strategy 2023-24 ratified and to be launched this month **Assure (1)** Seven Trainee Nursing Associate Apprentices have been offered a September Start. Placements in ED, Critical Care, Endoscopy and AMU. The NHS England bid to support the role of RNA in acute areas was successful (£40,000). Practice Educator

	support is planned to deliver bespoke acute/trauma training to this cohort. **Assure (2)** Maternity CQC training actions complete **Assure (3)** NHSE CPD 2023-24 funding confirmed for UHD £1,660,000. NMC and HCPC registrants are eligible. Additional funding for workforce bid in development.
Resourcing ***(4 Advise, 3 Alert, 1 Assure)***	**Alert (3)** **Alert (1)** Vacancy rate is being reported at 6.6% as at end of June. **Alert (2)** The Trust is in the Top 10 nationally for Whole Time Equivalent (WTE) HCSW vacancies. **Alert (3)** National disruption to the recruitment portal TRAC in the last 2 weeks of June 2023. **Medical Recruitment Activity** **Assure (1)** There were 5 new Medical Starters in June 2023, with 96 medical candidates in the pipeline, over half of whom are international candidates. **General Recruitment Activity** **Assure (2)** Despite national disruption to the Recruitment Portal TRAC, which was not available for use by Recruiting Managers, Applicants or the Recruitment Team for much of the last 2 weeks of June 2023, the number of adverts applications and offers in month has remained consistently high. Offers to over 100 Newly Qualified Nurses, and Trainee Nurse Associates were sent out. **Advise (1)** The Trust is working in alignment with the NHSE HCSW Direct Support Programme 2023/24 reviewing data and vacancy levels. **Advise (2)** Developing "Support Worker Induction Lite" to increase onboarding places from 32 to 54 per month. Those with previous/current care experience and/or Care Certificate eligible for Induction Lite. **International Recruitment Activity** **Advise (3)** Our first **International Radiographers** are due to arrive in July 2023 from the Philippines, with a further 4 in the process of being recruited. **Advise (4)** 25 RNDAs in recruitment pending September 2023 start across UHD.
Occupational Health and Wellbeing	In June 2023 OH received 183 management referrals, 79% of these were offered an appointment within 10 days of the referral being submitted. 382 pre-placements were received in June 2023, this is a 133% increase from May 2023 and relates to the success of our recruitment activities. The staff physio service and the PSC service both have a 3-week wait for a new appointment. Initial planning has started for the Autumn Vaccination program for UHD staff.
Workforce Systems (3 Advise, 2 Alert, 1 Assure)	**Alert (1)** ESR Data cleanse - Data from ESR and budgets need to be cleansed to ensure effective, correct and accurate data is presented about the workforce in the Trust. Concerns exist around completion by end of September 2023.

	Alert (2) Lack of rota Coordinators in Care Groups is impacting on medical rostering project **Advise (1)** ESR Data cleanse - The project is 16.5% complete with an expected date of completion as the 30 September 2023. Progress will be reviewed in mid-July. Lead role may need to be extended post review in July 2023. **Advise (2) Safe Care (safe staffing) -** Aim for the Safecare programme to be fully utilised by April 2024, this will be rolled out in 2 phases, phase 1 to re-introduce the Safecare sunburst into the daily staffing meetings in September, Phase 2 is based on training around the full abilities of Safecare **Advise (3) Template Reviews -** All 56 templates have been costed, comparisons to the current templates are being undertaken to assess differences.
Temporary Workforce ***(1 Advise, 1 Alert, 2 Assure)***	**Alert (1)** Nursing- demand for bank and agency remain high up 4.4% from previous month. **Advise (1)** Medical Bank and agency requirements indicate a marginal increase in duties requested on Locum Nest Medical Bank with a fill rate of 86%. This is a 5% reduction of fill from previous month **Assure (1)** The use of high volumes of RMNs from off-framework also contributed to the high spend in Q3/Q4 but this trend has been reversed since March. **Assure (2**) A review was undertaken of utilising appropriately skilled untrained Mental Health support has reduced the demand for registered mental health requirements to mainly support staff. A 'Bank Campaign' is now underway to grow the Mental Health Support workforce for UHD Bank. Hunter Healthcare is currently re-negotiating current agency MHSW charge rates to realise further savings. 93 bank applications were received for substantive staff in June – this is a 3.3% increase from May. Overall, 117 new bank workers were added into ESR by Payroll in June
Organisational Development ***(3 Advise, 2 Assure)***	**Advise (3) and Assure (2)** **Leadership & Talent Advise** • We will shortly be advertising spaces for this year's Coaching Apprenticeship through BPP • Successful closing session for Cohort 3 of the Leadership Fundamentals Programme, including Action Learning Sets. Cohort 4 has their final session w/c 3 July 2023. **Culture & Engagement Advise** • Work has commenced on the 2023 Staff Survey. • The first UHD Staff Awards was held on 15 June 2023. • Quarterly People Pulse is open during July 2023. **EDI Assure** • See Me First campaign launched to visibly acknowledge support required for our staff from an ethnic minority background to eliminate racist and discriminatory behaviour.

	• A UHD Cultural Awareness Day took place on the 7 July 2023 in partnership with the BAME staff network. **Health & wellbeing Assure** • Mental Health First Aider survey circulated. New information & application form created. MHFA Teams channel set up. Online MHFA update training arranged and 2 new cohorts of training organised for September & October 2023. • Wellbeing check in conversations developed and rolled out in therapies. Full Trust role out July 2023. **FTSU Advise** • A Deputy FTSUG will be commencing in post from 21 August 2023, for one year.
Trust Finance Position	**Strategic goal: To return to recurrent financial surplus from 2026/27** The Dorset ICS submitted a balanced revenue plan for the year, being the aggregate of individual organisational plans each of which confirmed a break-even revenue plan. However, the Trusts operational revenue budget for the year contains considerable financial risk. A range of mitigation plans have been identified and budgets continue to be actively managed to safeguard the financial performance of the Trust. At the end of June 2023 the Trust has reported a deficit of £7.3 million against a planned deficit of £4.4 million representing an adverse variance of £2.9 million. This is mainly due to energy cost inflation £1.379 million, the net cost of the Nursing and Junior Doctors Strike £923,000, unfunded escalation costs of £839,000 together with premium cost pay overspends in the Care Groups. This has been off-set in part by additional bank interest due to a higher cash holding and recent movement in Bank of England base rates and reduced depreciation charges due to the timing of capital expenditure. Cost Improvement Programme savings of £4.1 million have been achieved as at 30 June against a target £3.8 million. This includes non-recurrent savings of £2.5 million. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £17.9 million representing a shortfall of £15.5 million and a recurrent shortfall of £22 million. Mitigating this shortfall continues to be the key financial focus for the Trust. The Trust has set a full year capital budget of £199.6 million, including £172.7 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme. At the end of June 2023 the Trust has committed capital expenditure of £14.6 million against a plan of £51.8 million representing an underspend of £37.2 million. This underspend relates mainly to the New Hospitals Programme and STP Wave 1. The STP Wave 1 full year forecast remains consistent with the plan, however the NHP forecast is dependent on timings of approval and may result in a lower year end spend requiring a re-phasing of the national funding. As at 30 June 2023 the Trust is holding a consolidated cash balance of £101.4 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of capital funding for multiple schemes alongside a re-phasing of the capital programme spend. The

	balance attracts Government Banking Services interest of 4.89% at current rates, together with a PDC benefit of 3.5%. In June 2023 there has been a deterioration in the Trusts payment performance due to volume of temporary staffing invoices experienced through the Temporary Staffing Office however recruitment within this team is in progress to further mitigate this risk. Finance continues to work closely in supporting the team in clearing invoices within 30 days.
Key Recommendations:	Members are asked to: • Note the content of the report
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
Trust Management Group	July 2023	Pending
Quality Committee (Quality)	July 2023	Pending
Finance & Performance Committee (Operational / Finance Performance)	July 2023	Pending

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

University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: June 2023
Meeting Month: July 2023

Contents

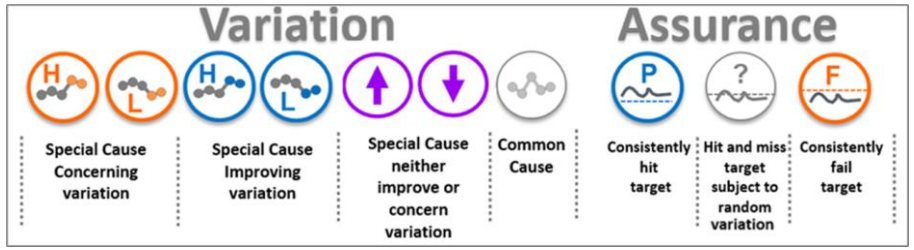
Performance at a Glance Indicators (1)

			standard	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
SAFE																
Quality	Presure Ulcers (Cat 3 & 4)			2	2	4	9	8	3	9	10	7	7	5	9	5
	Inpatient Falls (Moderate +)			1	5	7	5	3	2	5	9	3	3	5	2	7
	Medication Incidents (Moderate +)			0	2	2	1	0	2	1	0	1	0	0	0	2
	Patient Safety Incidents			1004	1205	1193	1096	1236	1216	1204	1166	1044	1201	1073	1190	1138
	Hospital Acquired Infections	MRSA		0	0	0	1	1	0	0	1	0	0	1	0	0
		MSSA		2	3	3	3	7	2	3	3	1	1	4	6	8
		C Diff		9	9	11	9	2	4	5	6	4	5	5	8	17
		E. coli		7	4	7	9	6	7	5	10	7	14	5	8	17
EFFECTIVE																
Mortality	HSMR (all Latest Mar 23	(source Dr Foster)		100.36	106.70	109.40	109.60	119.60	118.60	114.40	105.10	102.70	101.80			
	Patient Deaths	YTD		236	234	226	225	256	256	294	273	217	259	238	228	215
	Deaths within 36hrs of Admission			37	30	29	29	41	37	50	38	37	32	36	41	34
	Deaths within readmission spell			35	21	22	21	21	17	24	23	23	16	22	21	18
CARING																
	Complaints Received			80	78	83	90	98	100	75	92	84	86	73	95	91
	Complaint Response Rate (55 Days)			66.7%	67.7%	63.9%	56.6%	66.7%	58.7%	62.3%	52.5%	51.4%	47.4%	45.5%	45.5%	38.5%
	Friends & Family Test			88.3%	86.0%	90.4%	90.0%	89.8%	90.2%	87.8%	91.1%	92.7%	90.3%	90.9%	91.8%	91.0%
WELL LEAD																
Safety	Risks 12 and above on Register			34	34	35	38	37	35	37	38	41	38	38	40	43
	Risks 15 and above on Register			18	17	19	20	19	19	19	20	20	19	19	20	21
	Red Flags Raised*			45	86	128	142	107	74	84	41	43	38	21	43	25
People	Turnover			14.80%	14.50%	14.50%	14.70%	14.60%	14.70%	14.80%	14.94%	14.72%	13.90%	13.83%	13.66%	13.42%
	Vacancy Rate			5.68%	6.03%	8.88%	6.19%	7.96%	8.82%	7.3%	7.0%	6.4%	6.0%	5.8%	6.2%	6.6%
	Sickness Rate			5.1%	5.8%	4.7%	4.9%	5.7%	5.2%	6.4%	4.8%	4.7%	4.8%	3.9%	3.7%	3.9%
	Statutory and Mandatory Training			84.40%	85.54%	87.11%	86.75%	85.32%	85.80%	85.92%	86.31%	86.81%	86.98%	87.84%	88.45%	89.41%

Performance at a Glance Indicators (2)

		standard	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	
RESPONSIVE																
RTT	18 week performance %	92%	58.2%	58.3%	57.1%	54.9%	55.5%	56.1%	55.1%	55.4%	54.3%	53.8%	52.6%	54.3%	55.1%	
	Waiting list size	44,508	73,932	75,502	75,065	72,860	70,918	71,161	70,259	71,230	72,522	72,770	74,557	74,500	74,483	RAG based on trajectory
	No. patients waiting 26+ weeks		20,428	20,244	21,326	21,172	20,227	20,765	21,024	21,726	22,109	22,248	24,223	24,230	22,499	
	No. patients waiting 52+ weeks		4,493	4,170	4,010	3,559	3,468	3,634	3,472	3,565	3,861	4,100	4,380	4,813	4,574	RAG based on trajectory
	No. patients waiting 65+ weeks		1,714	1,405	1,464	1,420	1,449	1,342	1,195	1,127	1,147	1,070	1,249	1,242	1,053	
	No. patients waiting 78+ weeks	0	520	492	502	504	513	487	473	395	274	96	112	97	32	RAG based on trajectory
	No. patients waiting 104+ weeks	0	118	100	95	76	63	37	25	10	0	0	0	0	0	RAG based on trajectory
Theatre	Theatre utilisation (capped) - main	98%	78%	74%	75%	75%	69%	75%	73%	71%	71%	65%	72%	73%	73%	
	Theatre utilisation (capped) - DC	91%	73%	69%	69%	70%	74%	74%	69%	69%	67%	57%	69%	74%	73%	
	NOFs (Within 36hrs of admission - NHFD)	85%	2%	12%	18%	8%	40%	52%	43%	49%	24%	67%	54%	33%	37%	
Outpatients	**Outpatient metrics**															
	Overdue Follow up Appts		25,671	32,621	33,268	33,840	32,999	32,757	33,369	34,863	34,756	34,302	31,778	31,057	30,594	
	% DNA Rate	5%	8.3%	8.3%	8.0%	7.4%	6.8%	6.5%	7.5%	7.5%	6.5%	7.1%	7.6%	6.5%	6.1%	
	Patient cancellation rate		10.7%	11.2%	10.5%	11.4%	11.0%	10.5%	12.3%	10.6%	10.8%	9.2%	8.9%	11.3%	11.6%	
	% non face to face (telemedicine) attendances	25%	22.9%	22.5%	21.8%	21.1%	20.4%	20.0%	20.2%	20.8%	21.3%	18.5%	18.6%	18.6%	17.5%	
DM 01	**Diagnostic Performance (DM01)**															
	% of >6 week performance	1%	19.5%	20.2%	22.6%	20.0%	16.4%	11.0%	13.6%	10.7%	7.4%	7.0%	8.4%	6.0%	7.7%	
Cancer	28 day faster diagnosis standard	75%	66.9%	63.6%	62.9%	64.7%	63.1%	59.6%	68.4%	65.0%	71.0%	75.4%	71.2%	70.2%	71.9%	*June cancer position predicted and not finalised*
	62 day standard	85%	73.4%	66.2%	65.9%	71.2%	69.4%	64.3%	63.4%	63.6%	61.9%	65.4%	67.0%	62.7%	60.2%	
Emergency Dept	4 hour care standard												61.6%	65.9%	61.7%	
	Arrival time to initial assessment	15	18.0	21.6	30.0	15.0	16.0	15.0	20.5	11.0	15.0	13.0	16.0	19.0	22.0	
	Clinician seen <60 mins %		20.0%	20.9%	26.6%	26.0%	25.5%	24.3%	21.8%	31.6%	25.7%	26.1%	31.6%	27.6%	35.6%	
	Patients >12hrs from DTA to admission	0	105	97	103	129	295	157	343	234	294	211	220	82	13	
	Patients >12hrs in dept		769	879	779	886	1292	1074	2000	1108	1443	1238	849	637	504	
SW AST	Ambulance handovers		3696	3758	3743	3657	3716	3855	3545	3602	3360	3988	4001	4102	4015	
	Ambulance handover >60mins breaches		629	642	445	547	666	583	1568	733	859	900	698	345	383	
Patient Flow	Bed Occupancy (capcity incl escalation)	85%	93.4%	93.6%	93.4%	92.8%	94.2%	92.7%	93.3%	93.1%	94.1%	94.5%	93.6%	92.3%	94.4%	
	Stranded patients:															
	Length of stay 7 days		539	543	577	567	605	550	522	564	582	543	523	502	480	
	Length of stay 14 days		360	357	400	397	421	375	332	366	387	355	337	322	294	
	Length of stay 21 days	108	256	255	295	303	315	281	228	250	269	255	235	223	199	
	Non-elective admissions		5802	5778	5367	5472	5535	5817	5956	5693	5165	6203	5690	6288	6347	
	> 1 day non-elective admissions		3633	3652	3396	3475	3578	3676	3905	3673	3202	3881	3612	3826	3783	
	Same Day Emergency Care (SDEC)		2168	2126	1971	1996	1956	2141	2050	1979	1963	2316	2078	2458	2560	
	Conversion rate (admitted from ED)	30%	26.90%	26.50%	26.30%	27.60%	28.80%	29.10%	28.30%	30.90%	27.79%	28.30%	29.70%	29.90%	31.60%	

Statistical Process Control (SPC) – Explanation of Rankings



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

Quality Outcomes & Safety Patient Experience

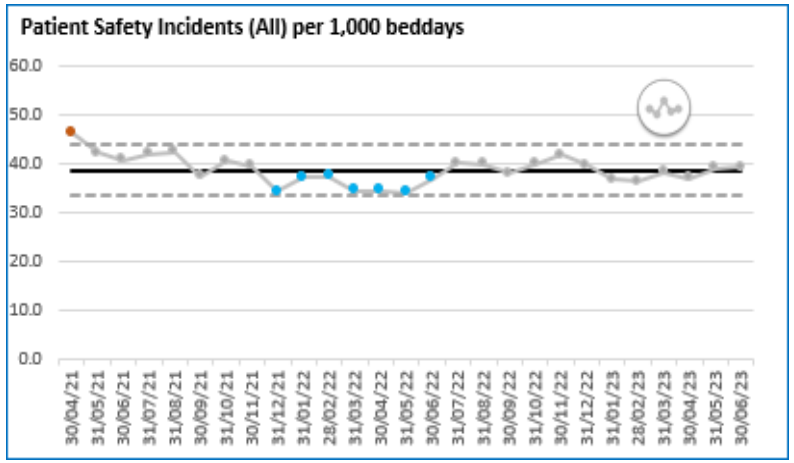
University Hospitals Dorset
NHS Foundation Trust


Professor Paula Shobbrook
Chief Nursing Officer/ Deputy CEO
Dr Peter Wilson
Chief Medical Officer

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

Committees:
Quality Committee

Quality (1) – Safe



Background/target description

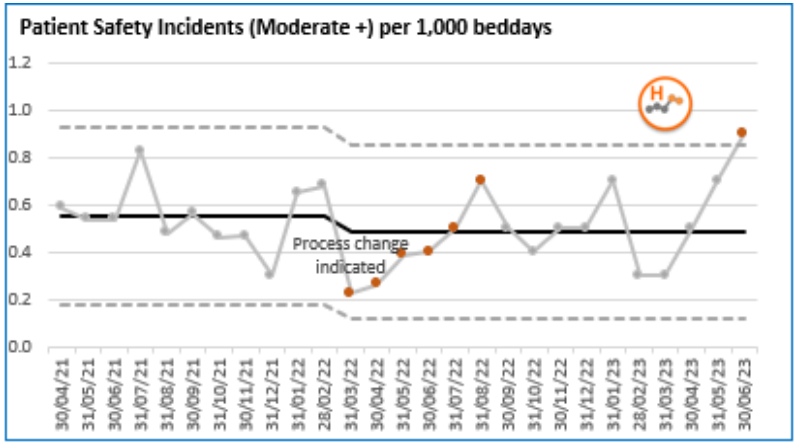
To improve patient safety.

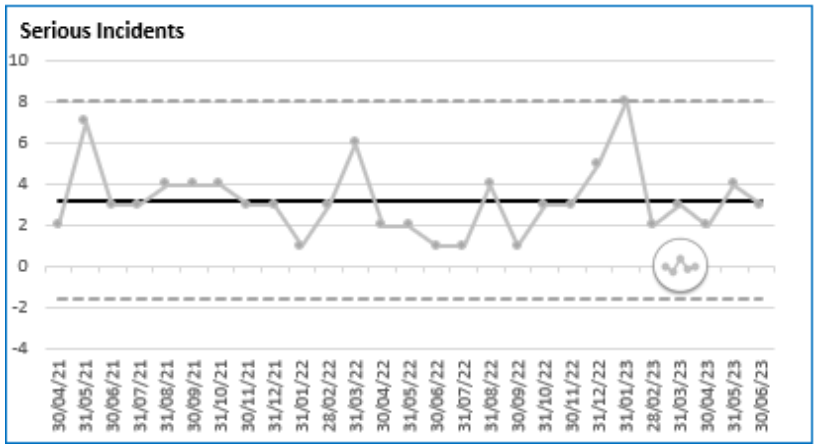
Performance

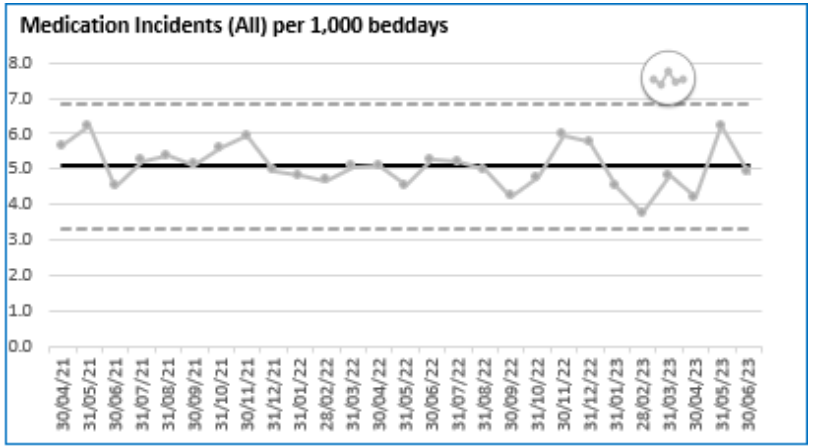
- Three (3) externally reported incidents reported in month (June 23).
- No significant trends or changes in metrics in month

Key Areas of Focus

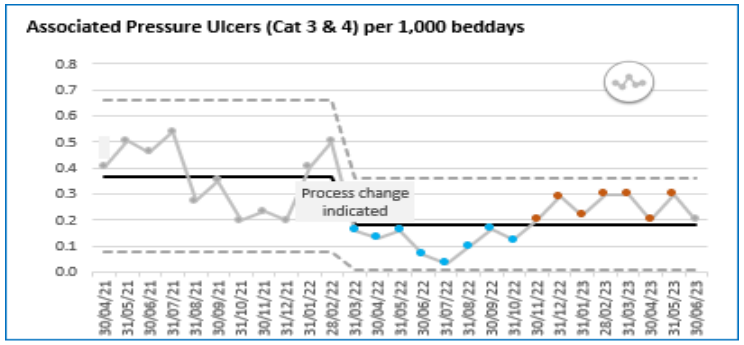
Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

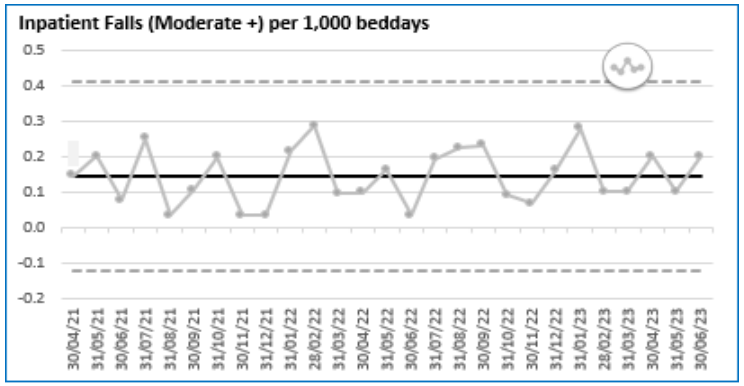


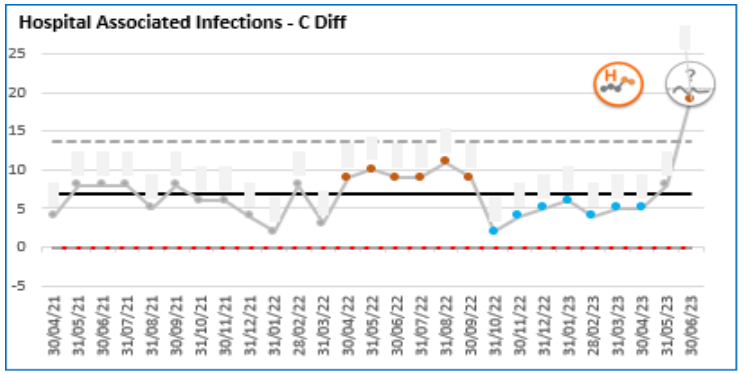




Quality (2) – Safe







Background/target description

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

Performance

Clinical practice:

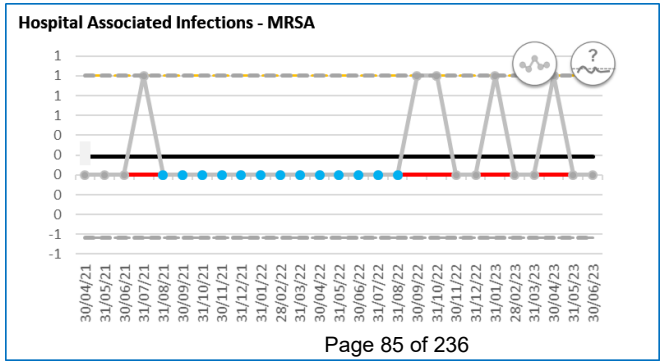
- There was a reduction in reported Pressure Ulcers in month with five new category three pressures ulcers reported which are following the appropriate investigation.
- There was an increase in number of serious falls incident in month with six falls reported. Five of which were severe and one documented as a moderate harm. These falls are following the appropriate scoping and investigation process.

IPC

- June saw reduction in ward closures as seasonal viral infections declined.
- New guidance for COVID screening appears to be largely adopted across UHD with some local exceptions e.g. Haematology
- New A-Z pathogens out for consultation, as is IC Principles Policy
- Increase in number of C. difficile cases identified - community and trust associated, which is in a national picture.. IPC Team working to understand trends.
- E. coli increase seen June an but seasonally increased - thought to be due to weather, increase in UTI as source.
- IPC nurse consultant interview process in progress

Key Areas of Focus

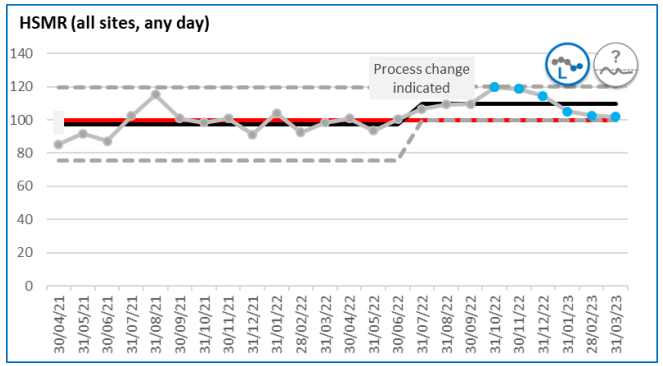
Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

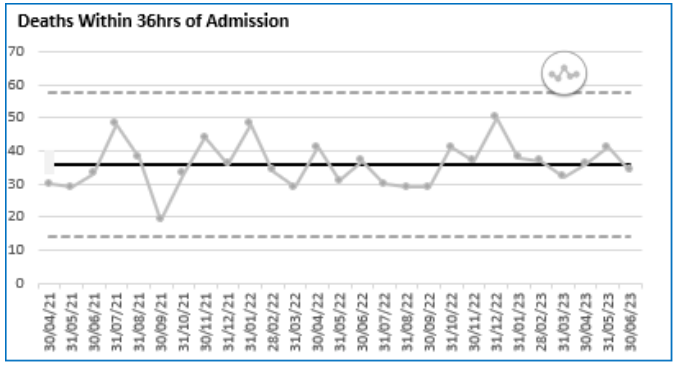


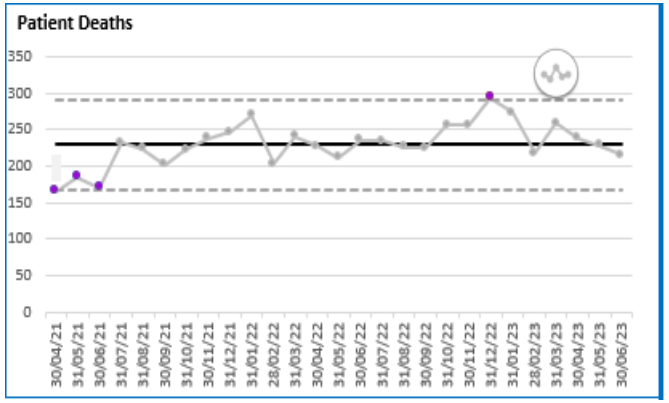
Hospital Associated Infections Summary for IPR

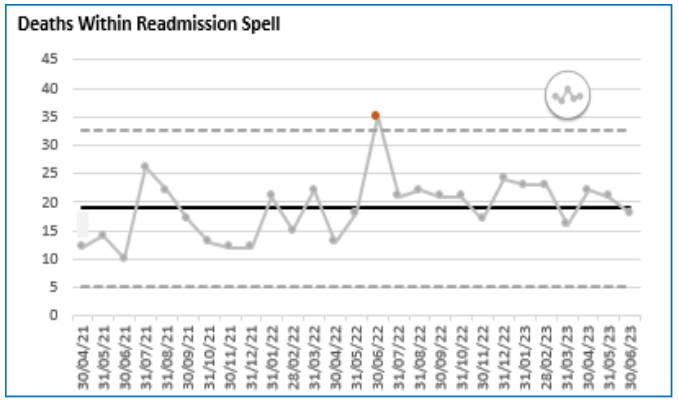
Month	C Diff	E Coli	MRSA	MSSA
Jun-22	9	7	0	2
Jul-22	9	4	0	3
Aug-22	11	7	0	3
Sep-22	9	9	1	3
Oct-22	2	6	1	7
Nov-22	4	7	0	2
Dec-22	5	5	0	3
Jan-23	6	10	1	3
Feb-23	4	7	0	1
Mar-23	5	14	0	1
Apr-23	6	7	1	5
May-23	8	8	0	6
Jun-23	19	17	0	8

Quality (3) – Effective & Mortality









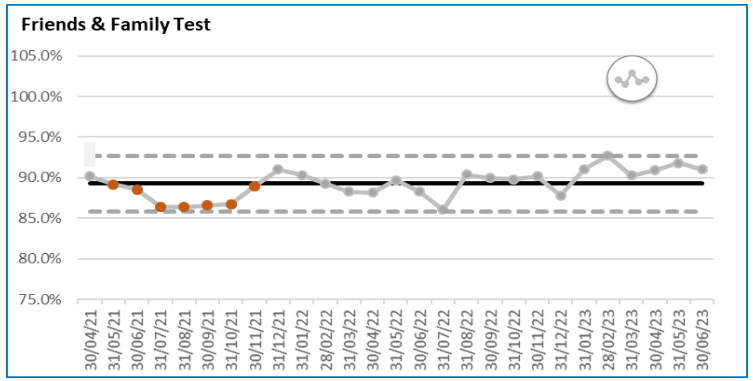
Please see the separate 'Mortality Update' which has been submitted to the Board outlining the imminent development of a new suite of mortality metrics. This new development will be the standard mortality output for all committees – Board, IPR and Quality Committee.

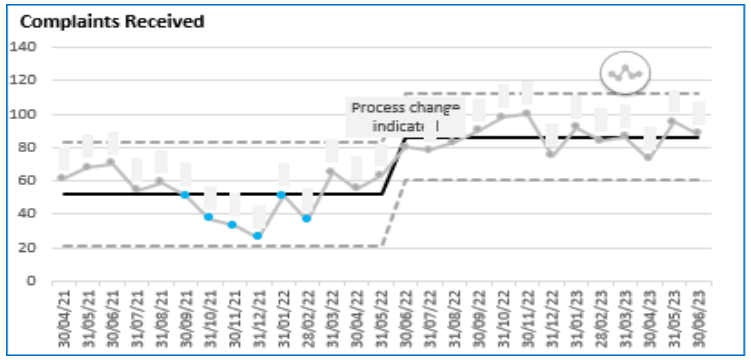
The headline mortality figure that we will report and which will align with the key metric in Patient First will be HSMR for the whole of UHD.
We will support this with an evolving suite of relevant metrics which will adapt to need and any risks.

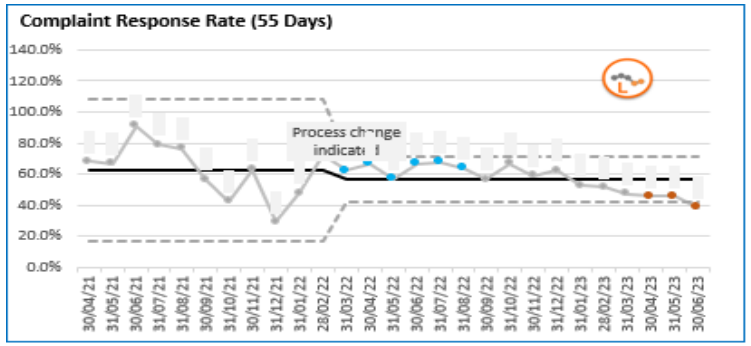
As previously reported to board, all formally reported mortality metrics are at least 5 months old and any trends are about a year old. As a trust we need to be mindful and sighted of this data and we will also use some more contemporaneous sources from the medical examiner and learning from deaths review.

We aim to have this reporting ready for the August output.

Quality (3) – Caring







PALS and Complaints Data for June 23:

Overview:

- 456 PALS concerns raised
- 76 new formal complaints (remain within our control measures)
- 13 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in June were 75.

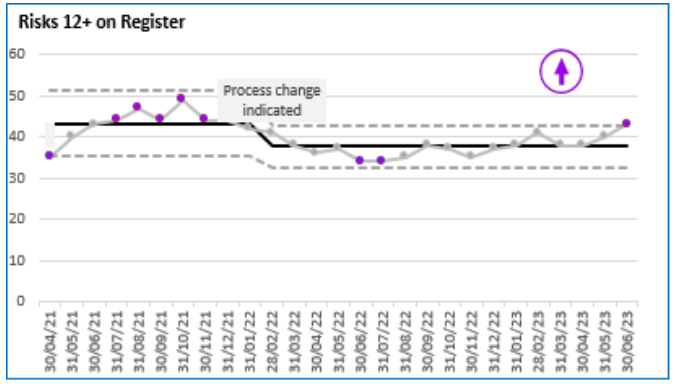
- Key themes from PALS and complaints:
  - Quality – clinical standards
  - Safety – errors, incidents and staff competencies
  - Communication – absent or incorrect
  - Respect – caring and patient rights

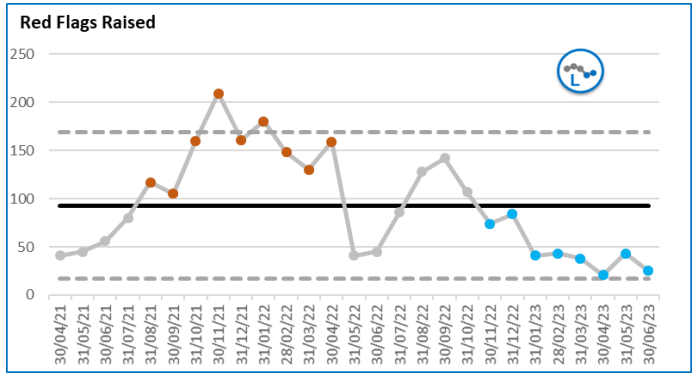
Alert: Additional resource to support responding to and closing complaints within the 55-day response has been recruited, some initial progress has been made. Further changes and recruitment planned to address these further.

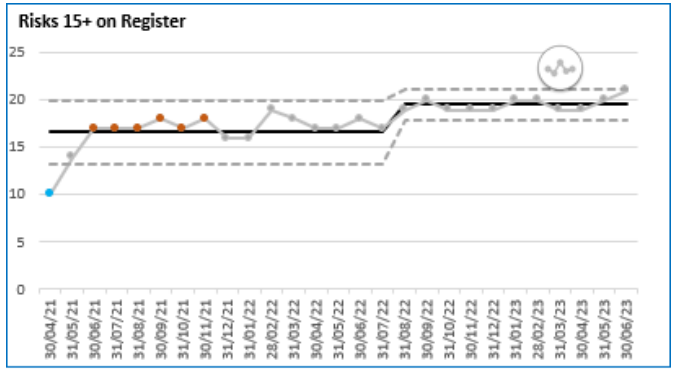
Friends and Family Test (FFT)
A return to normal response levels for FFT is noted and reported at 91% in June 2023.

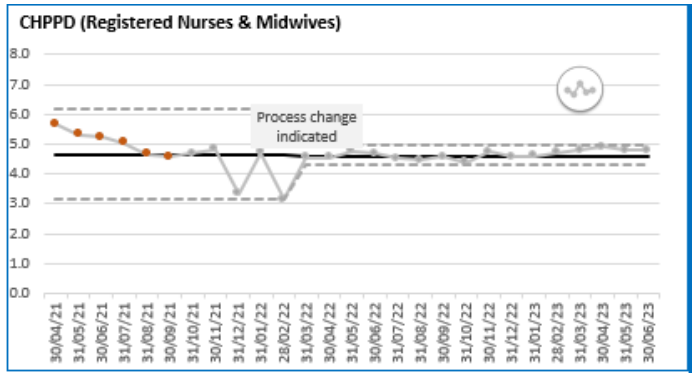
Mixed Sex Accommodation Breaches
There were no reported MSA incidents in June 2023

Quality (4) – Well Led









Performance

- CHPPD (Care Hours Per Patient Day) for registered nurses and midwives in June 2023 aggregated remained at 4.8, Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- June's red flag data shows that 25 on shift flags were raised. No critical staffing incidents were reported showing that all flags were mitigated, and safe staffing maintained.

Key Areas of Focus

- Risk register being aligned to new Committee structure and UHD Accountability Framework (approved May 23)
- Updated Risk Management Strategy approved at QC and Board in June 23. Revised Risk Appetite Statement being developed
- Additional guidance on identification and articulation of controls has been shared with CGG and TMB.
- Risk register update provided in Quality Committee, TMB, and Board report.
- BDO Internal Audit report on Risk Maturity to be presented to Audit Committee. Positive assurance.

Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) June 2023

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	15369	77233.7	76825.4	99.5%	5.0
Bournemouth & Christchurch	15600	74741.7	72335.9	96.8%	4.6
UHD Total	30969	151975.3	149161.4	98.1%	4.8

Maternity (1)

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

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

National position & overview

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

Findings of review of all perinatal deaths using the national monitoring tool

MBRRACE reportable cases:

There have been no reportable cases for MBRRACE in June .

However overall year to date figures remain high , above expected range and therefore in agreement with the ICB there will be an external review. The months of April and May will be revied by Somerset Trust.

Findings from this review will be shared with the Trust Board.

Early theme identified of reduced fetal movements and action has been taken to increase awareness of the importance of reduced fetal movements.

Matters for Board information and awareness

Incidences to note:

Top 3 incidences

1. Insufficient numbers of healthcare professional :
- Causing disruption in service and delay in care.
- Training compliance standards not being met
- 1 Opel 4 – no harm to patients noted

2. Avoidable term admissions to NICU at 5.5% (<6% above national average above regional average of 5%) :
- In depth review in progress no early theme identified .

3.Telecommunications failure :
- 13 incidences report of call bell system alerts
- Fault on system identified by the company
- SOP followed and patient safety maintained
- Ongoing monitoring by the estates team
- Risk identified on risk register (Low risk)

Trust Board Reading room
- Midwifery workforce 6 monthly report
- Final SI report L98396

Progress in achievement of Year 5 Maternity incentive scheme

MIS year 5

Year 5 standards have been released.

There has been extension to the safety standards with additional elements to achieve.

Saving babies lives element 6 outlines pathways which are multi disciplinary and will require trust wide pathway and response.

Good progress is being made on recording of all training on BEAT/Green Brain however this standard now requires training to be consistent over 12 months of 90 %. As our training figures from January to June have not met this standard, we are unable to achieve full compliance to the scheme however maternity safety remains the same priority to all of the team.

Work continues on all safety standards with monthly assurance meetings to monitor compliance .

The national team are reviewing standard 6 saving babies' lives (SBL) standard 8 training and standard 9 Board assurance and a further update will be provided to trusts on these elements.

Maternity (2)

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

Maternity Perinatal Quality Surveillance Scorecard

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	23-Jan	23-Feb	23-Mar	Apr-23	May-23	Jun-23
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	0	0	0
	3rd/4th degree tear overall rate	>3.5%	1.60%	1.40%	0.60%	3.1%	2.70%	4.2%
	Obstetric haemorrhage >1.5L	>2.6 %	4.20%	2.10%	4.30%	2.10%	3.0%%	3.7%
	Term admissions to NNU	National <6%, Regional <5%	5.80%	3.40%	6.20%	5.9%	6.50%	0.055
	Apgar < 7 at 5 minutes	<1.2 %	2.30%	2.40%	1.10%	2.3%	0.0%	1.10%
	Stillbirth number	Actual	0	1	0	4	2	0
	Stillbirth number/rate (per 1,000)	> /1000	0	3	0	13.29	7	0
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:23	01:23	01:25	01:25	01:24	01:24
Feedback	Number of compliments (Smiles via Badgernet)		62	18	43	42	37	41
	Number of concerns (PALS)		0	2	0	0	0	4
	Complaints	3	2	0	4	2	3	2
	FFT Repsonse -returns as % of deliveries not mandated now)			12%	40%	43%	46%	87%
Training	UHD Mandatory training - women's health	90%	79%	87%	86%	82%	84%	86%
	PROMPT/Emergency skills all staff groups	90%	96%	94%	94%	82%	82%	84%
	K2/CTG training all staff groups	90%	89%	85%	85%	91.76%	96%%	94%
	CTG competency assessment all staff groups	90%	89%	not known	not known	91.76%	96%%	94%
	Core competency framework compliance	90%	92%	not known	84%	84%	87%	89%
	Coroner Reg 28 made directly to the Trust	nal <6%, Regiona	N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action		Y (CQC)	Y (CQC)	Y (CQC)	Y (CQC)	Y(CQC)	Y(CQC)

Data and Targets

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

Performance

There are 2 areas currently flagging as red RAG rated :

- 3rd/4th degree tear overall rate :
- Obstetric haemorrhage >1.5L

There are 2 areas currently RAG rated as amber

- Term admissions to NNU - deep dive in progress
- Training –ongoing challenges to meet 90% compliance due to staff vacancies.

Improvement continues in the *Apgar <7 at minutes* metric has been noted following staff training

Key Areas of Focus

3rd/4th degree tear overall rate : performance for this metric has been reviewed and identified as not concerning as the rate is within normal range variation but has been red rated this month at 4.2% . The national rate is 3.5%.

Obstetric haemorrhage >1.5L : performance for this metric has been reviewed and identified as not concerning as the rate fluctuates but this will be monitored in next few months.

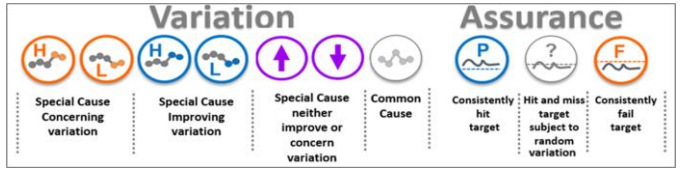
Term admissions to NNU : Avoidable term admissions to NICU (5.50%) is below the national average of <6% but above the region average of 5.0% . There have been 13 admissions.
Avoidable term admissions to NNU will be the subject of a deep dive with both the ODN and ICB and findings will be presented to the board.

Training
Not meeting 90% compliance for PROMPT and K2 CTG training- ongoing work with the team to improve this standard.

Performance at a glance
Quality - Key Performance Indicator Matrix

UHD Quality

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	Jun 23	0.2	-			0.2	0.0	0.4
Inpatient Falls (Moderate +) per 1,000 beddays	Jun 23	0.2	-			0.1	-0.1	0.4
Medication Incidents (Moderate +) per 1,000 beddays	Jun 23	0.1	-			0.0	-0.1	0.2
Medication Incidents (All) per 1,000 beddays	Jun 23	4.8	-			5.1	3.3	6.9
Patient Safety Incidents (All) per 1,000 beddays	Jun 23	39.5	-			38.6	33.4	43.9
Patient Safety Incidents (Moderate +) per 1,000 beddays	Jun 23	0.9	-			0.5	0.1	0.8
Serious Incidents	Jun 23	3				3	-2	8
Never Events	Jun 23	0	-			0	-1	1
Hospital Associated Infections - MRSA	Jun 23	0	0			0	-1	1
Hospital Associated Infections - MSSA	Jun 23	8	0			4	0	8
Hospital Associated Infections - C Diff	Jun 23	19				7	0	14
Hospital Associated Infections - E Coli	Jun 23	17	0			7	-2	16
Risks 15+ on Register	Jun 23	21	-			20	18	21
HSMR (all sites, any day)	Mar 23	101.8	100.0			109.8	99.6	120.0
Mixed Sex Accommodation Breaches	Jun 23	0	0			4	-15	22
Complaints Received	Jun 23	88	-			86	60	112
Complaint Response Rate (55 Days)	Jun 23	38.5%				56.8%	42.4%	71.3%
Friends & Family Test	Jun 23	91.0%	-			89.3%	85.8%	92.7%
			0					
Patient Deaths	Jun 23	215	-			229	168	291
Deaths Within 36hrs of Admission	Jun 23	34	-			36	14	57
Deaths Within Readmission Spell	Jun 23	18				19	5	33
Risks 12+ on Register	Jun 23	43				38	33	43
Red Flags Raised	Jun 23	25				93	17	169
CHPPD (Registered Nurses & Midwives)	Jun 23	4.8				4.6	4.3	5.0



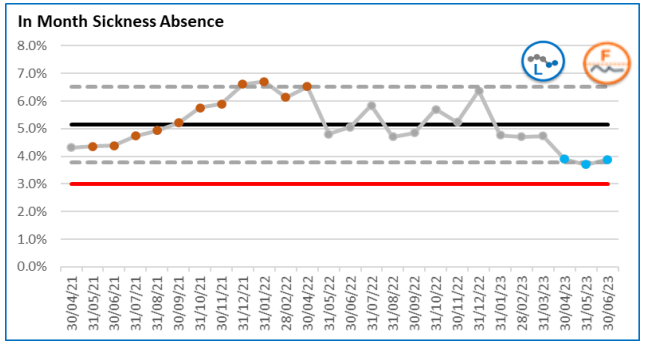
Our People

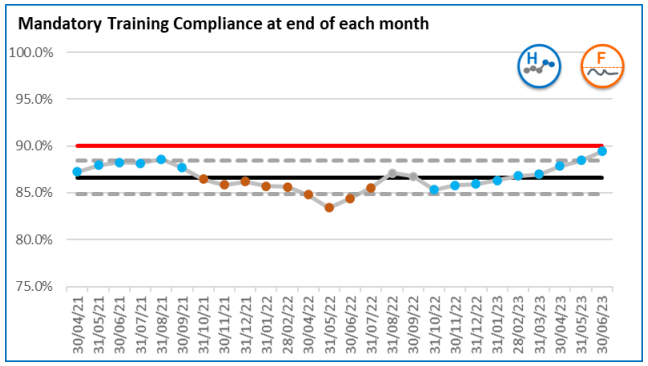
Karen Allman
Chief People Officer

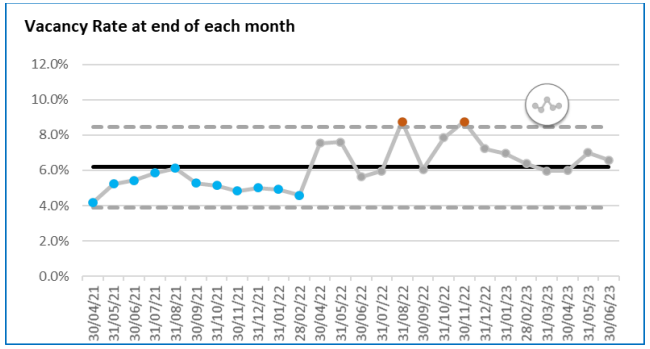
Operational Leads:
Irene Mardon - Deputy Chief People Officer

Committees:
People and Culture Committee

Well Led - Workforce (1)







Performance

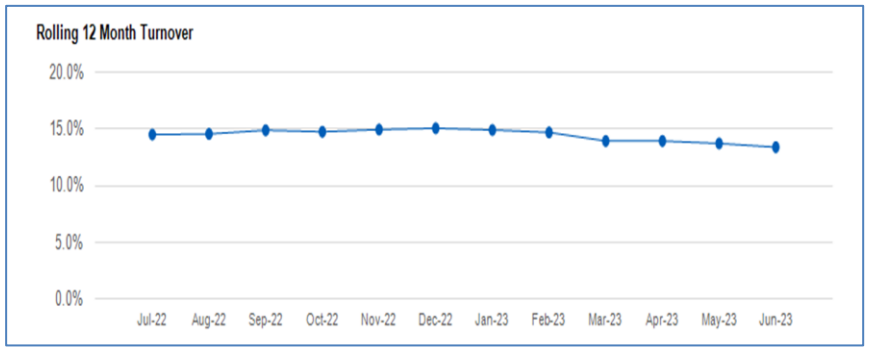
- Rolling 12 month Turnover rate (excluding fixed term temp) is at 13.4%, which is a slight reduction on last month and continues the downward trend.
- In month sickness absence for June 2023 was at 3.9%, slightly up from 3.7% previous month. Latest rolling 12 month rate (as at end of June 2023) is 4.9% which is a reduction on the previous month.
- Mandatory Training has improved slightly to 89.4% as at end of June 2023 but is still under the 90% across all sites.
- Latest vacancy position is 6.6% (June 2023). 10 Internationally Educated Nurses arrived in June, from Nigeria, India, Philippines, Ghana and Sri Lanka. The number of Non- Medical Starters was lower in June than in previous months, with half of those being internal moves. A new record of job offers was made in June for medical starters
- Appraisal compliance for values based as at end of June is 12.4%. Medical & Dental is 62.4%.
- Trust wide agency spend should be no more than 3.7% of the overall pay bill. Currently the Trust at M3 is at 4.61%

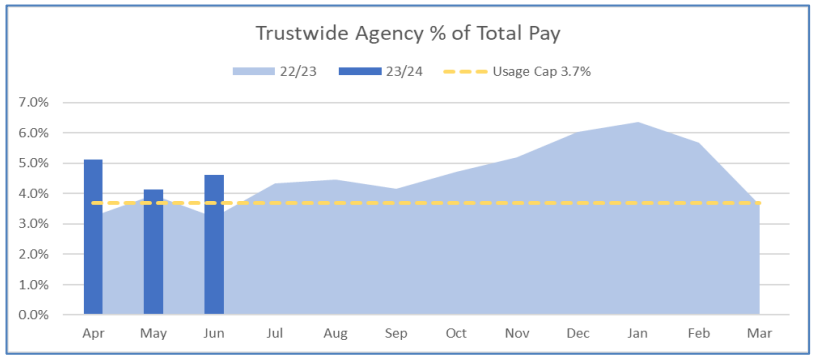
Underlying issues:

- Data continues to adjust as the ESR establishment work and data cleanse process continues.
- Agency spend has decreased in the Medical Care Group M2 8.18% to 7.98% in M3, The Surgical Care Group was 3.86% in M2 and is now 3.25% in M3. Women's, Children, Cancer and Support Services Care Group was 3.86% in M2 and is now 4.29% in M3. Surgical Care Group remains under 3.7% but has seen a rise in M3

Key Areas of Focus

Information Governance is currently below the 95% national compliance required – currently it is 92.1%.

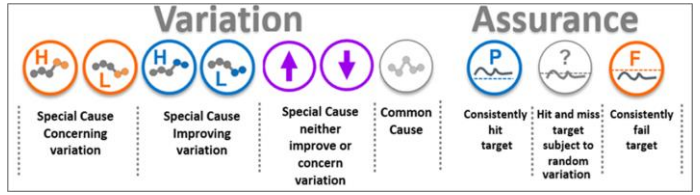




Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Jun 23	6.6%	-			6.2%	3.9%	8.5%
In Month Sickness Absence	Jun 23	3.9%	3.0%	L	F	5.1%	3.8%	6.5%
Mandatory Training Compliance at end of each month	Jun 23	89.4%	90.0%	H	F	86.6%	84.8%	88.4%
Temporary Hours Filled by Bank	Jun 23	53.0%	-			53.8%	46.7%	60.9%
Temporary Hours Filled by Agency	Jun 23	24.0%	-			15.0%	12.6%	17.3%



Population Health and System Working

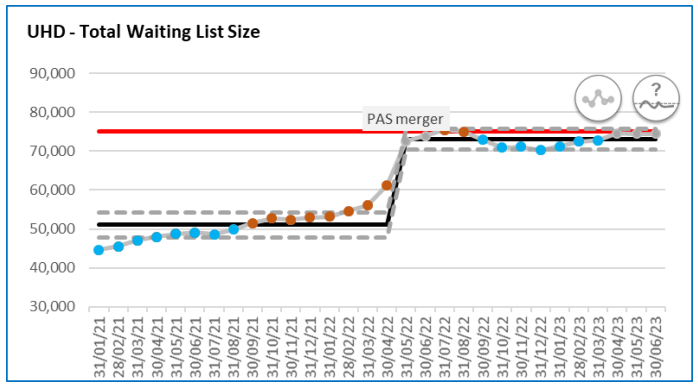
University Hospitals Dorset
NHS Foundation Trust

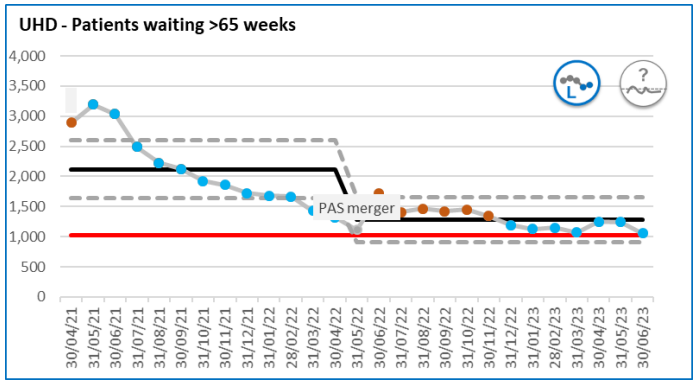
Mark Mould
Chief Operating Officer

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

Committees:
Finance and Performance Committee

Responsive – (Elective) Referral to Treatment)





	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	55.06%	
Waiting list size	51,491	74,483	17%
Waiting List size variance compared to Sep 2021 %	0%	44.7%	
No. patients waiting 26+ weeks		22,499	21%
No. patients waiting 40+ weeks		9,892	23%
No. patients waiting 52+ weeks (and % of waiting list)	6.1%	4,574	25%
No. patients waiting 65+ weeks (and % of waiting list)	1.4%	1,053	36%
No. patients waiting 78+ weeks (and % of waiting list)	0.0%	32	44%
No. patients waiting 104+ weeks (and % of waiting list)	0.0%	0	-
% of Admitted pathways with a P code		97.54%	

Data Description and Target

Total number of patients waiting on an RTT elective waiting list.
Number of patients on an elective RTT waiting list whose wait exceeds 78 weeks. National target 0 by March 2023.
Number of patients on an elective RTT waiting list whose wait exceeds 65 weeks. National target 0 by March 2024.

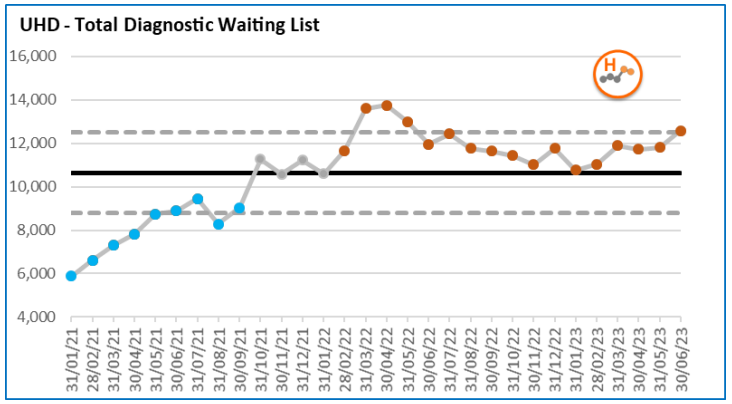
Performance

- 32 patients breaching over 78 weeks remain at the end of June; a reduction of 65 since May 23. Breaches are in 4 specialties: Trauma & Orthopaedics, Colorectal Surgery, Gynaecology and Community Paediatrics, School Age Neurodevelopment Service.
- The impact of industrial action in June meant that the Trust was not able to eliminate 78 week waits as planned, as cancer and clinically urgent patients were prioritised into outpatient and theatre capacity. Reduced preoperative assessment capacity in month has been mitigated by additional sessions running at weekends and prioritisation of patients for assessment.
- Two Orthopaedic 78-week breaches reported last month, due to waits for nickel-free orthopaedic joint replacements, are now both dated to come in.
- 1,053 patients are breaching 65 weeks at the end of June 2023. This is 30 above plan (1,023), however the variance to plan has reduced this month by 63. A sustained reduction in 65-week waits is being maintained.
- The total waiting list (PTL) was 74,483. This measure is not changing significantly; however, performance is 778 below the operational planning trajectory for June 2023 (75,261). Continuous validation of the waiting list is necessary to ensure data quality is maintained.

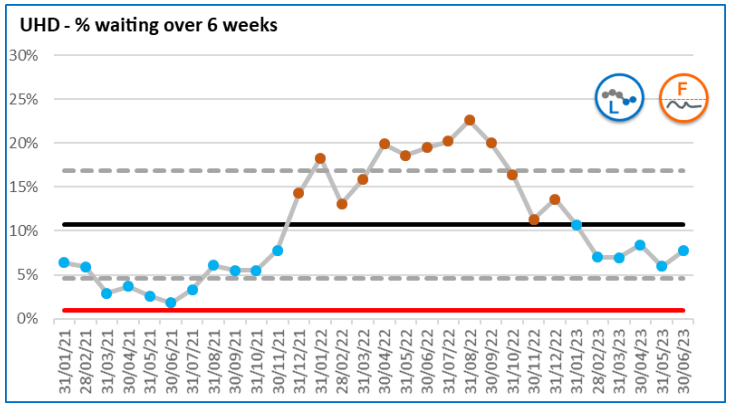
Key Areas of Focus

- Promoting excellence in the basics including extending the Trust's wait-in-line initiative to ensure capacity is used appropriately and an additional validation hub is planned in July in ENT services.
- Additional internal waiting list initiatives for both elective and cancer waits are scheduled in a range of services including Gynaecology, Community Paediatrics, Dermatology and Urology.
- Arrangements are being finalised to secure an Independent Sector Provider to provide additional School Age Neurodevelopment assessment capacity. This capacity is likely to be available in August 23.
- The Chief medical Officer and Chief Operating Officer are working with Care Group Medical Directors and Group Director of Operations to optimise our capacity for elective work during IA in July whilst maintaining patient safety and quality of care. It is anticipated that there will be a significant reduction in activity, however.
- Implementation of the enhanced pay rate scheme for theatre staff is supporting additional theatre sessions to run, whilst recruitment continues to onboard new starters.

Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)				
% of >6 week performance	*(6+ Weeks / Total)*	1%	975/12584	7.7%



Data Description and Target

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

Performance

Consistent significant improvement in overall diagnostics (DM01) performance has been delivered since January 2023. May performance was 6.0% compared to 7.7% at the end of June. Further improvement is required to meet the 1% target.

Endoscopy improved again in month to 13.9% at the end of June (17.5% at the end of May).

Echocardiography performance has deteriorated moving from 10.6% in May to 14.9% in June.

- Heart failure remains the challenge in achieving DM01 but improvement continues through good list utilisation and additional lists from our staff. 25% increase in referrals in month.

Neurophysiology remains at 9.8% in June.

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

Radiology performance has deteriorated since May (3.0%) to 5.4% in June .

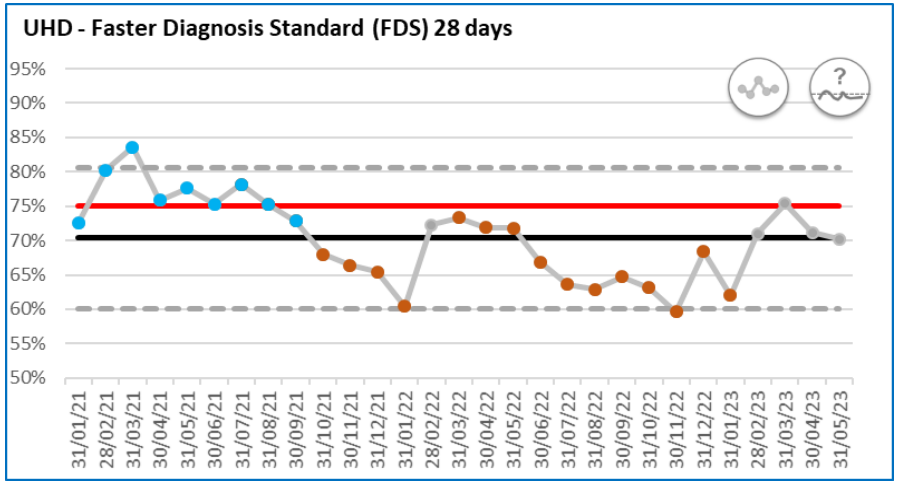
- Imaging – the target is not being achieved consistently, predominately due to ongoing reduction in cardiologist CT / MRI sessions. A locum cardiologist has now commenced and completing training; anticipated completion by August 2023.
- Increased numbers of ultrasound breaching patients due to BH and unfilled WLIs. Additional AECC provision in place to recover backlog.
- MRI scanning at the mobile unit situated at AECC has commenced.

Key Areas of Focus

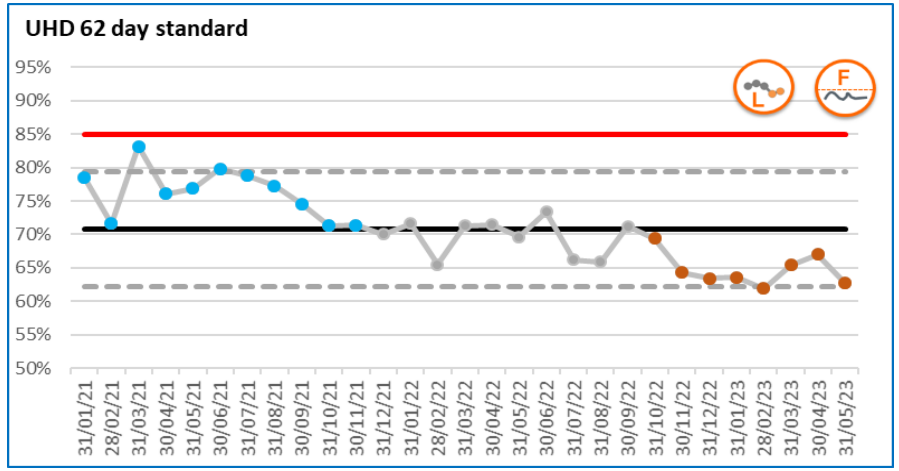
- Endoscopy: Ongoing insourcing requested from ERF for Q2 and Q3 in the form of 18WS and InHealth mobile unit. Workforce expansion plan underway to staff weekday lists at Wimborne.
- Dr Doctor to be integrated with e-Camis for Endoscopy with ongoing management of bookings team to ensure high utilisation (currently at 88%) and low DNAs. New report has been developed to pull utilisation data.
- Delivery of reduction in DNA using dedicated A&C support and recruitment campaigns continue in Echocardiology.
- Continued assistance from AECC planned in July for ultrasound and MRI recovery.
- Exploring potential move of cardiac CT/MR activity at UHD to DCH.
- Mitigation of the impact of industrial action in all modalities.

Responsive (Elective)
Cancer FDS 62 Day Standard

28 Day Faster Diagnosis Standard (Target 75%)
May Performance by Tumour Site (70.2%)



62-Day Standard (Target 85%)
May Performance by Tumour Site (62.7%)



Data Description and Target

- Percentage of patients informed of diagnosis within 28 days from referral. Faster Diagnosis Standard 75%
- Percentage of patients who receive their 1st treatment for cancer within 62 days. 62d Standard 85%
- The number of 62-day patients waiting 63 days or more on their pathway.

Finalised May Performance

- 28 Day Faster Diagnosis Standard - Performance in May was 70.2% and fell below the mean (1.8% below the trajectory). 6 out of 14 tumour sites achieved the target but the Trust is inconsistently achieving the target and is yet to show evidence of statistical improvement. Recovery plans are in place for the remaining tumour sites.

- 62 Day performance in May decreased by 4.3% compared to the previous month to 62.7%. Treatment numbers were 17.2% lower compared to May 2022 (likely due to 3 bank holidays and industrial action in the month), which impacted on performance.

- The total number on the UHD PTL in May over 62 days increased to 352.

Predicted June Performance (un-finalised)

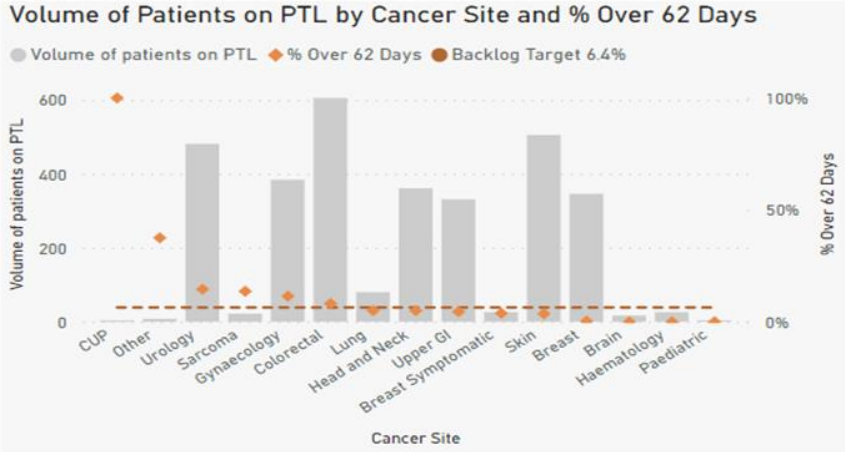
- 28 Day - June's performance is currently showing an increase of 1.7% to 71.9% (trajectory 73.5%). 6 out of 14 tumour sites achieved the standard, which is an increase of 2.

- 62 Day - The provisional performance for June is currently 60.2%, however, this is expected to increase as treatments are reported by month's end.

- The total number of patients over 62 days decreased in June to 291 and has further decreased to date, currently at 278 (July plan 225). Work is ongoing with Care Groups to reduce the number of patients over 62 days including clinical reviews of long waiters.

Responsive (Elective)
Cancer over 62 Day Breaches

62 Day Breaches (Target May: 250)
May Performance 352



High Level Performance Indicators

Cancer Standards	Standard	Final	Predicted
		May-23	Jun-23
31 day standard	96%	96.3%	96.2%
28 day faster diagnosis standard	75%	70.2%	71.9%
62 day standard	85%	62.7%	60.2%

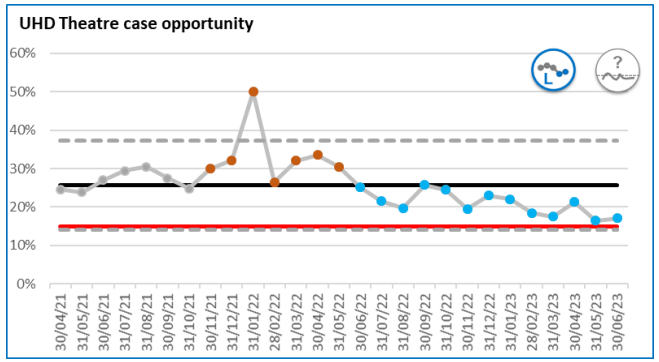
Key Areas of Focus

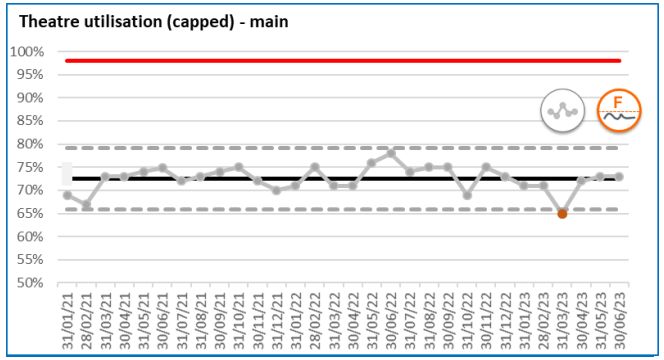
The priority areas for the next quarter continue to be Colorectal, Gynaecology and Urology.

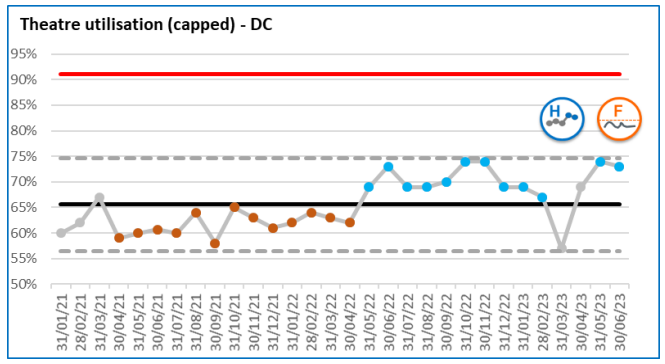
Key areas of focus include:

- Continuing to progress the development of a business case to move the Urology service to a nurse led diagnostic pathway planned to go live in Quarter 3, 2023/24.
- Delivery of additional Colposcopy clinics in Gynaecology, whilst the Gynaecology pathway transformation continues.
- Working with the Integrated Care System partners to ensure at least 80% of colorectal 2ww referrals are accompanied with a FIT test.
- Re-launch the Colorectal e-triage pilot to support the demand at the front end of the pathway.
- Delivery of waiting list initiatives for dermatology to increase OPA capacity (July to October 2023) and finalisation of the Tele-dermatology implementation proposals.
- Additional weekend clinics at Dorset County Hospital for breast patients.
- Promoting excellence in the basics including continuation of weekly clinical reviews of all long waiters to meet the over 62 Day trajectory for 220 patients by March 2024.
- Pathway mapping of the 2WW fast track bookings process and scoping of a digital solution using the Somerset Cancer Register to support efficient booking of patients at the beginning of their pathway.

Responsive (Elective)
Theatre Utilisation







Data Description and Target

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

Performance

- A significant reduction in the case opportunity has been consistently delivered. Further improvement is required to achieve this target.
- June 2023 month end snapshot of intended (booked) utilisation is 87% but actual utilisation of 73.4%. The drop in actual vs intended (booked) is in part driven by the 72-hour strike action. Excluding Orthopaedic lists, which are impacted by equipment issues, booked utilisation increases by 5% and capped utilisation to 78.7%.
- The reduction in case opportunity has been sustained over a period of time.
- There is an upward trend for both number of lists run and number of cases in month in addition to the average cases per session.
- Lost minutes to early finishes has shown a steady decline from 50min at the end of April to current average of 33min with less variation.
- The time spent in theatre carrying out procedures is also showing improvement with an increase to touch-time minutes and a decrease in inter-case downtime.
- Average late starts have further decreased from 29mins to 25 mins with much less variability, demonstrating a more controlled process.
- Workforce pipeline is improving with trajectory showing a reduction of c 17WTE by Sept 23 (assumes no leavers).

Underlying issues:

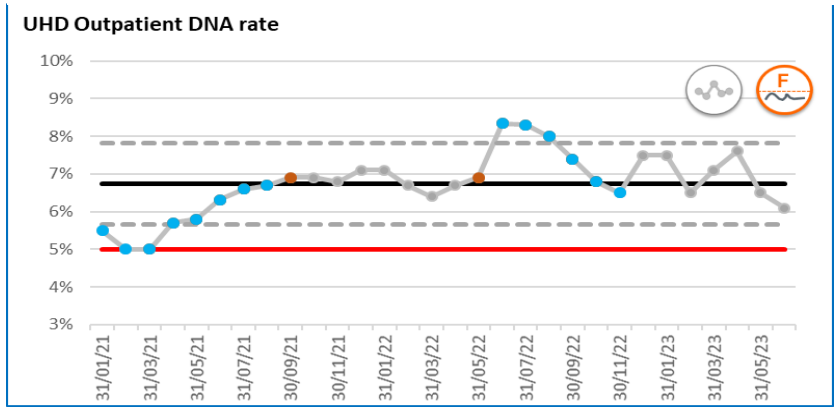
- Equipment issues including coordination of equipment has impacted orthopaedic late starts and an overall utilisation impact of c5%.
- Ongoing staffing shortages across theatres remains a significant barrier to providing a full template for all surgical specialities, noting improvement as above.
- Strike days are impacting across all theatre efficiency markers.

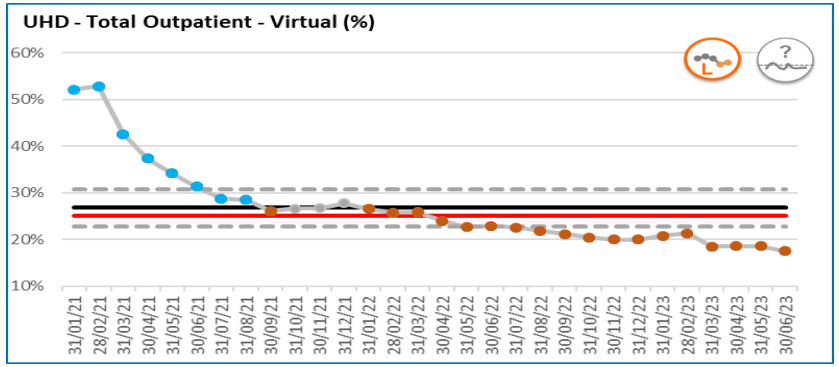
Key Areas of Focus

- Kit coordinator role progressed with interview scheduled w/c 10th July to support orthopaedic lists. Targeted work underway to focus on orthopaedic utilisation, including booking habits. This will increase number of patients being listed in addition to efficiency metrics.
- Ongoing improvement work focussing on theatre staffing is a top priority with workforce group in place and supported at Executive level. Improvement trajectories across all specialties to track progress.
- The implementation of the virtual pre-op assessment platform is also a key area of focus.

Responsive (Elective) Outpatients

Referral Rates (MRR Return)		Standard	Last Year	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	33580	19634	-41.5%
Total Referrals Rate year on year		-0.5%	53522	29811	-44.3%
Outpatient metrics					
Overdue Follow Up Appointments (Cons-Led Only)					30594
New Attendances					20536
Follow-Up Attendances					30552
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%		3345 / 51088	6.1%
Hospital cancellation rate	*Hospital Canx / Total Booked Appts)*			11072 / 74089	14.9%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*			8584 / 74089	11.6%
Reduction in face to face attendances (acute only)					
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%		8933 / 51088	17.5%





Data Description and Target

- Reduction in DNA rate (first and follow up) to 5%
- 25% of all attendances delivered virtually
- Reduction in overdue follow up appointments

Performance

DNA rate in June improved to 6.1%, however remains consistently above target levels.

- Broadcast messaging via DrDoctor is being used to notify patients of cancelled appointments, fill fast-track slots and send appointment reminders to reduce DNA rates. The text reminder facility launched in May 2023 and is expected to demonstrate further improvement as it is extended.
- Outpatient appointment letters are also now available via the digital portal.

17.5% of attendances were delivered via telemedicine/video. This is consistently below the national target.

The number of patients overdue their target date for a follow up appointment reduced in June and demonstrates consistent month on month improvement. A pilot of using the 'quick question' functionality in DrDoctor to support validation of the follow up waiting list in Gynaecology was delivered in May and is now being extended to other services.

Continued industrial action at UHD has had an impact on outpatient booking teams' capacity and clinic capacity.

Key Areas of Focus

- Continued DrDoctor expansion to build on the soft launch undertaken of its 'Quick Question' and Broadcast messaging functionality within all services.
- Delivery of outpatient productivity improvements, which support a reduction in DNA rates, increased use of Patient Initiated Follow ups and increased clinic utilisation rates.
- Embedding the outpatient performance dashboard (including all Outpatient KPIs) into performance management practices at Care Group and speciality level.
- Continuing to promote telemedicine/video and the benefits for patients.

Responsive - (Elective) Screening Programmes

Breast Screening

High Level Board Performance Indicators
JUNE position :

Breast Screening	Standard	ACHIEVED
Round Length within 36 months	90.00%	100%
Screening to first offered assessment appointment within 3 weeks	98.00%	93%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36

Background/target description
To ensure the breast screening access standards are met.
Performance:
- All but one of the KPI targets have been reached this month and round length is recorded as 100% for June.

Underlying issues:
- The screen to assessment target has been missed due to a delay in film reading as a result of the ongoing Radiology cover shortage. There is also pressure to cover the symptomatic service.
- Screening uptake is showing a steady increase with a return to timed booked appointments for recall women.

Actions:
- An IT assisted project is underway to enable a text messaging service which is planned to start this month.
- Our new Facebook page is also having a good reach across the region, and this will have a very positive impact on information sharing around the County.
- Health promotion is now a significant focus for the unit. A learning disability event was recently held which proved to be very successful. This will raise our profile and increase knowledge of our service to cohorts of our population that may have been under-represented previously.

Bowel Screening

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

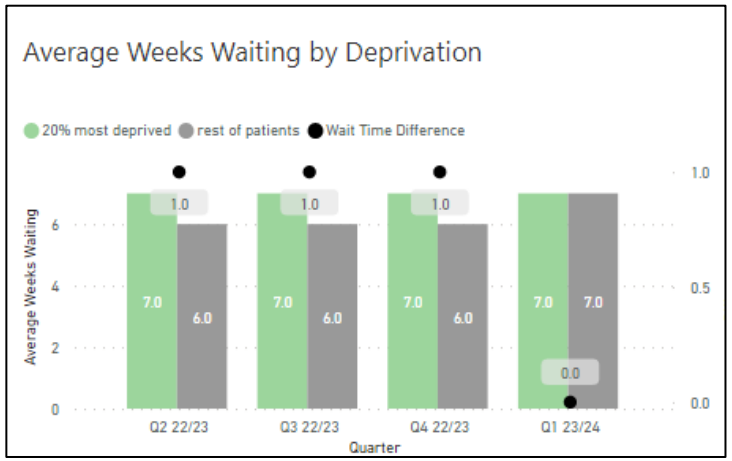
Background/target description
To ensure the bowel screening access standards are met.
Performance:
- SSP Clinic Wait Standard : The wait standard continues to be maintained at 100%.
- Diagnostic Wait Standard : The standard was achieved in June 2023.

Underlying issues:
- Lynch syndrome roll out has gone live for prospective patients and is rolling out later this month for retrospective patients.
- Next phase of age extension roll out is scheduled for August 2023. Delays in agreeing the finance plan with Commissioners have caused delays in recruitment for Specialist Screening Practitioners (SSPs).
- Senior doctor strike action will impact diagnostic list capacity in July 2023.

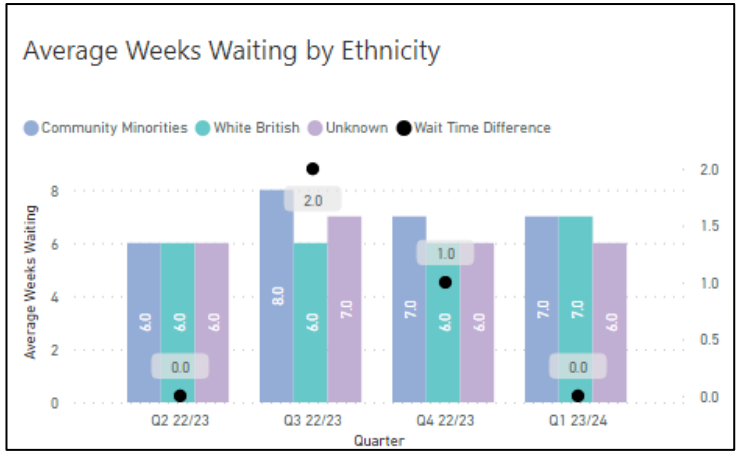
Actions:
- Plan for insourcing activity throughout 23/24 once finance plan finalised.
- Develop a succession plan for accredited screeners.

Health Inequalities

Median Weeks waiting by Deprivation Group



Median Weeks waiting by Ethnicity Group and Age



Average Weeks Waiting by Age

Age Band	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
0-9	6.0	11.0	12.0	11.0
10-19	7.0	8.0	10.0	9.0
20-29	7.0	7.0	7.0	6.0
30-39	7.0	7.0	6.0	7.0
40-49	6.0	7.0	6.0	6.0
50-59	6.0	6.0	6.0	7.0
60-69	6.0	6.0	6.0	7.0
70-79	6.0	6.0	6.0	6.0
80+	6.0	6.0	6.0	5.0

Data Description and Target

Analysis of variation in weeks waiting on an elective waiting list according to the patient's Index of Multiple Deprivation, age and ethnicity grouping to understand areas of variation.

Performance

Waiting list by Index of Multiple Deprivation (IMD) Analysing RTT activity in Quarter 1 to date, the median weeks waiting at the point of treatment shows **no variation** between the 20% most deprived and the rest of the population treated. At sub-Trust level variation in waiting by deprivation is greatest in Elderly Medicine, Paediatrics, Cardiology, and Ophthalmology.

Waiting list by ethnicity: An analysis of the median weeks waiting by ethnicity grouping identifies **no variation** between patients within community minority groups and White British populations in Quarter 1 to date; this represents a change from the position reported last month when a variation of 1 week was noted. At sub-Trust level variation in waiting by ethnicity is greatest in Neurology and Elderly Medicine.

Waiting list by age band: There is variation between age and length of wait on the waiting list with the greatest variation between 0-19yrs and 20+ age bands. However, this variation has reduced in Q1 to date. Paediatric waiting times in oral surgery, ENT and community paediatrics contribute to this variation.

Key Areas of Focus

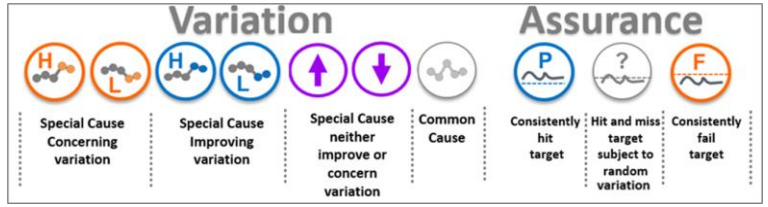
The Trust Health Inequalities group are working to:

- Deliver the Trust's strategic objectives for population health and system working; with a focus on ((i) reducing outpatient DNAs and variation according to IMD and ethnicity and (ii) managing High Intensity Users of emergency care.
- Align its health inequalities programme with the ICS key strategic priorities.
- Expand the data that's captured on the Dorset DiiS Population Health System to enable further data insights against the Core20Plus5 areas for adults and children.
- Promote awareness raising on health inequalities and population health through education and training opportunities.

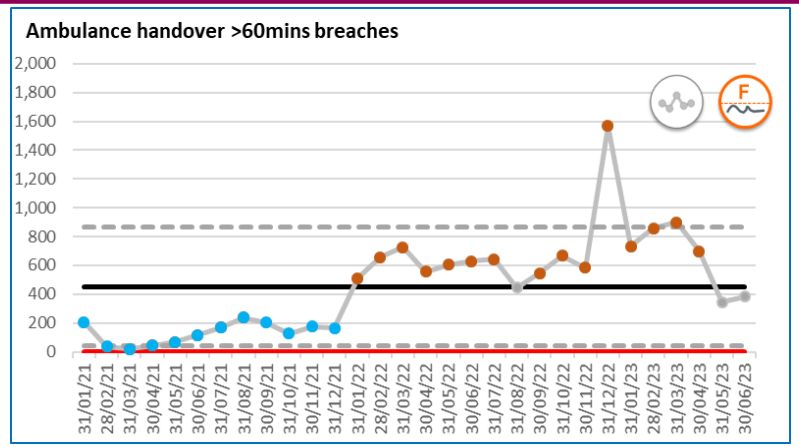
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Indicator

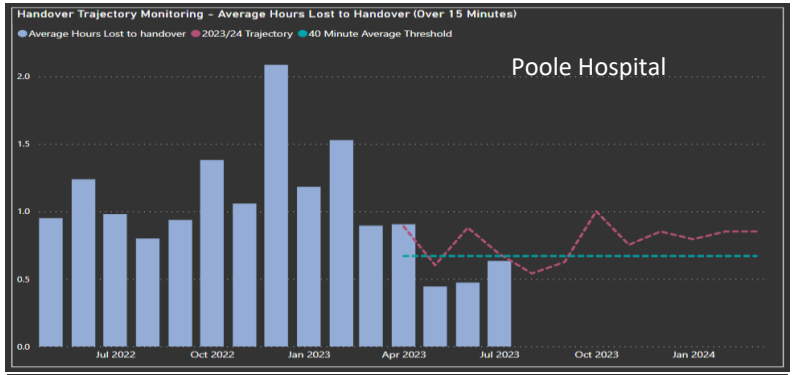
UHD Elective Care

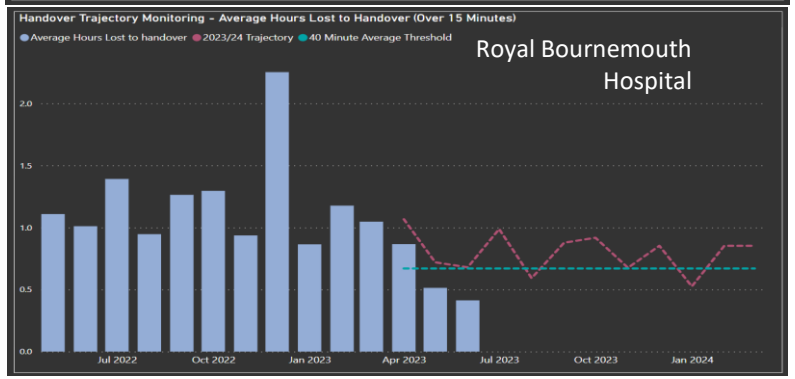
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Jun 23	74483	75073			73023	70356	75691
UHD - Patients waiting >104 weeks	Jun 23	0	0			107	32	182
UHD - Patients waiting >78 weeks	Jun 23	32	-			752	462	1042
UHD - Patients waiting >65 weeks	Jun 23	1053	1023			1687	1256	2118
UHD - Patients waiting >52 weeks	Jun 23	4574	-			3809	2966	4651
UHD - Patients waiting >52 weeks non admitted	Jun 23	3442	0			2219	1429	3009
UHD - RTT Performance against 18 week standard	Jun 23	55.1%	92.0%			59.1%	55.4%	62.7%
			0					
UHD - Total Diagnostic Waiting List	Jun 23	12584	-			10651	8776	12526
UHD - % waiting over 6 weeks	Jun 23	7.7%	1.0%			10.7%	4.6%	16.9%
			0					
UHD - Faster Diagnosis Standard (FDS) 28 days	May 23	70.2%	75.0%			70.3%	60.1%	80.6%
UHD 62 day standard	May 23	62.7%	85.0%			70.8%	62.2%	79.4%
			0					
Trauma Admissions	Jun 23	397	-			361	295	428
% of NOF patients operated on within 36 hrs of admission	Jun 23	37.0%	85.0%			29.6%	-14.6%	73.8%
			0					
UHD - Total Outpatient - Virtual (%)	Jun 23	17.5%	25.0%			26.8%	22.8%	30.7%
UHD Outpatient DNA rate	Jun 23	6.1%	5.0%			6.7%	5.7%	7.8%
Theatre utilisation (capped) - main	Jun 23	73.0%	98.0%			72.5%	65.9%	79.1%
Theatre utilisation (capped) - DC	Jun 23	73.0%	91.0%			65.6%	56.5%	74.6%
UHD Theatre case opportunity	Jun 23	17.1%	15.0%			25.7%	14.1%	37.3%



Responsive – (Emergency) Ambulance Handovers







Data Description and Target

Number of ambulance handover delays greater than 60 minutes from arrival to a receiving Emergency Department. 15 minutes is the target for an Ambulance to handover to a receiving ED from arrival. There should be no ambulances waiting over 60 minutes.

Number of ambulance hours lost due to handover delays. There is a site level recovery trajectory for lost ambulance hours per day.

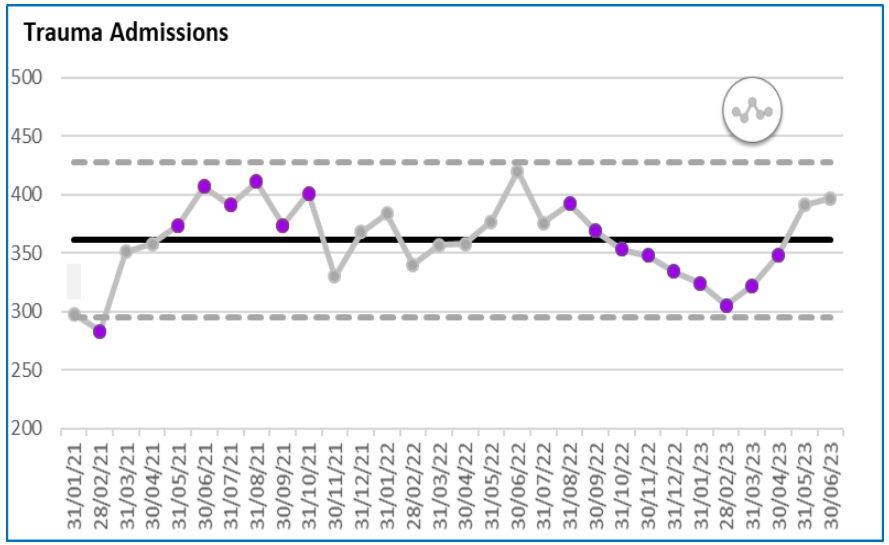
Performance

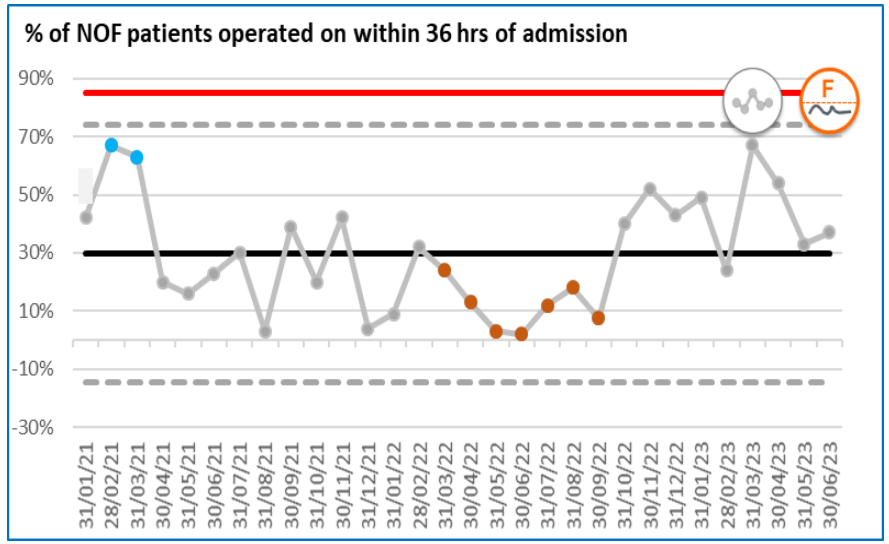
- Overall, a significantly improved picture for UHD with continued and sustained improvements.
- Ambulance arrivals remained static at the RBH site but saw an increase across Poole.
- 383 Ambulances waited over 60 mins in June, which marks a sustained significant decrease from 707 in April and 904 in March.
- In total there were 599 hours at PH and 540 hours at RBH totalling 1139 hours lost in June vs 1039 in May and 2284 hours reported as lost at UHD sites in April.
- Regionally however there was an improvement against handover delays with SWAST experiencing 18,180 lost hours vs 20,159 in May across the South-West.
- Discrepancy in lost hours reported continues to be a focus of improvement with regional partners via the SWASFT/ED working group along with Southwest wide task and finish group.

Key Areas of Focus

- Dorset ICB have re-established the joint meetings with UHD and SWAST to address the handover challenge, including a data cell.
- The SLA with ECS for corridor co-horting has formally ended as of June. Co-horting continues with SWAST and UHD staff for quality and safety purposes.

Responsive (Emergency)
Trauma Orthopaedics





Data Description and Target

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

Performance

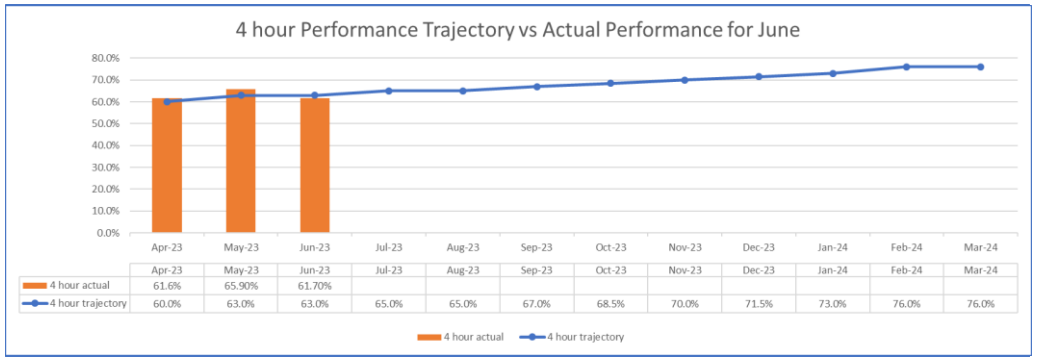
June performance for time to theatre for fractured neck of femur (# NoF) patients: 51% achieving surgery within 36 hours of being fit for surgery and 39% with surgery within 36 hours from admission.

- Large backlog (12) at the start of the month and high volume of referrals from fracture clinic causing challenge to time prioritisation.
- 165 Shaft of femur (SoF) fractures admitted in June, 14 had surgery, 9 required revision Total Hip Replacement (THR) for their fracture.
- 11 patients required 2 or more trips to theatre, resulting in an additional 17 trips to theatre, some of which were complex revisions and septic patients.
- The barn theatres are working well. Ongoing work to review case mix and paediatric capacity.

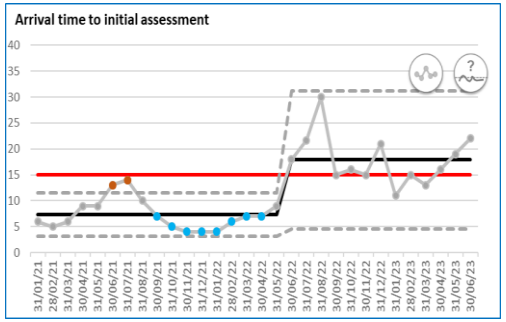
Key Areas of Focus

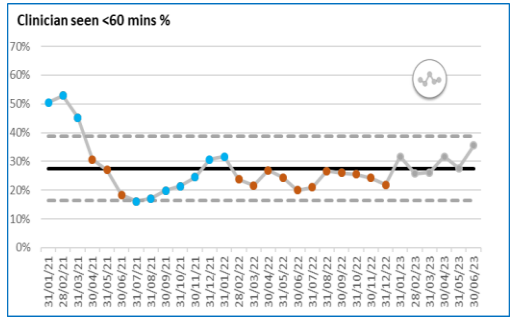
- e-Trauma , implementation and integration group commenced with dedicated T&O Lead in post; technical scoping complete.
- Trauma and Orthopaedic Ambulatory Care Unit (TOACU) - new location (old day theatres) complete. Review of activity to potentially relocate procedure room.
- Liaison with Trust operational flow project around timely admission and discharge (TAD) continues to support reduction in high level of MRFD patients across trauma (28%).
- #NOF summit areas of focus agreed to include pre-hospital "Pre alert" and #NOF admission pathway (mirror approach of stroke/cardiology). "Go live" 6th July.

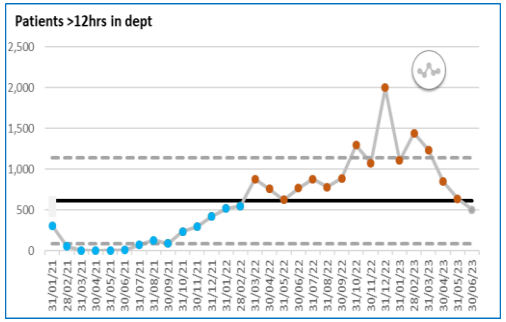
Responsive (Emergency) Care Standards

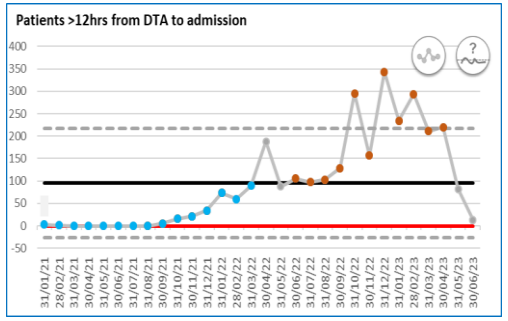


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
4 hour actual	61.6%	65.90%	61.70%									
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	70.0%	71.5%	73.0%	76.0%	76.0%









Data Description and Target

UHD has now returned to reporting against the national 4-hour standard. The national requirement is to achieve 76% of all patients leaving ED within 4 hours of arrival by March 2024.

Performance

The Trust started reporting against the national 4 Hour Emergency Standard as of the 15th May. The Trust met its trajectory for both April and May 23, however June has proved to be a challenging month with the go-live of a new electronic PAS system 'Agyle.' This went live at the Poole site on the 13th June and at Bournemouth in July. Despite this period of instability, the department has managed to maintain its performance position at 61.7%, however it has been a contributory factor in being below target against the planned trajectory.

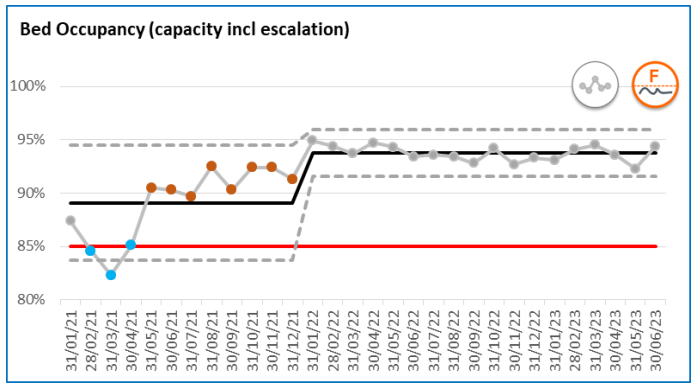
There has been a sustained improvement in reducing the number of patients spending more than 12 hours in both departments, which reduced by a further 133 patients in June. This was 504 vs 637 in May and 849 in April. There was also an improvement in the number of patients waiting for more than 12 hours after a decision to admit of 69 patients; 13 vs 82 in May and 220 in April, which is also the lowest in nearly two years marking a clear improvement in hospital flow.

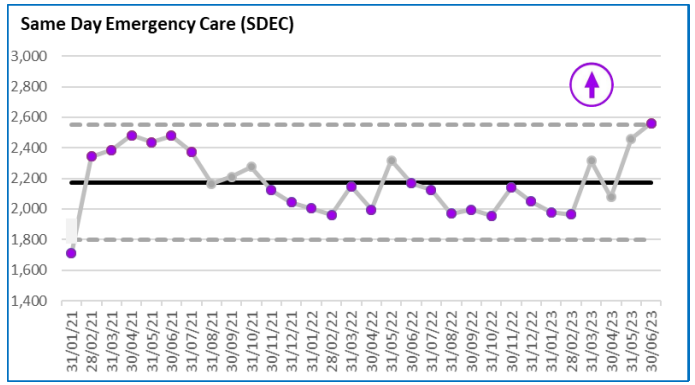
Key Areas of Focus

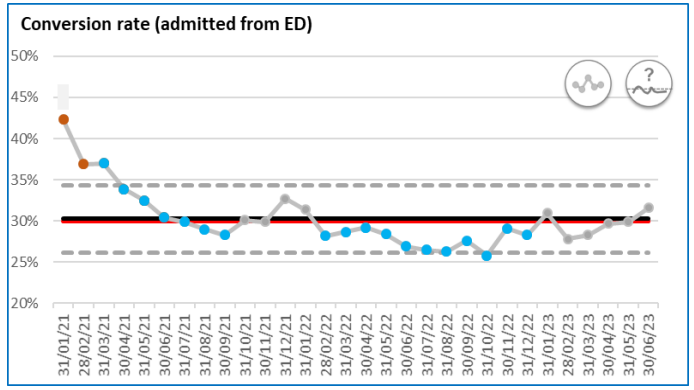
Full implementation of the new PAS (Agyle) system at the Poole site and embedding of the system at RBH following July roll out. Whilst there will be a period of bedding this in, ultimately the system will support more efficient patient management within the department as an enhanced clinical system, as well as a broader understanding of our breach analysis.

Continue on-going review of pathways out of ED with specific actions related to direct to admit pathways and onward flow following admission.

Responsive – (Emergency) Patient Flow







Data Description and Target

88% bed occupancy would support flow and delivery of rapid progression from the Emergency Department within an hour of being clinically ready to proceed

Performance

Bed occupancy is stable but not reducing and continues to include high levels of escalation throughout June.

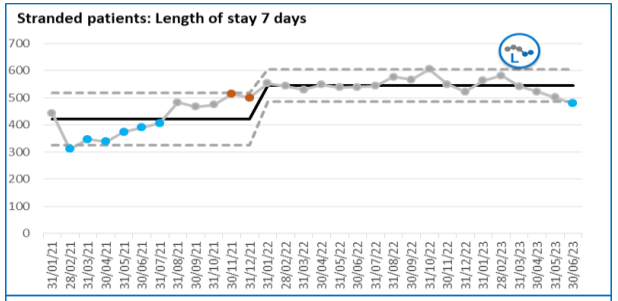
Additional capacity has been required to support the flow from ED, high occupancy, maintaining elective activity and emergency care demand.

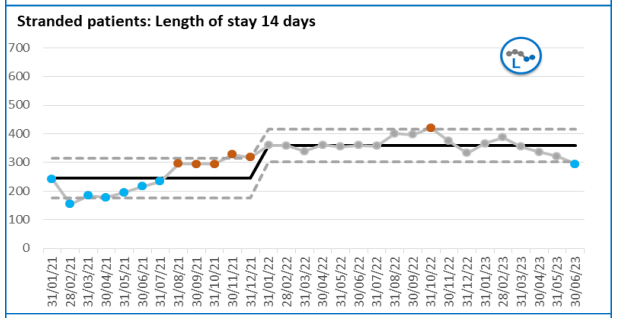
- High occupancy is driven by high numbers of patients with No Criteria to Reside although there has been sustained improvement in May and June.
- June saw an increase in ED conversion rate resulting in more patients admitted than discharged (net difference of 41 patients). There remained a consistent need to open surge capacity to manage high occupancy and MRFD levels.

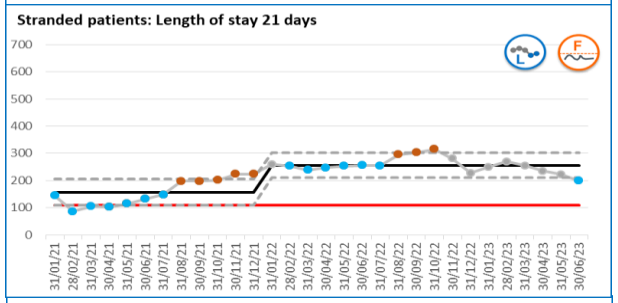
Key Areas of Focus

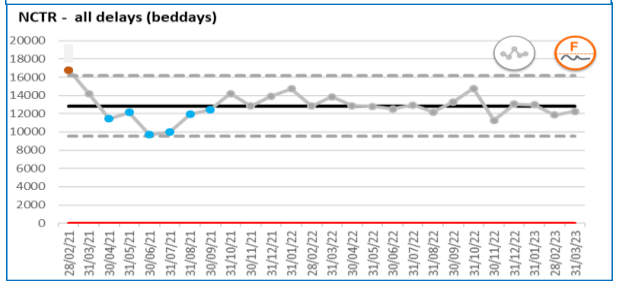
- Revised focus on Timely Admission and Discharge (TAD) process and significant improvement in utilisation rates of Departure Lounges.
- The Discharge to Assess model continues to embed, with System working in place to identify gaps in service provision and where flow through the out of hospital capacity has not achieved the required pace to prevent delays in hospital.
- Rapid review of daily bed management processes, including implementation of the centralised bed model trial in May and June 2023, with expected improvements in oversight, coordination and transfer time.

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









Data Description and Target

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

The proportion of delays in discharge for whom the patient has no criteria to reside. Target to reduce the number of patients with No Criteria to Reside (NCtR) by 30% in Q1, and 50% Q2.

Performance

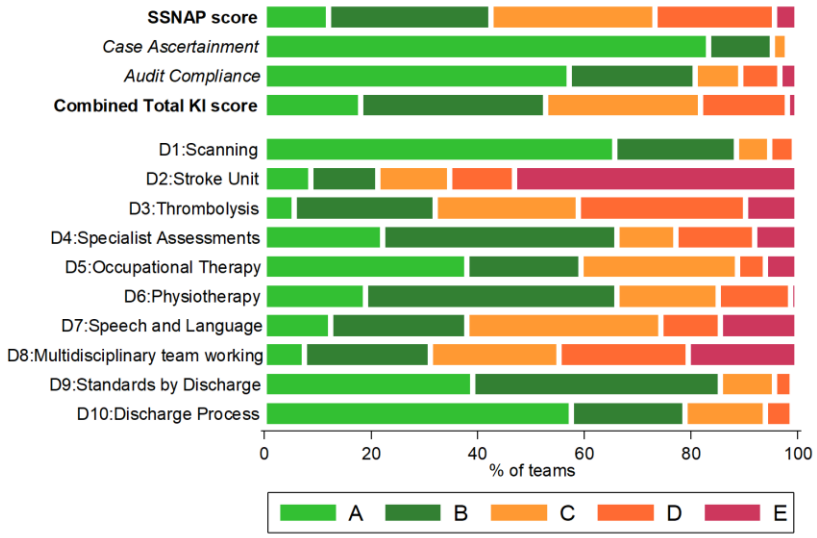
The average daily number of patients who are ready to leave/have no criteria to reside was 166 in June, 13 less than May which continues the downward trend.

- The ICB ambition to achieve a reduction of 30% in No Criteria to Reside was not achieved for Q1.
- The overall delayed discharge position continues to challenge hospital flow.
- The number of internal delays fell to 20%, work continues to improve internal processes with improvements seen in early June.
- The number of 21+ day patients shows improvement but at a slow rate, with increased focus through enhanced weekly reporting and review of patients in place.
- Delays in accessing community health and social care due to workforce and capacity remain factors impacting LoS

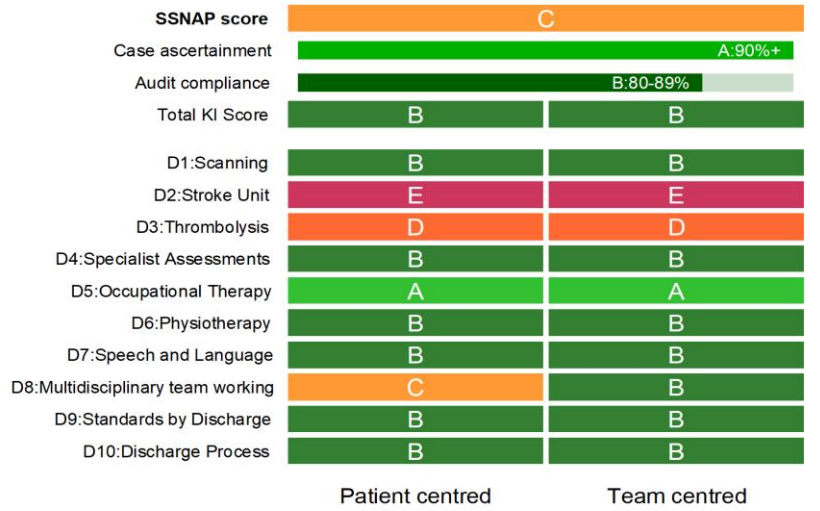
Key Areas of Focus

- Internal delays are reviewed and challenged daily, key themes include completion of therapy assessments and discharge referrals.
- Ongoing work with partners to broaden the D2A offer following learning from MADE events and patient reviews being taken forward through the regional Home First Steering Group and associated workstreams.
- Weekly high-level report being shared with all senior clinicians and Care Group Leads
- Daily partner meetings focusing on No Criteria to Reside, System working to redesign complex discharge pathways and Admission Avoidance strategy in ED and Assessment units
- System led Discharge to Assess (D2A) model implementation continues on all pathways, with some gaps for complex patients.
- Dorset System visits to UHD and Community Hospitals identified key system themes and opportunities for improvement. A weekly forum with the ICB and partners is in place to manage discharges for patients with an extended hospital stay.
- Via the Hospital Flow Programme Workstream 4, there is a focus on improving early discharge planning, ward MDT recording of Expected Date of Readiness (EDR) to leave hospital and D2A pathways in Health of the Ward (HotW).
- Development of electronic referral management for all MDT partners.

Responsive – (Emergency) Stroke



Source: SSNAP Jan to Mar 2023
Patient-centred results at national level



Source: SSNAP Jan to Mar 2023
Team level results

Team 560

Data Description and Target

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

- Q4 SSNAP C. Q1 data not yet available – date for data lockdown 8th August 23
- Reduction in MDT working 0.5 point off B
- Audit compliance 1.9 points off B
  - Mainly due to National Institute of Health Stroke Scale (NIHSS) on arrival and @ 24hrs
  - Over management of stroke mimics leading to reduced capacity in outreach team

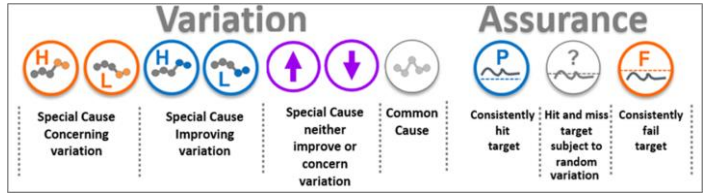
Key Areas of Focus

- Address audit compliance issues with team focusing on NIHSS scoring
- Align stroke pathways and processes across teams on Stroke Unit and Ward 9 stroke unit
- Data analysis for SDEC/TIA modelling completed, SBAR being developed. Space allocation to be agreed.
- Estates work for build on stroke unit delayed due to changes in funding
- 43 bedded workforce template to be finalised
- Development of Stroke ANP role to facilitate timely access including clerking and thrombolysis on the unit
- SQuIRE catalyst funding bid in progress to increase complexity in ESD service
- Potential bid being put forward through NHSI for pre-hospital video triage – in discussion with SWAST for agreement

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

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Arrival time to initial assessment	Jun 23	22	15			18	5	31
Clinician seen <60 mins %	Jun 23	36%	-			28%	16%	39%
Patients >12hrs from DTA to admission	Jun 23	13	0			95	-27	218
Patients >12hrs in dept	Jun 23	504	-			614	91	1136
4 hour safety standard	Jun 23	61.7%	76.0%			63.1%	51.8%	74.4%
Ambulance handovers	Jun 23	4015	-			3945	3448	4442
Ambulance handover >60mins breaches	Jun 23	383	0			454	44	864
			0					
Bed Occupancy (capacity incl escalation)	Jun 23	94%	85%			94%	92%	96%
Stranded patients: Length of stay 7 days	Jun 23	480	-			545	485	605
Stranded patients: Length of stay 14 days	Jun 23	294	-			360	303	417
Stranded patients: Length of stay 21 days	Jun 23	199	108			256	210	303
UHD NCTR % - all delays	Jun 23	38.5%	-			49.0%	41.4%	56.6%
			0					
Non-elective admissions	Jun 23	6347	-			5897	4959	6835
> 1 day non-elective admissions	Jun 23	3783	-			3721	3076	4365
Same Day Emergency Care (SDEC)	Jun 23	2560	-			2174	1797	2550
Conversion rate (admitted from ED)	Jun 23	31.6%	30.0%			30.3%	26.2%	34.3%
			0					
NCTR - all delays (beddays)	Mar 23	12250	0			12838	9531	16145
Ready to leave (beddays)	Mar 23	9356	0			7941	6366	9517
			0					



Sustainable Servicers

Pete Papworth
Chief Finance Officer

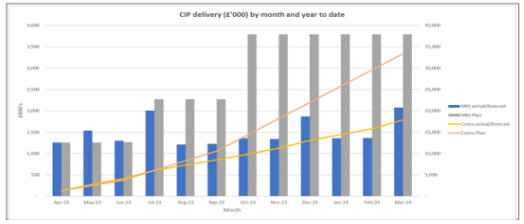
Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

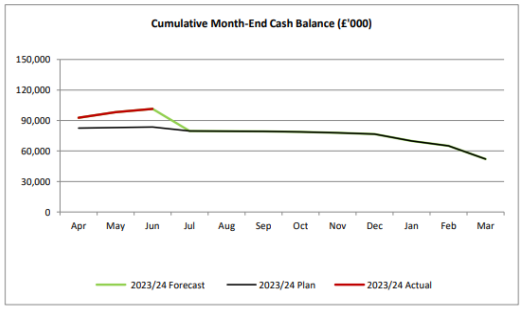
Committees:
Finance and Performance Committee

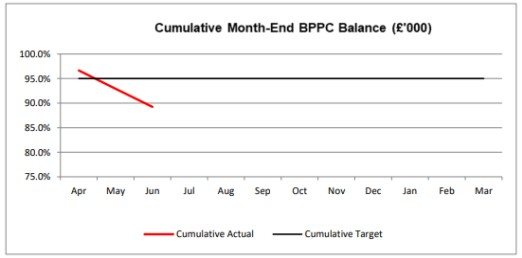
Finance

Executive Owner: Peter Papworth (CFO)

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(4,384)	(7,303)	(2,920)
Capital Programme	51,800	14,604	37,196
Closing Cash Balance	83,565	101,398	17,833
Public Sector Payment Policy	95.0%	89.2%	(5.8)%







Commentary

The Dorset ICS submitted a balanced revenue plan for the year, being the aggregate of individual organisational plans each of which confirmed a break-even revenue plan. However, the Trusts operational revenue budget for the year contains considerable financial risk. A range of mitigation plans have been identified and budgets continue to be actively managed to safeguard the financial performance of the Trust.

At the end of June 2023 the Trust has reported a deficit of £7.3 million against a planned deficit of £4.4 million representing an adverse variance of £2.9 million. This is mainly due to energy cost inflation £1.379 million, the net cost of the Nursing and Junior Doctors Strike £923,000, unfunded escalation costs of £839,000 together with premium cost pay overspends in the Care Groups. This has been off-set in part by additional bank interest due to a higher cash holding and recent movement in Bank of England base rates and reduced depreciation charges due to the timing of capital expenditure.

Cost Improvement Programme savings of £4.1 million have been achieved as at 30 June against a target £3.8 million. This includes non recurrent savings of £2.5 million. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £17.9 million representing a shortfall of £15.5 million and a recurrent shortfall of £22 million. Mitigating this shortfall continues to be the key financial focus for the Trust.

The Trust has set a full year capital budget of £199.6 million, including £172.7 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme. At the end of June 2023 the Trust has committed capital expenditure of £14.6 million against a plan of £51.8 million representing an underspend of £37.2 million. This underspend relates mainly to the New Hospitals Programme and STP Wave 1. The STP Wave 1 full year forecast remains consistent with the plan, however the NHP forecast is dependent on timings of approval and may result in a lower year end spend requiring a re-phasing of the national funding.

As at 30 June 2023 the Trust is holding a consolidated cash balance of £101.4 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of capital funding for multiple schemes alongside a re-phasing of the capital programme spend. The balance attracts Government Banking Services interest of 4.89% at current rates, together with a PDC benefit of 3.5%.

In June there has been a deterioration in the Trusts payment performance due to volume of temporary staffing invoices experienced through the Temporary Staffing Office however recruitment within this team is in progress to further mitigate this risk. Finance continue to work closely in supporting the team in clearing invoices within 30 days.

Digital Dorset / Informatics

Peter Gill
Chief Information Officer

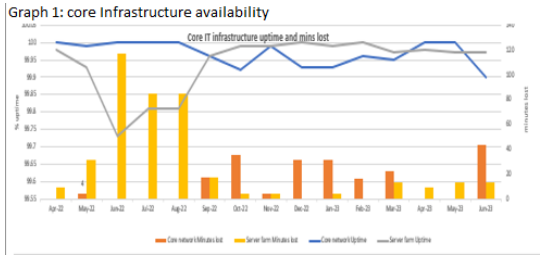
NHS
University Hospitals Dorset
NHS Foundation Trust

Well Led - Informatics

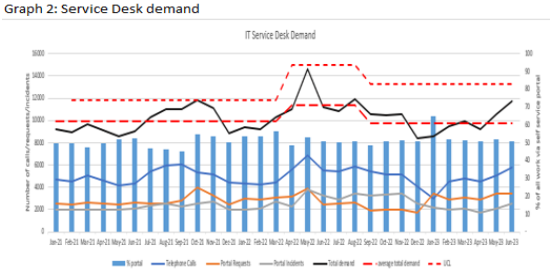
Executive Owner: Peter Gill (CIO)

Business as usual / Service Management

Graph 1: core Infrastructure availability



Graph 2: Service Desk demand



Projects / Developments / Security / IG

Table 3: Project Totals and Escalation

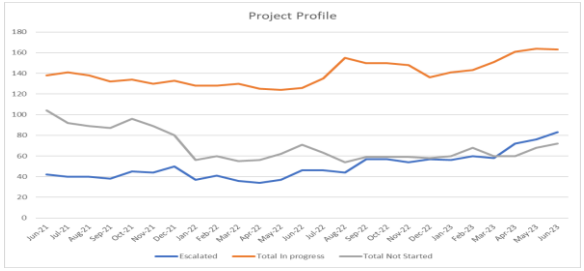


Table 4: Information Asset Compliance

All Active Assets

Status	Total	%
Draft Only (Pending Updates)	6	2.23%
Awaiting IAO Review/Approval	23	8.55%
Awaiting IG Review/Approval	60	22.30%
DSPT Compliant (2022/23)	180	66.91%
Total	269	

Table 5: Training Statistics

Total Trained in June: 682

Table 6: Cyber Security - Obsolete systems

	Supported	Obsolete	Mitigated	Unsupported
Windows Desktops	97.0%	3.0%	0.0%	3.0%
Windows Servers	88.2%	11.8%	0.0%	11.8%

Table 7: FOI compliance

	Total rec'd	Compliance
February '23	63	73%
March '23	60	70%
April '23	58	76%
May '23	57	70%

Commentary

Graph 1: The uptime remained above the expected level (99.9) even though there was some planned maintenance outages for server patching.

Graph 2: The Service Desk Demand remains within the bounds of common cause variation.

Table 3. The dominant work over June, was the implementation of the new Emergency Department IT system called Agyle from Fortrus. The cutover to this new system took place on 14 June at the Poole site with a plan to deploy to RBH on 10 July. The graph shows an increase in the number of escalated projects from 40 to 83 over the last 12 months. This is unsustainable and Informatics is engaging with the Patient First Process entitled Corporate Project Filter to address this. 12 projects were completed in June which were all new or updated electronic forms.

Table 4: Progress was made on the Information Asset Compliance work but at the point of submitting the national return only 67% of our high priority assets had the sufficient level of assurance.

Table 5 show the staff trained by system in June.

Table 6: 97% of our Windows desktop devices are now on supported operating systems and 88% of our server estate.

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 8.1

Subject:	Patient First Improvement Strategy 2023-26
Prepared by:	Deborah Matthews, Director of Organisational Development
Presented by:	Paula Shobbrook, Chief Nursing Officer and Deputy Chief Executive

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	Patient First
Purpose of paper:	Decision/Approval
Executive Summary:	The *Patient First* Improvement Strategy will support the delivery of UHD's refreshed strategy and strategic priorities. The overall vision of Patient First is to *develop a sustainable culture of continuous improvement at UHD* by creating the following conditions: • Strategic Intent • Patients as Partners • Culture and Relationships • Leadership Behaviours • Improvement Toolkit • Management System A systematic approach to improvement led delivery of quality is recognised by CQC as a key enabler to a well led organisation. The Patient First methodology and programme approach is evidence-based using Lean and other proven improvement methods and in line with (inter)national best practice recommendations and guidance. As part of Patient First, our UHD continuous improvement approach, we will also commence phase 3 of our culture programme. This will involve Culture Champions working with individual teams and senior

	leaders to support them to make local changes for improvement.
Background:	Patient First builds upon our first UHD Quality Improvement (QI) strategy shared with the Board in 2020/21. It has also been developed in line with the *Patient First* Project Initiation Document (PID) and the recommendations outlined in our Readiness Assessment phase completed in February 2023.
Key Recommendations:	Board members are asked to: • support the *Patient First* Improvement Strategy • note an executive summary for wider public circulation will be published in due course
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**
Trust Management Board	25/07/2023	Meeting has not taken place at the time of submission of this report.

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

Patient First Improvement Strategy | 2023 - 2026

Contents

Forward

Siobhan Harrington
Chief Executive

Rob Whiteman
Chair

Welcome to our new Patient First Improvement Strategy.

This document describes how we are developing a culture of continuous improvement to support the delivery of our refreshed strategy and strategic priorities.

We have so much to be proud of at UHD. The strength and spirit of Team UHD and the kindness and professionalism of our staff are at the heart of what we do as we continue to deliver high quality, safe services for our patients, carers and their families.

Equally, the last few years have been hard on everyone. The NHS is experiencing some of the most severe pressures in its 75-year history and UHD is not short of major challenges following a merger, a significant period of organisational change, restructuring and recovery from the pandemic.

Our staff have also told us that despite coming to work to do their best for patients, sometimes things get in the way. Given these complex challenges, a fundamental change to the way we do everyday business at UHD is now required.

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

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

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

To Team UHD and our patients, we look forward to working with you on our improvement journey.

Thank you.

Why do we need an improvement strategy?

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

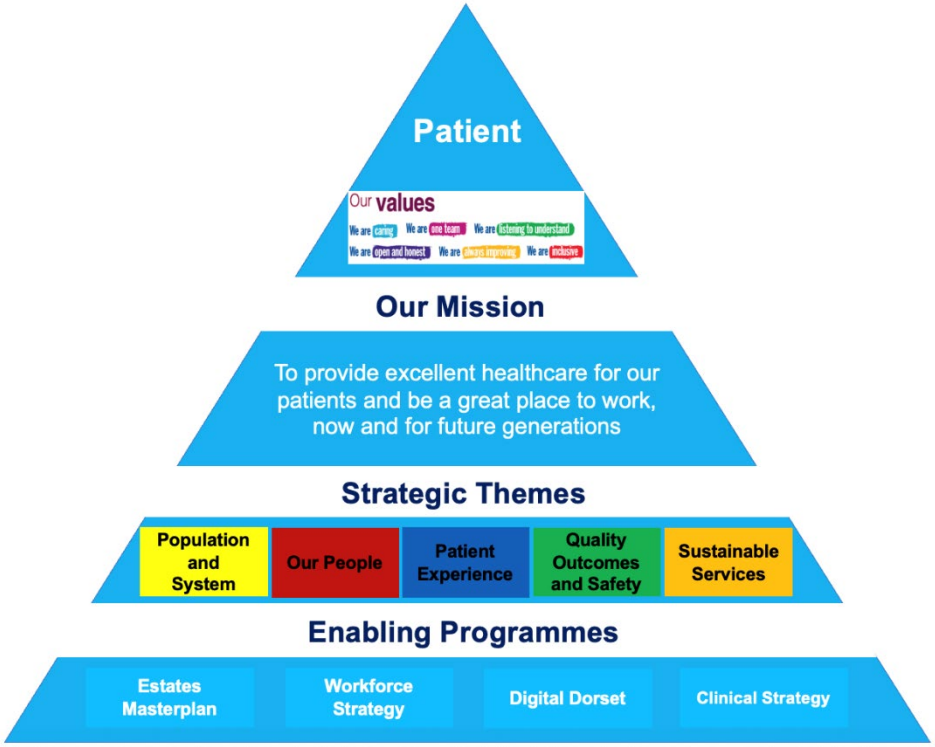
Patient First is a systematic approach to improvement led delivery of quality that will help build upon UHD strong foundations and what works well within the organisation. It will refresh our culture of excellence and further developing *the way we do things around here*.

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

Patient First is the UHD Improvement Method

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

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



What are we trying to accomplish?

Our vision and values

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

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

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

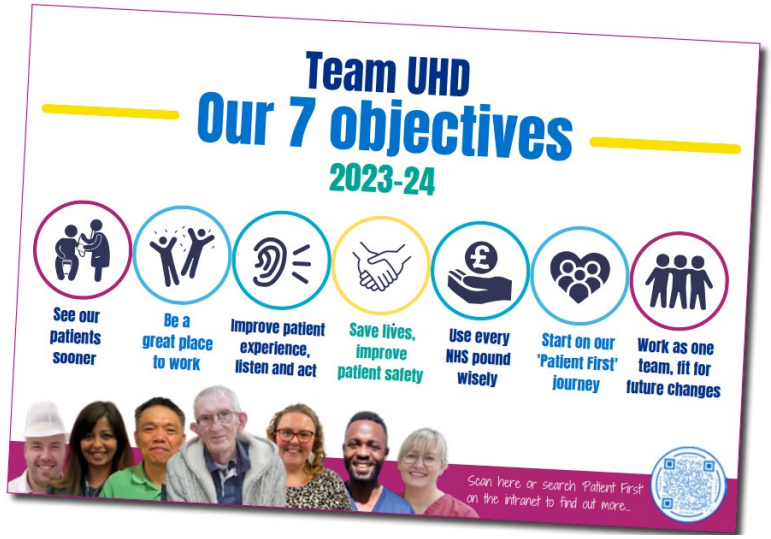
Our Vision

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

What are we trying to accomplish?

Our strategic themes

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



Our strategic themes will support the delivery of our vision and shape our 'breakthrough' annual objectives and enabling programmes

How will we know how we are doing?

Our strategic targets

By 2026/27 we aim to achieve the following:

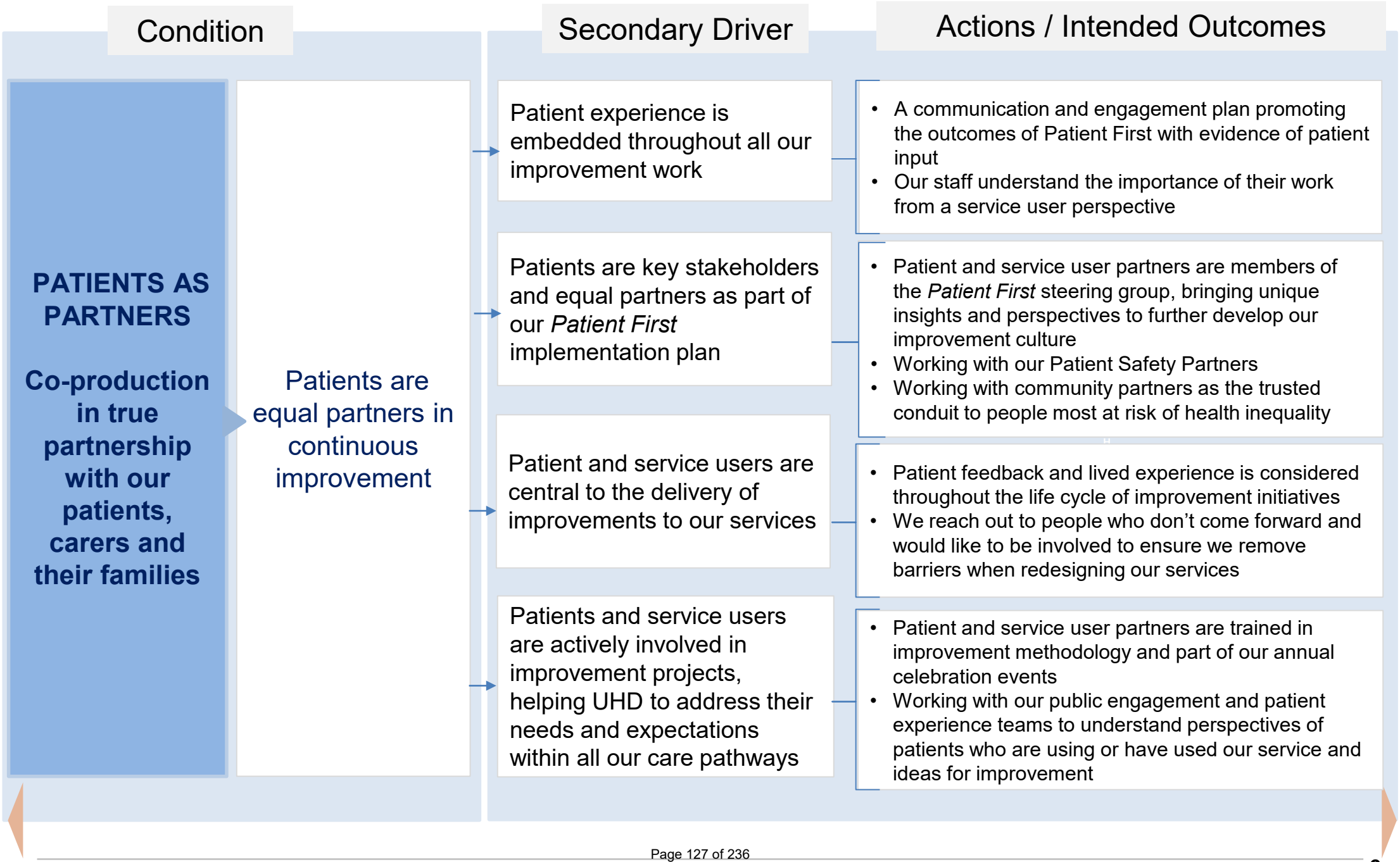
PATIENT EXPERIENCE	• Rated as Outstanding by CQC for Caring • Over 80% of our employees see patient care as a top priority for UHD • In the top 20% of NHS Acute Hospital Trusts on the overall experience section in all CQC national surveys
QUALITY OUTCOMES AND SAFETY	• In the top 20% of trusts in country for Hospitalised Standard Mortality Ratios (SMR) • Rated as Outstanding by CQC for Safety • Decreased severe / moderate harm Patient Safety Incidents (as a ratio of all incidents) by 30% • Over 80% of employees believe the Trust promotes a safety culture
SUSTAINABLE SERVICES	• Return to recurrent financial surplus from 2026/27 • Rated as Outstanding by the CQC for our Use of Resources
OUR PEOPLE	• Significantly improved staff experience, engagement and retention • NHS Staff Survey results in the top 20% of comparator Trusts
POPULATION AND SYSTEM	• Meeting the patient national constitutional standards for Planned and Emergency care, supporting inequalities in outcome and access and improving productivity and value

Improvement principles and ambition

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

Improvement principles and ambition

Improvement principles and ambition



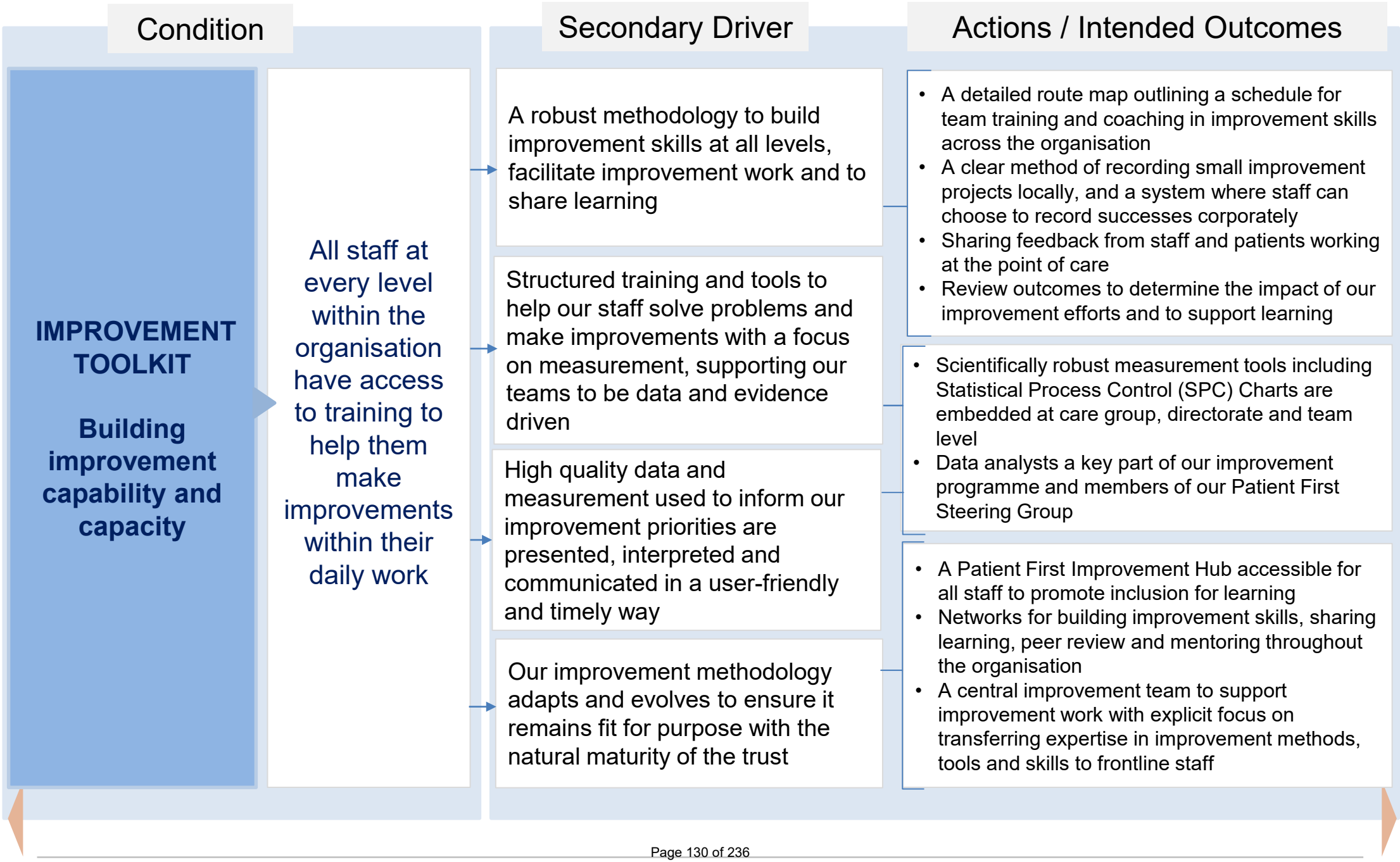
Improvement principles and ambition

Condition	Secondary Driver	Actions / Intended Outcomes
CULTURE AND RELATIONSHIPS **Continuous improvement is at the heart of everything we do**	We pay attention to the social (relational) side of change that fosters collaboration, engagement, psychological safety and employee well-being	• A comprehensive culture development programme '*building on the best of what we do*' to support the achievement of our vision and overall strategy for high quality, sustainable care
Our staff feel empowered and equipped to do the very best for our patients and one another	High performing teams learning, problem solving and innovating together	• A robust team coaching offer and *consulting for change* model to support team effectiveness
	We encourage opportunities for staff to connect, have conversations and work together towards shared organisational and improvement goals	• Working closely with staff networks to encourage participation of all staff and ensure their voices and lived experience shape our improvement approach and what matters to them
	We assess and measure our improvement journey to track cultural change	• An integrated culture dashboard available at care group and corporate directorate level to encourage feedback and identify areas for support • Completion of an annual readiness assessment to ensure our improvement approach remains valid and fit for purpose
	Staff feel empowered to problem solve and make improvements, no matter how small. They feel safe and secure to learn from mistakes and question poor practice	• Improvement projects led by frontline staff presented at national and international improvement conferences • Our improvement approach is amplified via trust induction, appraisal and personal development reviews

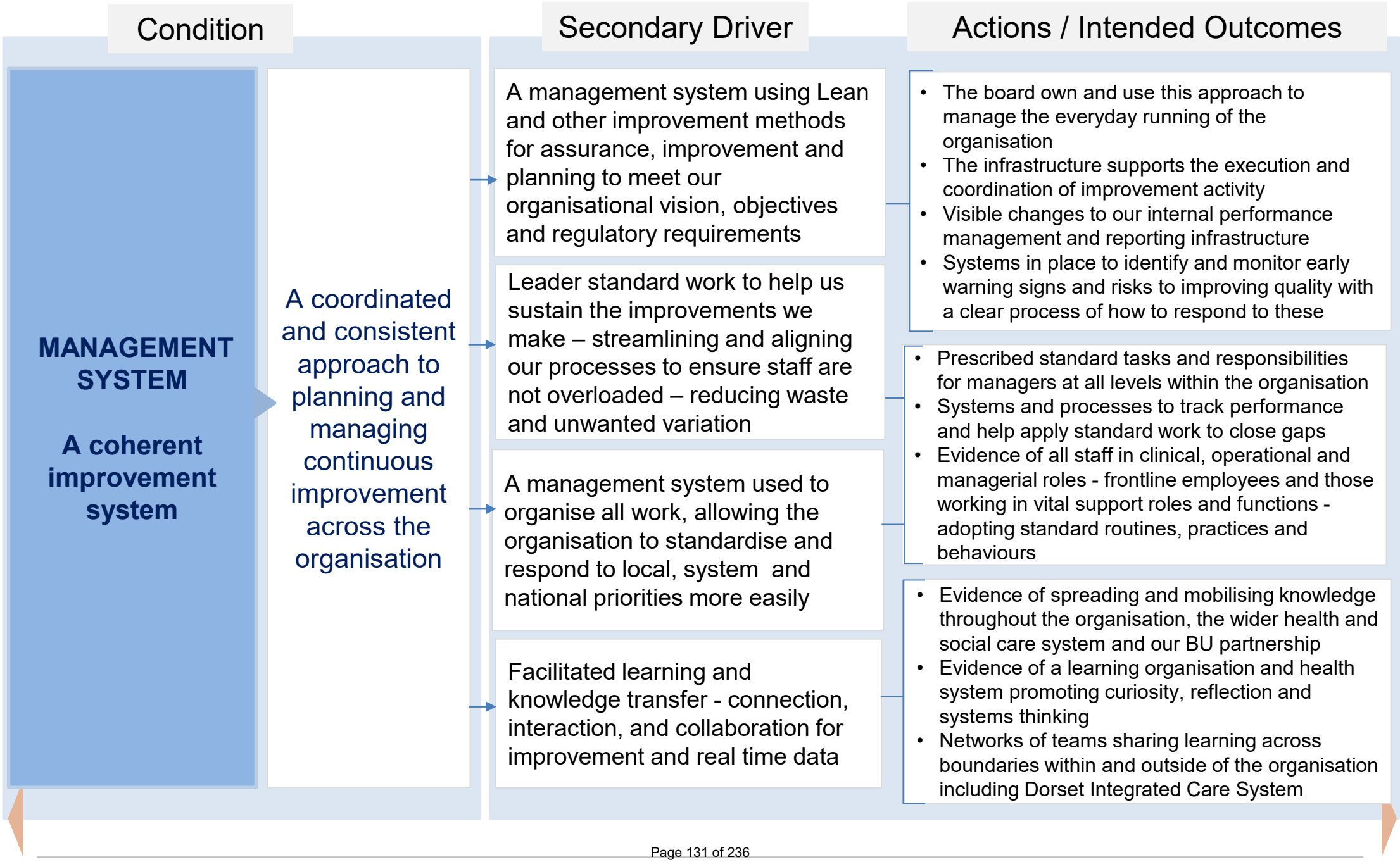
Improvement principles and ambition

Condition		Secondary Driver	Actions / Intended Outcomes
LEADERSHIP BEHAVIOURS **Compassionate and inclusive leadership**	Our leaders effectively build organisation-wide commitment to continuous improvement	Our leaders are visible to frontline staff and adopt a coaching style to encourage staff engagement in improvement activities Our leaders ensure staff have a regular time to take part in improvement activity	• Senior leadership team attend frequent huddles and ward / department visits to engage and coach staff who are delivering on the front line • 'Leaders as coaches' and effective coaching conversations at every level within the organisation to support the need for change from problem-solving to problem framing
		Our leaders consistently role model behaviours that enable improvement They exhibit humility and curiosity, challenge their own assumptions, and are committed to shared learning across the organisation and within the wider health and social care system	• A leadership development strategy outlining improvement capability requirements and access to training • All leaders undertake our Patient First leadership programme to develop their skills and expertise in continuous improvement • Ongoing coaching, mentoring and personal development support to encourage self-awareness • Leadership behaviour framework linked to values for effective role modelling and a public declaration of behaviours alongside a statement of commitment to *Freedom to Speak Up*
		Distributed clinical leadership to foster inter-professional collaboration. Clinicians visibly engaged and working with multi-disciplinary teams and managers to improve patient quality and safety (clinically led - managerially enabled)	• An equitable talent management strategy to support the development of a diverse talent pipeline for senior leader roles via sponsorship, reverse mentoring and coaching • A senior clinical leadership programme to develop skills and expertise in continuous improvement

Improvement principles and ambition



Improvement principles and ambition



Methodology and programme framework

Our approach is designed around an integrated continuous improvement (CI) system called Patient First

Patient First is shaped by our principles and ambition for improvement and comprise of **three main components** as demonstrated in the graphic.

All components are equal however developing our leadership behaviours is our Foundation Stone

Leadership Behaviours and Culture

A strong foundation of 'leaders as coaches'. Our values are a product of compassionate and respectful behaviours.

High Performance Management System

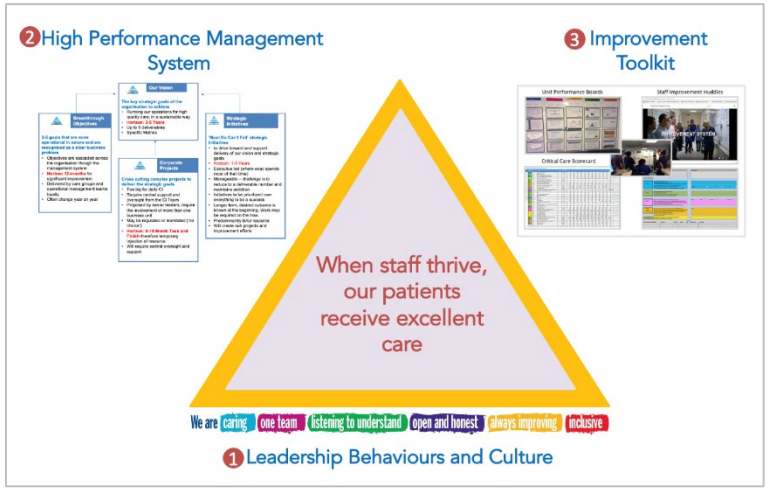
A set of improvement priorities cascaded through the organisation – a performance management system from our frontline staff to the Board genuinely built into everyday standard work and routines.

Improvement Toolkit

Structured training and tools to help our staff solve problems and make improvements – supporting our teams to be data and evidence driven.

Methodology and programme framework

Four pillars will support the phased implementation and delivery of *Patient First* with senior leadership oversight.



P1 Strategy Deployment	P2 *Patient First* Improvement System	P3 Continuous Improvement Projects	P4 Capacity and Capability
Chief Strategy and Transformation Officer	Chief Informatics Officer	Chief Finance Officer	Director of Organisational Development

Pillar 1: Strategy Deployment
Identifying a number of strategic priorities and cascading these throughout the organisation. A lean improvement and performance management system Frontline to Board – aligned to our '*True North*'

Pillar 2: Patient First Improvement System
Developing management level capabilities and standard systems for managing improvement across the organisation – within all our wards and departments

Pillar 3: Continuous Improvement Projects
Identifying specific high impact improvement initiatives based on selected processes or projects

Pillar 4: Capability and Capacity Building
Developing leadership capability and staff engagement across the organisation underpinned by Lean

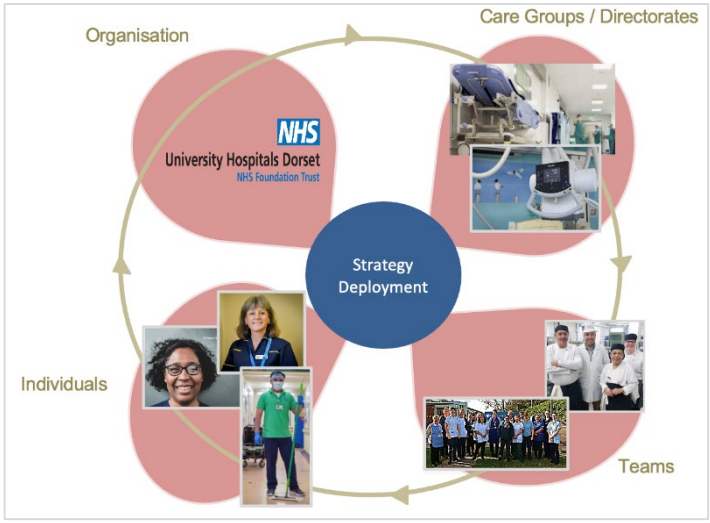
Pillar 1: Strategy Deployment

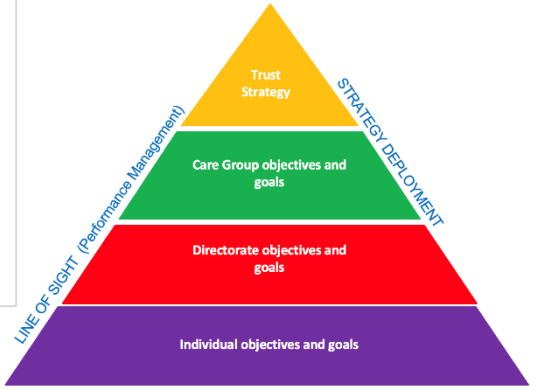
***Patient First* Strategy Deployment** focuses on identifying a number of strategic priorities and cascading these throughout the organisation. It is the adoption of a lean improvement and performance management system from frontline staff to Board – aligned to our strategy or '*True North'*.

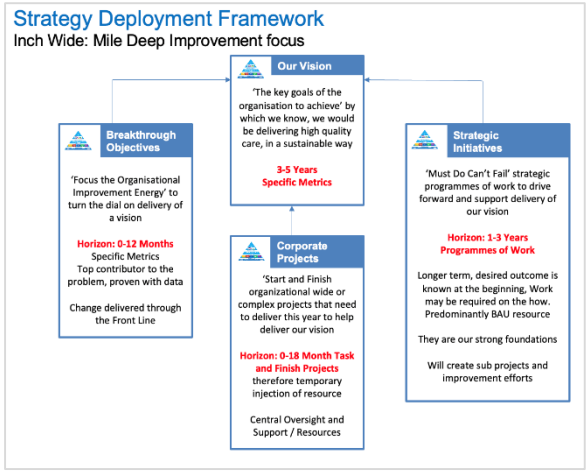
The Strategy Deployment and Review pillar will:

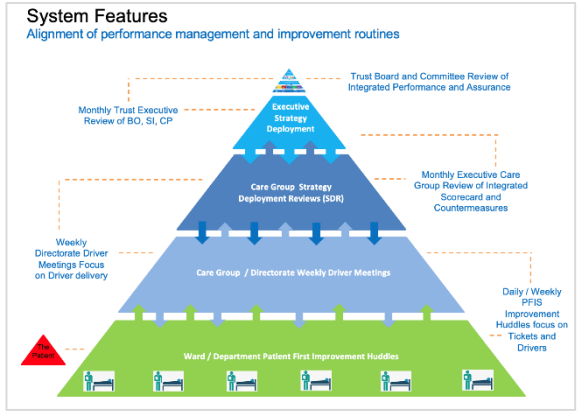
- Cascade the strategic priorities of the organisation from the top level down through our Care Groups, Directorates, Departments and to Individuals
- Ensure alignment throughout the organisation - everyone's goals support the overall vision, and we are all pulling in the same direction
- Focusing and aligning managers' efforts on the real problems that require resolution
- Ensure metrics are relevant to the goals of the organisation using visual management and scorecards
- Encourage team working and ownership of performance within teams and individual areas.

It is our *golden thread*









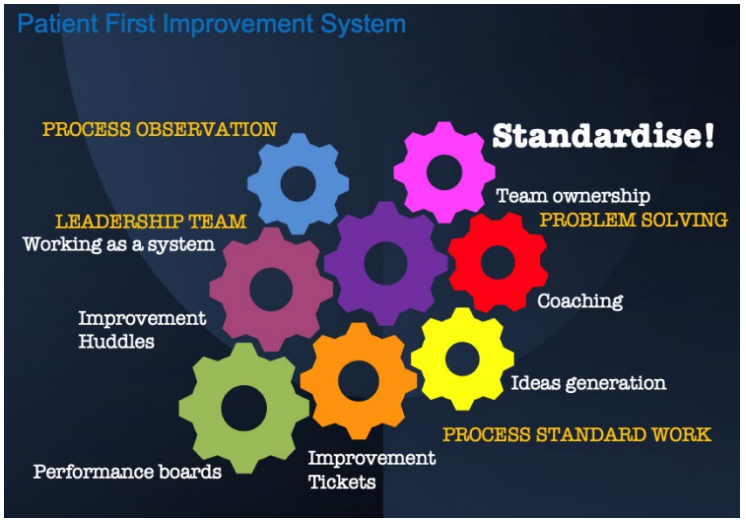
Pillar 2: Improvement System

***Patient First* Improvement System** focuses on developing management level capabilities and standard systems for managing improvement across the organisation – within all our wards and departments.

The Improvement System pillar will:

- Deliver training in 4 x ½ day face to face modules for **teams** (specialty / ward / department level)
- Following the taught sessions, out teams will be supported by visits to offer further coaching in their working environment
- This will take place at a time that is convenient for the specialty / ward / department e.g., to coincide with huddles
- We aim to make this programme the 'UHD way' and ensure signposting to other relevant development and training

All improvement effort, no matter how small, will be captured and celebrated to encourage a social movement for *#continuousimprovement*



Module 1

- What is an improvement system and why are we introducing it?
- How does it fit into the UHD strategy?
- Introduction to Lean [5s, Standard Work, Visual] management

STARTING WORK ON:
- a development plan for our dept/ ward leadership team
- our status sheet
- our driver metrics

Module 2

- Introduction to coaching
- Divisional scorecards and driver watch metrics
- Improvement System Leadership –supporting improvement at a local level
- Elevator pitches
- A3 structured problem-solving [Steps 1-3]

STARTING WORK ON:
- our A3s
- our unit score card

THEN:
- hold our first dept / ward leadership team meeting
- launch and try running a daily improvement huddle

Module 3

- Improvement huddles – layout of the improvement board and how to raise tickets
- Benefits tracking – how tickets move through the board
- Coaching refresher
- A3 structured problem-solving [Steps 4-6]

START WORKING ON:
- our process standard work
- our process observation
- our leader standard work

THEN:
- practice running another huddle

Module 4

- Recap on measurement for improvement
- Monitoring performance
- Lean core concepts (PDSA – value and waste)
- Human dimensions of change
- A3 structured problem-solving [Steps 7-9]

STARTING WORK ON:
- elevator pitches

THEN:
- Agree plan for next 10 weeks

Pillar 3: Continuous Improvement Projects

***Patient First* Continuous Improvement Projects** focuses on identifying specific corporate projects and improvement initiatives to support our refreshed strategy (True North), strategic initiatives and breakthrough objectives.

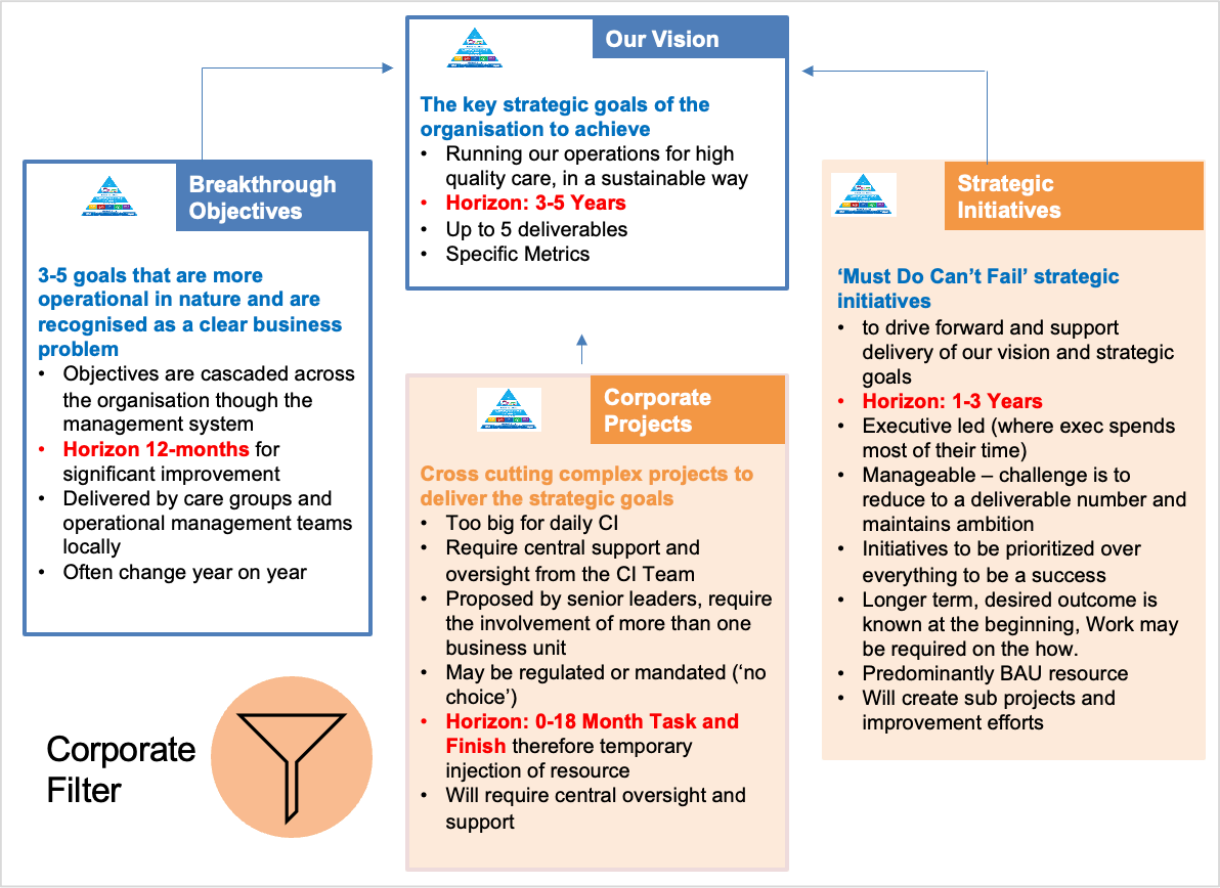
The Continuous Improvement Project pillar will:

- use a *prioritisation filter* method and *x-matrix* to systematically identify projects for delivery at key levels within the organisation:
- Mission Critical [Corporate]
- Care Group
- Corporate Services

- risk assess for 'wait and de-select' projects currently active within the organisation

- be applied to 'business as usual' in due course

We will 'de-clutter' workloads, wasted and / or un-coordinated effort



Pillar 4: Building Capability and Capacity

***Patient First* Capability and Capacity Building** focuses on developing leadership capability and engagement across the organisation underpinned by Lean and supporting our culture programme for staff engagement.

The Building Capability and Capacity pillar will:

- Train our senior leadership team in A3 problem solving
- Provide Patient First for Leaders training delivered in 2 x ½ day classroom sessions [Modules 1 – 4] and 4 x ½ day practical sessions [Modules 5– 8]
- Focus on the cascade from executives to trust leaders and provides the senior leadership team with the tools to succeed
- The organising principle is '*knowing, running and improving your service + developing your leadership style and behaviours*
- Oversee our UHD culture programme and recruitment of culture champions to ensure ongoing conversations and dialogue with staff

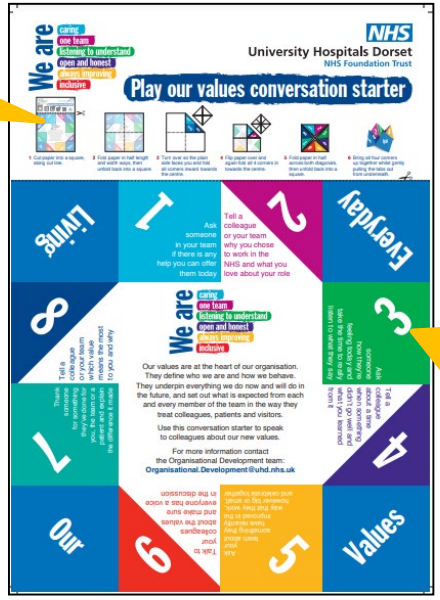
An inclusive approach and signposting for ongoing personal and leadership development

Module 1 Strategy Development	Module 2 Data for Improvement	Module 3 Strategy Deployment	Module 4 Coaching for Leadership
Strategy genesis, delivery, and socialisation. Why does an organization develop strategy? What's our strategy? How do we disseminate this in a large organisation? Exploring our *True North* Strategic Themes, Initiatives, Breakthrough Objectives and Corporate Projects	Data for improvement Understanding Statistical process Control (SPC) Pareto Run Charts Effective use of RAG ratings	What is strategy deployment and how does it align with the improvement system? What is the unique contribution of my care group / specialty/ corporate directorate to achieving these improvements? Care Group / Corporate directorate 'catchball' Introducing scorecards and countermeasure summaries	Introduction to Leader Standard Work and personal A3s Developing a coaching style as a leader How to GEMBA Exploring leadership impact on organisational culture [how do leaders help teams solve their own problems, not solve them for them?]

Leadership Behaviours

A3 methodology

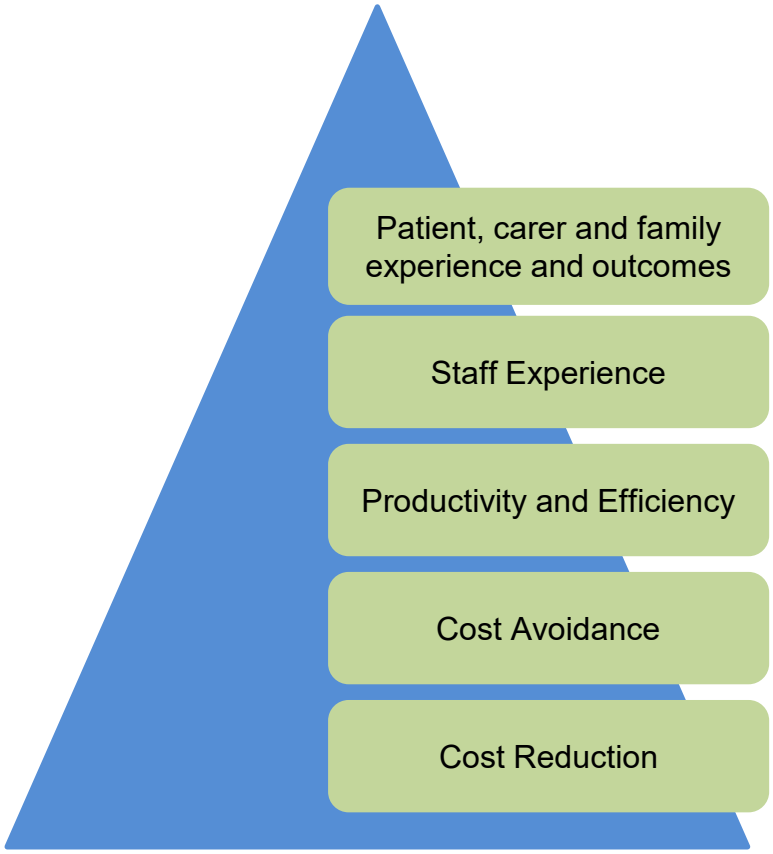
Our Patient First intranet site is up and running!



'Let's have a Conversation!' sessions to promote inclusion and how all staff can get involved

Strategy governance and delivery

A Patient First Steering Group will oversee the delivery of this strategy, reporting to our Trust Management Board and Board of Directors. Progress against the mobilisation plan and mitigation of risks will be recorded on a monthly basis in the Board Assurance Framework (BAF). A full benefits realisation plan will be completed, and delivery of outcomes monitored by the Patient First Steering Group. We will track for evidence of new ways of working and the required changes in leadership behaviour.



A systematic approach to improvement led delivery of quality is recognised by CQC as a key enabler to a well led organisation. A summary of benefits linked to the Key Lines of Enquiry:

KLOE	Model Headline Response
1. Is there the leadership capacity and capability to deliver high quality sustainable care?	Leaders trained in improvement methodology and developing compassionate and inclusive leadership behaviours. Leaders as coaches and highly visible.
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?	Refreshed Patient First strategy and 'board to frontline' deployment of improvement priorities linked to performance review. Improvement Management System in place.
3. Is there a culture of high-quality sustainable care?	Inspiring shared purpose via a culture of continuous improvement. SMART 'breakthrough' annual objectives.
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Strategic Deployment Review process provides Ward to Board clear line of sight through daily performance huddles and visual management.
5. Are there clear and effective processes for managing risks, issues and performance?	Patient First Improvement Programme enabling a clear and effective process for raising and managing risks, issues and performance.
6. Is appropriate and accurate information being effectively processes, challenged and acted upon?	Use of standard work approaches defines triggers for review and describes actions for improvement as part of the routine monthly performance and improvement cycle.
7. Are the people who use services, the public, staff and external partners engaged and involved to support high-quality, sustainable services?	Patient First Improvement programme is inclusive and actively engaging all levels of staff in problem solving for improvement as part of their daily routines. Patients as partners trained and involved in improvement work.
8. Are there robust systems and processes for learning, continuous improvement and innovation?	All frontline staff trained in standard improvement tools and given the time to problem solve and make positive changes for patients.

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The information in this report is correct to the best of our knowledge as of July 2023

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 9.2.1

Subject:	Statement of Commitment to Safeguarding children, young people and adults at risk
Prepared by:	Pippa Knight, Head of Safeguarding
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership Our people Patient experience Quality: outcomes and safety Sustainable services Patient First programme One Team: patient ready for reconfiguration	☒ ☒ ☒ ☒ ☐ ☒ ☐
BAF/Corporate Risk Register: (if applicable)	None	
Purpose of paper:	Decision/Approval	
Executive Summary:	Annual update of UHD Board Commitment to safeguarding.	
Background:	N/A	
Key Recommendations:	The Board of Directors is requested to approve the enclosed statement. This will then be uploaded onto the website as a public commitment to safeguard vulnerable people at risk	
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
Quality Committee	18/07/2023	Meeting not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust

Statement of Commitment to Safeguarding children, young people and adults at risk.

Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.

Those most in need of protection include:

- *Children and young people*
- *Adults at risk, such as those receiving care in their own home, people with physical, sensory and mental impairments, and those with learning disabilities*

NHS England (2022)

At University Hospitals Dorset we take our responsibility to safeguard very seriously. We recognise that anyone could be at risk of abuse or neglect, that a person may be more or less vulnerable at different times of their life and that we are in a position to hear, recognise and respond accordingly. This is aligned to our Trust objectives and values to continually improve and ensure our services are safe, compassionate, timely, and responsive.

We believe safeguarding requires a 'Think Family' approach as children, young people, adults and their families and carers do not exist or operate in isolation. We recognise safeguarding is part of building a safer community, to prevent exploitation and harm. Working in partnership with others strengthens safeguarding and we share information appropriately to protect people at risk. UHD participates fully as a member of Dorset and the Bournemouth, Christchurch & Poole Safeguarding Adults Boards and their sub-groups, and Pan-Dorset Safeguarding Children Partnership sub- groups.

We believe that safeguarding is everybody's business. Every member of our staff has an individual responsibility for safeguarding; all our staff and volunteers are equipped with training to recognise abuse and respond accordingly. We continually seek to improve and develop our training for staff. Our staff are supported by the Safeguarding Team.

The Trust Board provides the support and resources to enable the delivery of statutory responsibilities. The Executive Lead for Safeguarding is our Chief Nursing Officer/Deputy Chief Executive, supported by the Deputy Chief Nursing Officer and safeguarding professionals across the Trust.

Chief Executive — Ms Siobhan Harrington

Chief Nursing Officer — Professor Paula Shobbrook

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 9.2.2

Subject:	Infection Prevention and Control Annual Report 22/23
Prepared by:	Kate Crowther Interim IPC Lead CNS Matthew Hodson – Deputy Chief Nurse
Presented by:	Paula Shobbrook – Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive Summary:	The Board of Directors is required to publish an annual infection prevention and control report which outlines the commitment that UHD makes in relation to the 10 hygiene code criteria detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015.
Background:	This annual report incorporates information and data pertaining to healthcare associated infections during the period 1 April 2022 until 31 March 2023. It provides a summary of the Infection Prevention and Control (IPC) work undertaken, the management and governance structures and the assurance processes. The format follows the 10 hygiene code criteria detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015 The Annual plan also sets out the Workplan for the IPC team over the next year (2023/2024). The timeframe for delivery is being developed by the team.

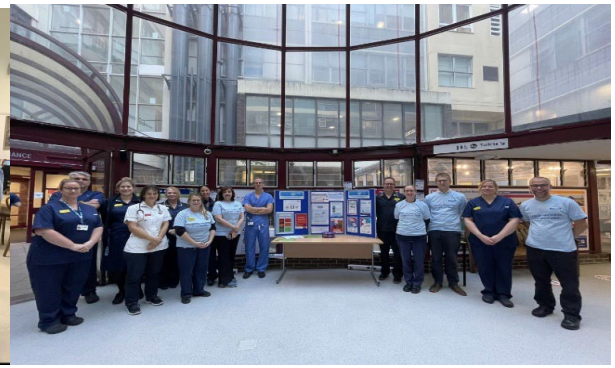
Key Recommendations:	Once approved, the annual plan will be published on the Trust's website to inform the public of the oversight of the IPC and our future plans.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☐ Operational Performance ☐ People (inc 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**
Infection Prevention and Control Group	13/07/2023	The IPC Group approved the report and for escalation to the Quality Committee.
Quality Committee	18/07/2023	Meeting not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust

Infection Prevention and Control Annual Report 2022/2023



UHD Antibiotic Awareness Day 2022

DOCUMENT DETAILS	
Author:	Kathryn Crowther
Job title:	Interim Lead for Infection Prevention and Control
Directorate:	Nursing
Version no:	1.1
Target audience:	Board of Directors
Approving committee / group:	Infection Prevention and Control Group
Date:	13.07.2023

1. Executive Summary

1.1. This report will be the third Infection Prevention and Control annual report for University Hospitals Dorset.

1.2. A huge thank-you to our Infection Prevention and Control and Microbiology Teams for their continued efforts and support to teams during 22/23 and during the Covid-19 Pandemic.

1.3. University Hospitals Dorset consists of several sites providing inpatient and outpatient care plus a separate sterile services department. This is spread within the boundaries of Bournemouth, Christchurch and Poole local authority area.

1.4. UHD offers a range of services.

1.5. The Bournemouth site consists of 606 beds, around 87% of admissions to the Trust are non-elective. On the Christchurch site is predominantly outpatients' departments with the Macmillan unit providing hospice care.

1.6. The Poole site consists of 601 beds, around 91% of admissions to this site are non-elective. On the site is Forest Holme, a hospice and St. Marys. St Marys includes care facilities for post and ante natal care as well as NICU.

1.7. The Christchurch site is mainly devoted to delivering outpatient care but includes the Macmillan Unit.

1.8. The Trust also includes an Outpatient Service contained within the premises of Beales within the Dolphin Shopping Centre.

1.9. Across site, the services are delivered through the structures of 3 care groups each of which have services and teams based on both sites.

1.10. During 2022/23 the Trust experienced the impact of subsequent waves of the COVID-19 Pandemic. A separate report has been written covering the impact and lessons identified from the healthcare acquired cases identified within the Trust and subsequent outbreaks.

1.11. During 2022/23 the Trust maintained systems and processes to direct the delivery of the 10 standards outlined in The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections. However, the pandemic, ongoing extreme pressure on operational flow and higher than average acuity have all had an impact on teams across the Trust to meet these standards consistently.

1.12. The DIPC, Department of Medical Microbiology and the Infection Prevention & Control Team are responsible for the leadership of the investigation, surveillance, prevention and control of infection in patients, healthcare workers and visitors to the Trust. There is also a responsibility to work closely with NHS Dorset, Infection Prevention and Control colleagues in others healthcare providers, UK Health Security Agency and the Local Authority Public Health Teams.

1.13. There has been a continued nationally observed increase in cases of Clostridioides difficile as we have moved further through the pandemic. A South West Collaborative group (of which we are part) is looking at possible sources for these cases so that we can implement action plans and care bundles to reduce incidence.

1.14. MRSA bacteraemia case numbers have continued to remain stable with 3 cases identified across UHD however the incidence of MSSA has increased within UHD. Cases of Pseudomonas aeruginosa, Klebsiella series, E.coli bacteraemia have remained static or reduced within UHD.

1.15. The Estates team continue with an active programme to manage water quality in the Trust including reducing the risk from Legionella and Pseudomonas. Challenges with standards of environmental cleaning have been robustly managed and new systems introduced to improve the standards.

1.16. Performance on anti-microbial stewardship has continued to be effective. A separate report to the Infection Prevention and Control Group covers this.

INTRODUCTION

This annual report incorporates information and data pertaining to healthcare associated infections during the period 1 April 2022 until 31 March 2023. It provides a summary of the Infection Prevention and Control (IPC) work undertaken, the management and governance structures and the assurance processes. The format follows the 10 hygiene code criteria detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015.

Health and Social Care Act 2008.Code of Practice Compliance Criteria

CRITERIA 1
Systems to manage and monitor the prevention and control of infection.

1.1. Infection Prevention and Control Team (IPCT)

The role of Director of Infection Prevention and Control (DIPC) is undertaken by the Chief Nursing Officer. The Deputy Chief Nursing Officer (and deputy Director of Infection Prevention and Control) retains line management responsibility for the IPC nursing team.

The Trust has a dedicated IPCT working across both sites. There have been several changes in staff since the beginning of the pandemic and in this last year the team have recruited to fill 3 band 6 vacancies. Additionally, the Band 8b post became vacant in February 2022 and the full time Band 7 stepped up to Band 8a as an interim lead until this vacancy can be filled. At the time of writing this report the team consisted of:

- Band 8a 1.0 WTE Registered Nurse (Interim)
- Band 7 0.8 WTE Registered Nurse
- Band 6 3.6 WTE Registered Nurses
- Band 6 1.0 WTE Registered Podiatrist
- Band 4 1.0 WTE Nursing Associate (now student nurse)
- Band 4 1.0 WTE Assistant Practitioner
- Band 4 1.0 WTE Fit Test Co-ordinator
- Band 4 0.85 WTE Data Analyst
- Band 2 1.0 WTE Admin support

IPC team is supported by a 1.0 PA Infection Control Doctor post, this is in addition to the daily support for follow up of cases by the Microbiology Team. It continues to be noted that 1 PA is insufficient to support current activity but reflects the continued vacancy factors within the Microbiology team.

The IPCT is well integrated into existing Trust governance structures with representation at several key groups as shown in table 1 below. While the substantive Band 8b post remains vacant the Deputy DIPC and Interim Band 8a strive to meet the gaps in terms of representation, with support from the IC team. The team had two away days during the year, one being run by another internal team and this was a team building activity. The second meeting reviewed roles and responsibilities and established a joint vision and aims for the year.

Table 1 List of meetings

Chief Nursing Officer	Deputy Chief Nursing Officer	Head of Infection Prevention and Control	Infection Control Nurses/ Practitioners	Infection Control Doctor/ Consultant Medical Microbiologist
Infection Prevention and Control Group	Infection Prevention and Control Group	Infection Prevention and Control Group	Infection Prevention and Control Group	Infection Prevention and Control Group
Quality Committee	Quality Committee			
	Outbreak Control Meeting	Outbreak Control Meeting	Outbreak Control Meeting	
Trust Board	Trust Board			
TMG	TMG			
Senior Nurse and AHP Group	Senior Nurse and AHP Group	Senior Nurse and AHP Group		

	Dorset IPC ICS	Dorset IPC ICS	Dorset IPC ICS	Dorset IPC ICS
	SW Regional IPC Cell	SW Regional IPC Cell	SW Regional IPC Cell	SW Regional IPC Cell
		Cleaning & contract review meeting/ Risk and cleaning meeting	Cleaning and contract review meeting/ Risk and cleaning meeting	
		Essential Core Skills Meeting	Essential Core Skills Meeting	
	Post infection review	Post infection Review	Post Infection Review	Post Infection Review
			Decontamination Group	Decontamination Group
		IC champions Meeting	IC champions meetings	
			Medical Device Group	
			Water Safety Group	
			Health and Safety Group	
			Waste Management Group	
			C.Diff Board Round	C.Diff Board Round
		Ventilation Group	Ventilation Group	Ventilation Group
	Fit Test Group		Fit Test Group	

			Care Group IC meetings	
			Linen Contract meetings	
		Transformation/ New builds	Transformation/ New builds	
		Cleaning Contract Tender meetings		
	Nutrition and Hydration Group		Nutrition and Hydration Group	
			IV line group	

1.2. Infection Control Group

The Trust Infection Control Group meets quarterly and is chaired by the DIPC or Deputy in their absence. The group comprises representation from the IPCT, Care group Directors of Nursing, Heads of Nursing and Professions, Care Group Matrons and Consultants, Estates team, Pharmacy, Occupational Health and Decontamination Services. The group has an open invite to the IPC Leads within NHS Hampshire and Isle of Wight ICB and Dorset ICBs. The summary of the minutes or escalations from this group are submitted to the Quality Committee. There is a direct reporting line to the Trust Board through the Chief Nursing Officer.

The Group receives reports from the Risk and Cleaning Group, Domestic Contract Review Meeting, Water Quality Group, the Decontamination Group, Ventilation Group and IPC Cell.

The Care Group Directors of Nursing provide a summary report of compliance with the key performance indicators and learning from post infection reviews, outbreaks, clusters, audit findings and cases of note.

The IPC Team provides a report on current Trust performance against national trends and action plans.

The Infection Control Group establishes an annual work plan to direct activity in meeting the local and national priorities for reducing healthcare associated infection. The plan is reviewed at the Group. Attendance at the Group demonstrates good nursing representation with lower attendance amongst estates and medical staff. The group would also benefit from wider AHP attendance.

1.3. Surveillance of Microorganisms and Infection

The ongoing surveillance of microorganisms is a critical part of the Trust's activity. In addition to the monitoring of in-patients, the screening of patients on admission to hospital and liaison with other health-care providers is critical for early identification of organisms and instigation of appropriate control measures.

The IPC Team using version 7 of ICNET that is managed through Dorset Healthcare and is a Dorset wide ICNET contract, with the exception of the ICB team who hope to join in the future. This enables teams to share clinical information and IPC decisions on patients as they move from acute trusts to the Community and back again. The software provides real-time surveillance of new microbiology results as they are authorised. ICNet supports the following work based activities:

- Surveillance of re-admission of patients with an existing CPI flag

- Daily audit of in-patients requiring isolation and IC support
- Recording notes and results of patient investigations
- Outbreak management
- Contract tracing
- Extended properties for HCAI reportable organisms
- Surgical site infection module pending introduction with surgical teams

The system supports the provision of the weekly, monthly and quarterly reports across the Trust. The Trust complies with mandatory reporting requirements set by UKHSA with respect to certain key microorganisms as discussed below in figure 2.

This year the team have explored the potential for clinical site teams to use ICNet for some activities and to improve communication and awareness. This had limited success as Trust activity levels did not allow for staff to attend training sessions. This will be reviewed ahead of the winter season.

Figure 2

Abbreviations for HCAI	**HealthCare Associated Infections**	**Definitions**
HOHA	Hospital-onset, healthcare associated	date of onset is greater than 2 days after admission (where day of admission is day 1).
COHA*	Community-onset, healthcare associated	is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date).

COIA**	Community-onset, indeterminate association	Not categorised as HOHA and patient has not been discharged from the same reporting organisation in the 28 days prior to specimen date but has been discharged within 3 months of sample.
COCA	Community-onset, community association	is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date).The patient has no interaction with the reporting organisation within the previous 3 months.

*COHA cases are included in Trust trajectory calculations for the year. To date, there have been few findings where prior admission caused post discharge bacteraemia. This will need further One Dorset collaboration to understand preventability. **This category is withdrawn for 2023-24

Annual figures for 2022-23 are taken from two sources

1. UK.gov Fingertips site for UHD trends against national data. These are calculated by rates, the denominator figure being set against 'per 100,000 bed days'. The data allows comparison with other organisations of different sizes.

   Local Authority Health Profiles - OHID (phe.org.uk)

2. The second source of data is extracted from the UKHSA monthly surveillance report for the South West of England. 'OFFICIAL: Mandatory HCAI Monthly Surveillance Report April 2023'

Figure 3 gives a brief overview of how UHD compares to national statistics for all reportable organisms. The columns on the right allow quick reference to UHD against national mean ranges. Individual organisms are reported in relevant sections. This, in summary, identifies that at UHD we are slightly above national average with E.coli and MSSA bacteraemia. We are below average for Klebsiella spp. And P.aeruginosa. It is worth noting we are at national average for MRSA bacteraemia and this is further described in this document.

Figure 3

Quintiles: Low ●●●●● High ○ Not applicable

Recent trends: – Could not be calculated ➡ No significant change ⬆ Increasing ⬇ Decreasing

Indicator	Period	University Hospitals Dorset			Trust type	England	England		
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
E. coli									
E. coli bacteraemia all rates by reporting acute trust and financial year	2021/22	➡	467	131.9	124.0	115.4	0.0		96.6
E. coli bacteraemia hospital-onset counts and rates by NHS acute trust and financial year	2021/22	➡	91	25.7	19.8	21.5	0.0		
E. coli bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2023	➡	367	101.5	96.1	88.2	0.0		99.8
E. coli hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2023	➡	86	23.8	20.4	22.5	0.0		
E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2023	➡	453	125.2	116.5	110.8	0.0		182.7
E. coli completion of risk factor information, by NHS acute trust New data	Mar 2023	➡	3	8.6%	55.7%	45.3%	0.0%		
E. coli known risk factor information, by NHS acute trust New data	Mar 2023	–	8	34.8%	69.7%	71.4%	0.0%		100.0%
E. coli completion of antibiotic information, by NHS acute trust New data	Mar 2023	➡	4	11.4%	49.5%	41.1%	0.0%		
E. coli known antibiotic information, by NHS acute trust New data	Mar 2023	–	43	67.2%	72.0%	72.4%	0.0%		100.0%
Klebsiella spp.									
Klebsiella spp. bacteraemia all counts and rates by acute trust and financial year	2021/22	➡	140	39.5	33.6	34.7	0.0		
Klebsiella spp. bacteraemia hospital-onset counts and rates by acute trust and financial year	2021/22	➡	41	11.6	8.9	11.2	0.0		
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2023	➡	113	31.2	33.0	33.8	0.0		
Klebsiella spp. hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2023	➡	28	7.7	9.2	11.2	0.0		
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2023	➡	85	23.5	23.8	22.6	0.0		
P. aeruginosa									
P. aeruginosa bacteraemia all counts and rates by acute trust and financial year	2021/22	➡	41	11.6	12.7	13.2	0.0		
P. aeruginosa bacteraemia hospital-onset counts and rates by acute trust and financial year	2021/22	➡	13	3.7	3.8	4.9	0.0		
P. aeruginosa bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2023	➡	35	9.7	8.0	7.7	0.0		
P. aeruginosa hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2023	➡	14	3.9	3.7	4.9	0.0		
P. aeruginosa bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2023	➡	49	13.5	11.7	12.6	0.0		
MRSA									
MRSA bacteraemia all rates by reporting acute trust and financial year	2021/22	➡	4	1.1	1.9	2.0	0.0		
MRSA hospital-onset counts and rates by reporting acute trust and financial year	2021/22	➡	1	0.3	0.6	0.7	0.0		
MRSA bacteraemia all cases counts and 12-month rolling rates, by acute trust and month New data	Mar 2023	➡	5	1.4	2.3	2.2	0.0		
MRSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2023	➡	2	0.6	1.5	1.4	0.0		
MRSA cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month New data	Mar 2023	➡	3	0.8	0.8	0.8	0.0		
MSSA									
MSSA bacteraemia all rates by reporting acute trust and financial year	2021/22	➡	153	43.2	37.9	37.3	0.0		58.1
MSSA hospital-onset rates by reporting acute trust and financial year	2021/22	➡	47	13.3	10.2	11.3	0.0		
MSSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2023	➡	99	27.4	27.9	26.4	0.0		
MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month New data	Mar 2023	➡	41	11.3	10.7	11.2	0.0		
MSSA total cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2023	➡	140	38.7	38.6	37.5	0.0		97.1
C. difficile									
C. difficile all rates by reporting acute trust and financial year	2021/22	➡	128	36.1	43.9	43.3	0.0		
C. difficile hospital-onset rates by reporting acute trust and financial year	2021/22	➡	34	9.6	15.2	16.2	0.0		
C. difficile infection counts and 12-month rolling rates of all cases, by reporting acute trust and month New data	Mar 2023	➡	154	42.6	44.2	44.5	0.0		
C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month New data	Mar 2023	➡	64	17.7	19.6	20.6	0.0		
C. difficile infection counts and 12-month rolling rates of community onset-healthcare associated, by reporting acute trust and month New data	Mar 2023	➡	20	5.5	7.2	7.3	0.0		
C. difficile infection Hospital-Onset Healthcare Associated (HOHA) counts and rates, by acute trust and financial year	2021/22	➡	39	11.0	17.2	18.3	0.0		
C. difficile infection community-Onset Healthcare Associated (COHA) counts and rates, by acute trust and financial year	2021/22	➡	31	7.2	6.9	6.7	0.0		
C. difficile toxin tests per 1,000 bed-days carried out by reporting acute trust and quarter	2022/23 Q3	➡	2,455	25.8	0.0*	18.5	-		*Insufficient number of values for a spine chart*
Miscellaneous									
Blood culture sets per 1,000 bed-days performed by reporting acute trust and quarter	2022/23 Q3	➡	6,780	71.2	67.5*	67.6	-		*Insufficient number of values for a spine chart*
Surgical Site Infection Hip Prosthesis by acute NHS trust and financial year	2021/22	➡	0	0.0	0.5	0.5	0.0		
Surgical Site Infection Knee Prosthesis by acute NHS trust and financial year	2021/22	➡	0	0.0	0.4	0.4	0.0		

1.4. Clostridioides difficile infection (CDI)

Figure 4.

Trust **Trajectory = 63**	**COCA**	**COIA**	**COHA**	**HOHA**
UHD **20+66=86 cases**	50	22	20	**66**

The trajectory set for 2022-23 was 63 HOHA and COHA cases, with the final number being 66 cases, with 86 cases in total (74 cases 2021-22), see figure 4

As described in last year's annual report there is a nationally recognised increase in C. difficile cases in the South West Region. UHD continues to work collaboratively to understand prevalence and risk for our patients. The team have attended national meetings as well as regional data sprints for cases.

Recent data suggests a national increase in CDI from April 2019, with men over the age of 80 more likely to have severe disease and that HOHA cases are at higher risk of poorer outcomes. There is national concern whether C.difficile transmission is occurring more often previously known. With no other relatable biometrics, such as prescribing patterns or changes in ribotypes to explain the national increase in HOHA cases (25% increase), this remains a trend that needs to be kept under surveillance to ensure the basic measures to prevent and control infection are measured and met.

Figure 5 demonstrates CDI rates by 100,000 bed days comparing UHD with England data. UHD have a high rate of testing which assures appropriate testing. Trusts with reduced/declining numbers of tests performed are potentially under reporting and seeing more transmission through undetected infection. The Trust has a lower rate of HOHA cases than nationally, with a local rate of 17.7 against national rate of 20.6. Trust trend for 2022-23 remains stable.

At UHD all C. *difficile* cases are discussed at weekly multi-disciplinary meetings which now include duty microbiologist, antimicrobial pharmacist, consultant gastroenterologist (when able), dietician and infection prevention and control team members (Chaired by IPCT). Patients who are at higher risk are under regular, enhanced surveillance and during this year there have been no patients who have died of C. difficile infection. After MDT discussion details of review are published on Graphnet although this is manual, is time consuming and risks inaccuracy. A project request has been accepted to support an electronic version in line with other MDT groups.

There have been two patients who the group have recommended undertake faecal transplantation (FMT).

During this year, the Trust reviewed how C.difficile cases are presented to the Dorset PIR group. Previous years have required monthly presentation of cases where no lapse in care was identified to remove from Trust trajectory of cases. These are only removed informally, as a local agreement, and it was reflected that the time spent completing each would be better directed looking at themes.

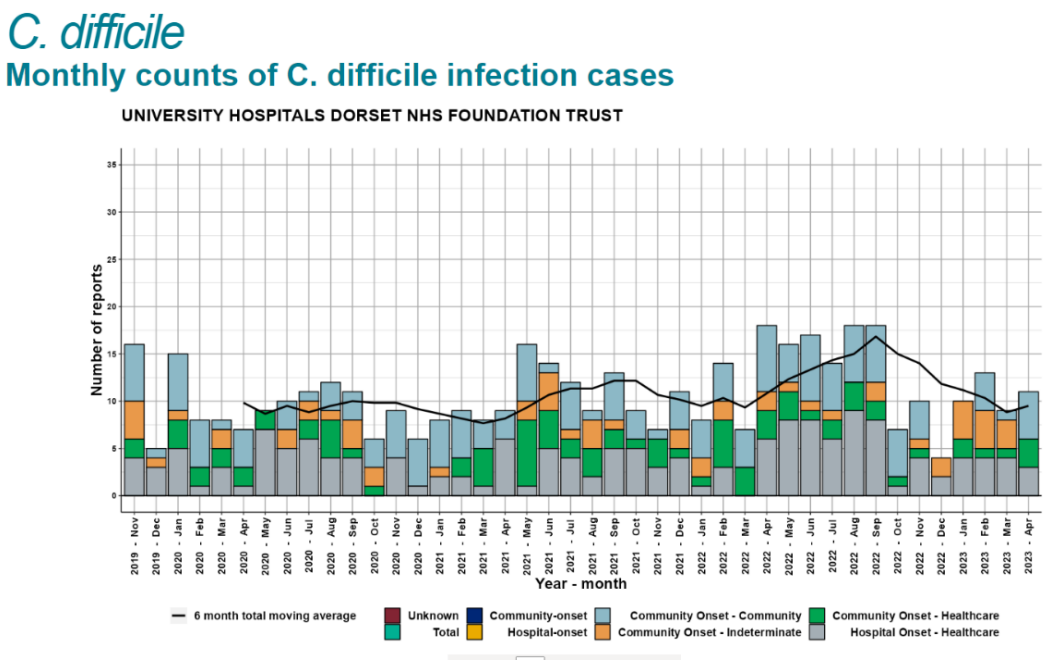
Community onset, hospital associated cases. Investigation focused on prescribing history prior to discharge and discharge medication, to assure these were in line with recommendations. Assurance patients were not discharged with diarrhoea that was not tested is also within the process for learning whether a previous hospital stay may have influenced a post discharge infection. Prescribing was reasonable for all patients and there were very little findings regarding omissions in testing prior to discharge. Patients developed C.difficile post discharge for a variety of reasons and risk factors that were not avoidable in hindsight.

Hospital onset, hospital associated cases. There remains a theme around late sampling for patients developing diarrhoea. This is a common and recurring theme not just at UHD but nationally. SIGHT algorithm (Suspect, Isolate, Gloves, Hand hygiene, Test) is used to promote suspicion of infective cause for loose stool but inevitably there are a multitude of reasons for diarrhoea on initial presentation and this tends to account for late identification of C. difficile infection (CDI). It does not account for patients developing CDI. A second theme noted last year was the number of patients who develop CDI after multiple courses of antibiotics while the prescribing itself was identified as reasonable and appropriate by the *C.difficile* MDT. The only prescribing finding was around late administration of CDI treatment and this was resolved with pharmacy teams and updating antimicrobial prescribing policy (microguide) with information about this.

There have been national updates to treatments for C.difficile away from Metronidazole as first line treatment to Vancomycin. This also advised about further options. These were communicated via Microguide and Trust wide communications by the Antimicrobial Pharmacy Team.

There was one Period of Increased Incidence of C.difficile (PII) reported to the ICB in 2022-23 within the Medical Care Group, although this was closed once ribotyping excluded common types among cases. There were findings around commode cleaning and this has been noted across the organisation. Good practice has been highlighted and promoted with the introduction of a ‘Golden Commode’ award to wards demonstrating 100% clean commodes on audit by IPCT. The team also developed a video on cleaning technique that is awaiting final edit.

Figure 5



1.5. Methicillin Resistant Staphylococcus aureus (MRSA) Bacteraemia

Figure 6

Trust **Trajectory is taken as '0'**	**COCA**	**COHA**	**HOHA**
UHD	2	0	**3 (0 2021-22)**

There is no national trajectory target set for MRSA bacteraemia. However, the organisation aims to have no hospital associated MRSA bacteraemia and follows up any reported with a post infection review that is presented to the Dorset PIR panel of experts.
UHD reported five MRSA bacteraemia's identified in blood cultures in total, same as last year. However, this year three of these are healthcare associated. All cases were investigated with findings being:

- none had history of MRSA
- none were in a shared environment with an MRSA positive patient
    - two people had complicated comorbidities and risk factors
- source of bacteraemia was difficult to identify in all of them
- There were some incidental findings in both hand hygiene and cannulae observations.

Figure 7

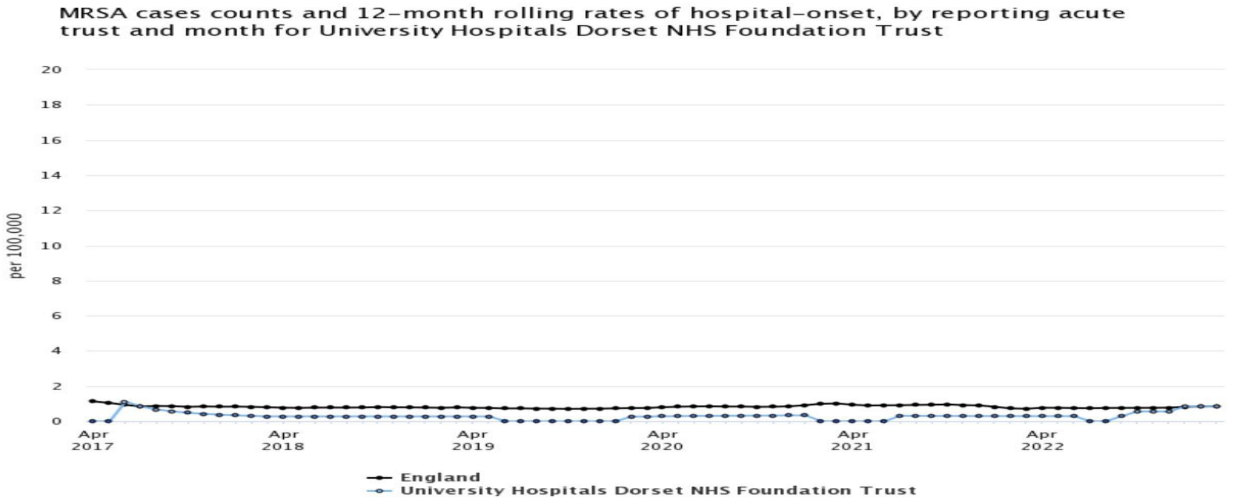
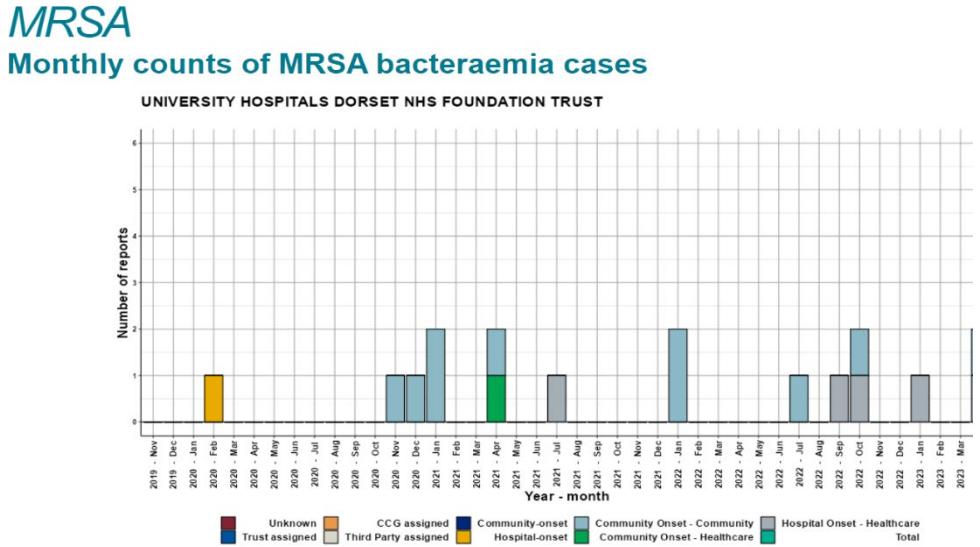


Figure 7 shows UHD as lower than national average until late 2022/23 when it meets the national average for the first time since 2017. These remain very small patient numbers for UHD, as figure 6 & 8 detail, and so statistically this may not be significant. Every patient has a post infection review and there are no themes regarding hospital acquisition although cannulae observations remain a workflow to re-establish an electronic system following withdrawal of the previous electronic system. The IPCT are in discussion with the practice education team to improve completion of this data.

Figure 8



Although national policy has not changed, our Infection prevention and control MRSA policy is due a review, as part of our policy review. This year a microguide has been updated to agree guidelines across sites and Poole Hospital are changing decolonisation products to come into line with Bournemouth prescribing.

1.6. Methicillin Sensitive Staphylococcus aureus (MSSA)

Figure 9

Trust	COCA	COHA	HOHA
UHD	188	11	94 (87 cases 2022)

It is a requirement for Trusts to report all cases of MSSA bacteraemia although there is no target set. The final number of hospital associated cases for the year is 105 cases in total (74 cases 2021-22) which is an increase in the previous year, see figure 9. Nationally there has been an annual increase in cases as previously reported and there has also been a noted rise during the pandemic period.

UHD have continued to see a higher than average MSSA rate, see figure 10

Figure 10

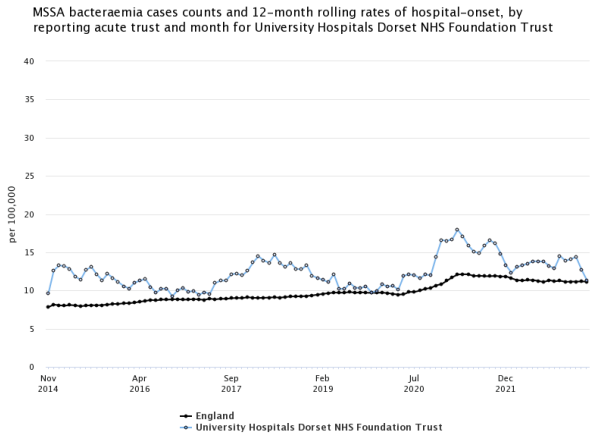


Figure 10 figures show hospital cases at UHD. Of note, both community and hospital cases have been above national trends but have fallen into line with national averages towards the end of this period (see figures 10 & 11) The South West had a higher incidence of COVID-19 than nationally with this also falling at the same time. For details of case identifications see figure 12.

Figure 11

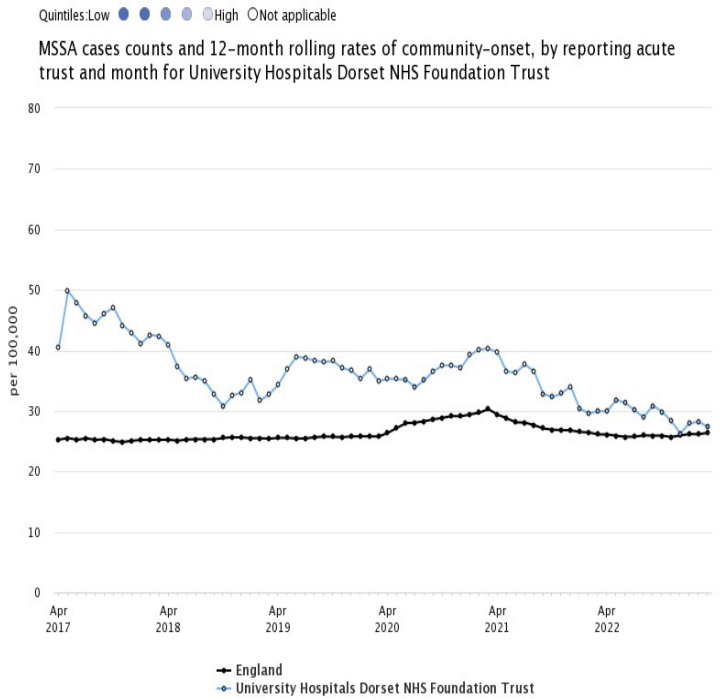
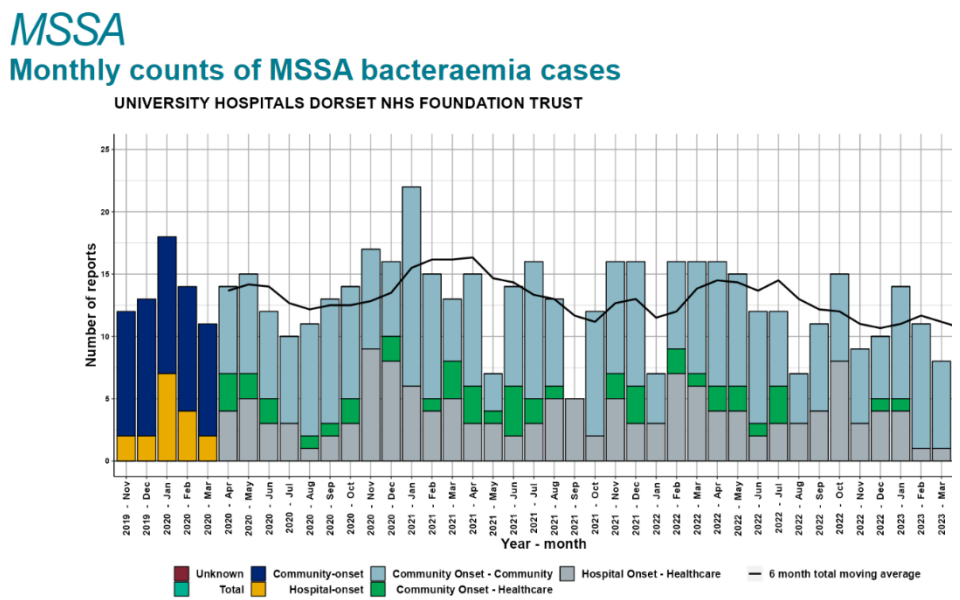


Figure 12



Investigations of source have, like the other reportable organisms, highlighted complex needs of patients, multiple cannulae with inconsistent obervations of sites. While there has been an increase in cannula related infections cannulae will always provide a risk. Projects to prompt staff to manage cannula and to aim for prompt removal will be on the ambitions for work in 2023-24. Identifying source of bacteraemia has been complicated and prevention actions hard to plan. The organisation would benefit from a dedicated surveillance nurse to understand underlying risk factors and where to focus actions to reduce these.

Last year there was an aspiration to assess the impact of skin colonisation for patients having elective surgery. The team hoped to explore a disinfecting body wash to reduce bioburden, with the hope of further reduce post operative infection. This remains in discussion and will be on IPCT action plan for support in our 23/24 plans.

1.7. E. coli bacteraemia

Figure 13

Trust E.coli bacteraemia 2022-23 **Trajectory = 118**	**COCA**	**COHA**	**HOHA**
UHD **49+85= 134 cases**	318	49 (42 in 2021-22)	85 (90 in 2021-22)

The trajectory set for 2022-23 was 118 of HOHA and COHA cases, with the final number being 134 cases in total (132 cases 2021-22), see figure 13.

Urinary Tract Infection continues to be the leading cause of E. coli bacteraemia. Key areas to focus for prevention work are urinary catheter management, patient hydration and oral hygiene. The organisation has been above national average for cases again this year although in the local area it is recognised E.coli bacteraemia is a risk for our local population due to age, frailty and warm summers.

A key project for the year was to improve invasive device care, hand hygiene for patients and hydration. Only hydration has progressed as planned with the IPCT and other representatives in the organisation representing UHD in a SW collaborative as well as a local NHS Dorset project. As mentioned, electronic alternatives for paper VIP charts is ongoing.

Hand hygiene for patients will be promoted this year with a project in progress with clinical audit.

As with other bacteraemia a single source has been difficult to identify in a number of patients in the previous year although further work may well provide this detail and inform awareness of the impact of these themes. There have been no novel themes picked up this year

however, there are findings around catheterisation in terms of indication for insertion, removal, and care that would benefit from further project work.

Figure 14

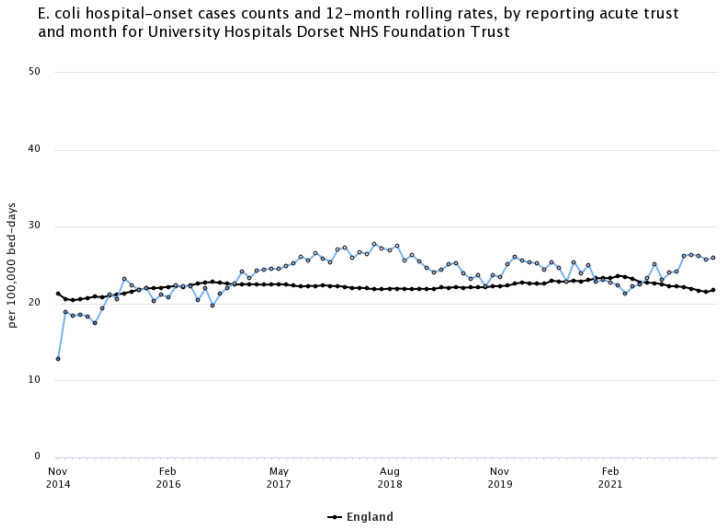
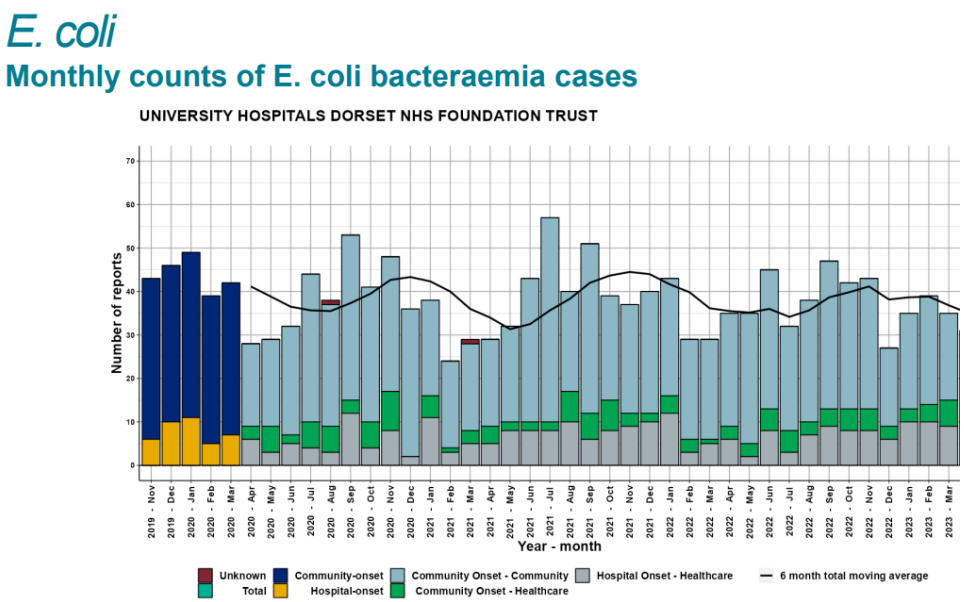


Figure 15



1

1.8. Klebsiella species and Pseudomonas aeruginosa

Figure 16

Trust Klebsiella bacteraemia 2022-23 **Trajectory = 39 cases**	**COCA**	**COHA**	**HOHA**
UHD **5+28=33 cases**	80	5	28

The trajectory set for 2022-23 was 39 HOHA and COHA cases, with the final number being 33 cases in total (cases 2021-22), see figure 16.

The trust has below national average for Klebsiella, see figure 17 & 18. Themes and learning are the same as per other gram negative organisms. Klebsiella, being an enterobacterales group of organisms like E.coli, carries the additional threat from multi-drug resistant patterns. Addressing effective cleaning of shared equipment with appropriate technique and chemicals is key to maintaining low risk of these organisms becoming endemic in our healthcare environment.

Figure 1

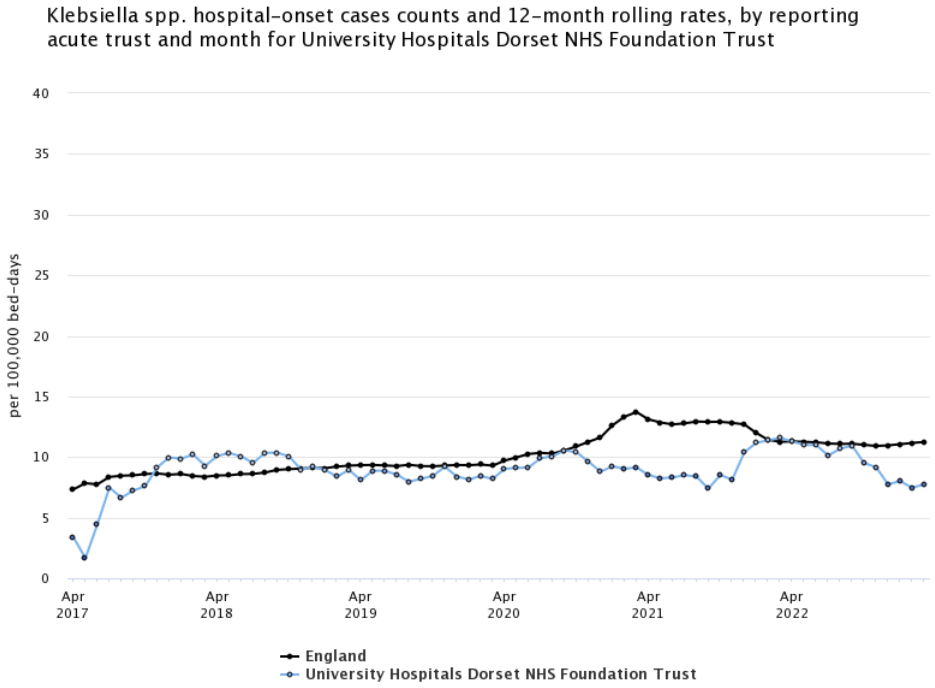
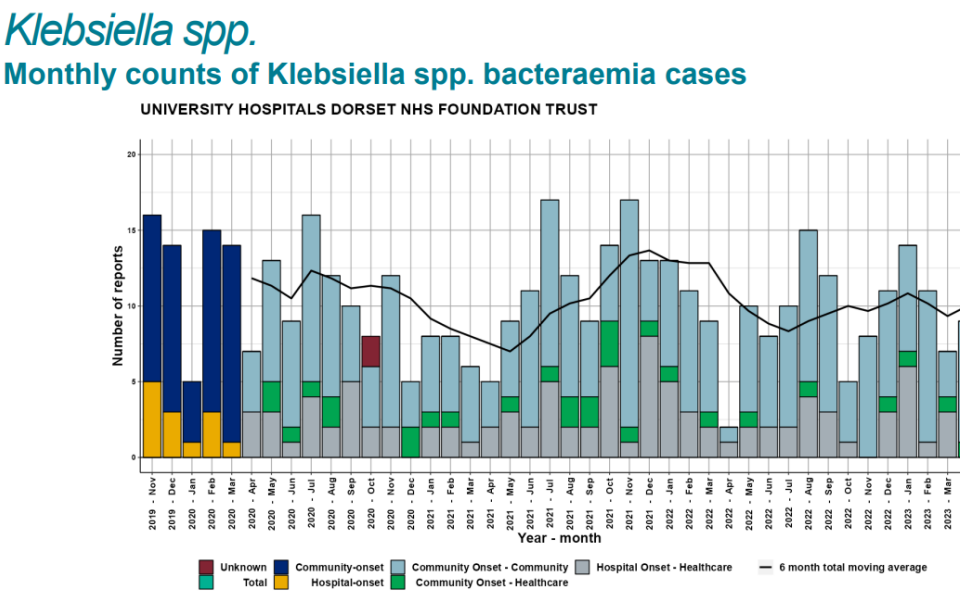


Figure 18



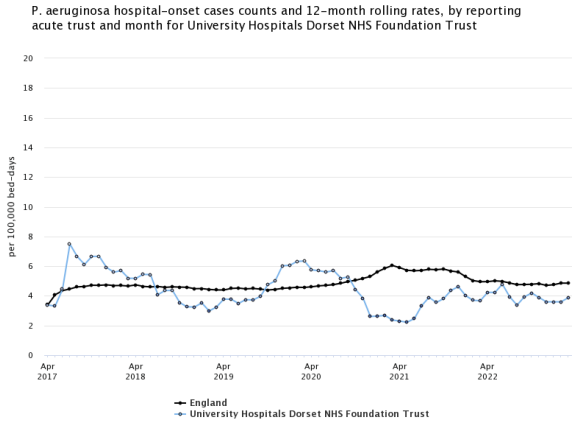
1.9. Pseudomonas aeruginosa

Figure 19

Trust bacteraemia 2022-23 **Trajectory = 21**	**COCA**	**COHA**	**HOHA**
UHD **7+14=21 cases**	28	7	14

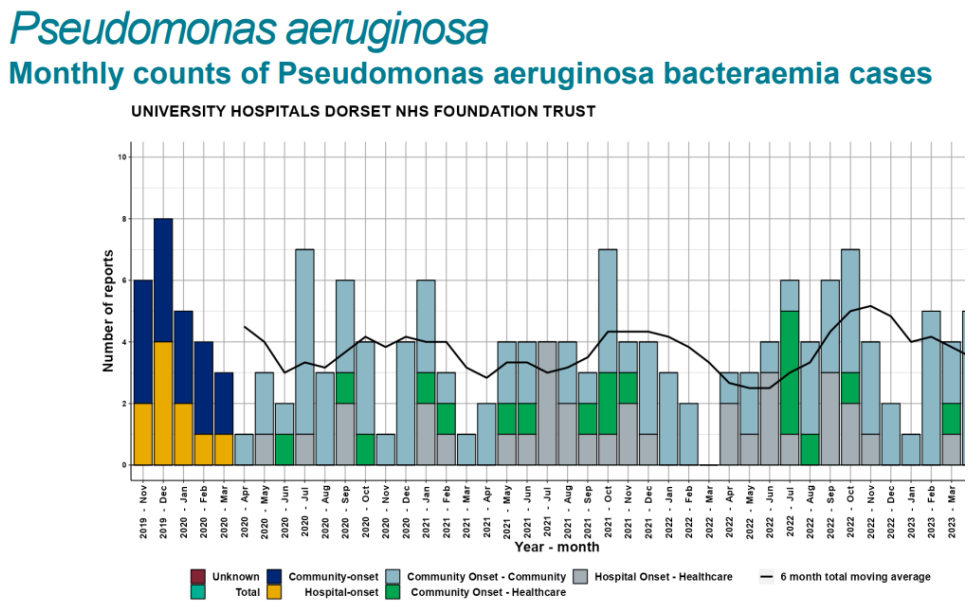
The trajectory set for 2022-23 was 21 HOHA and COHA cases, with the final number being 21 cases in total, see figure 1

Figure 20



Cases of pseudomonas bacteraemia during 2022-23 was low however, some cases showed a higher number of resistance to antimicrobials and were sent to the reference laboratory. It was identified that a patient had a pan-resistant profile, resistant to all treatments and it was only through liaising with external experts that microbiologists were able to recommend treatment that was successful. Ward staff are to be commended that no other cases arose during this inpatient stay. There were more cases at Bournemouth Hospital site (14) than Poole (7) which is a pattern that will be monitored in the coming year. There are no water quality factors contributing to this. See figures 20 and 21 for trends.

Figure 21



1.10. Seasonal Influenza and other circulating viral causes of ILI

1.10.1. **RSV**

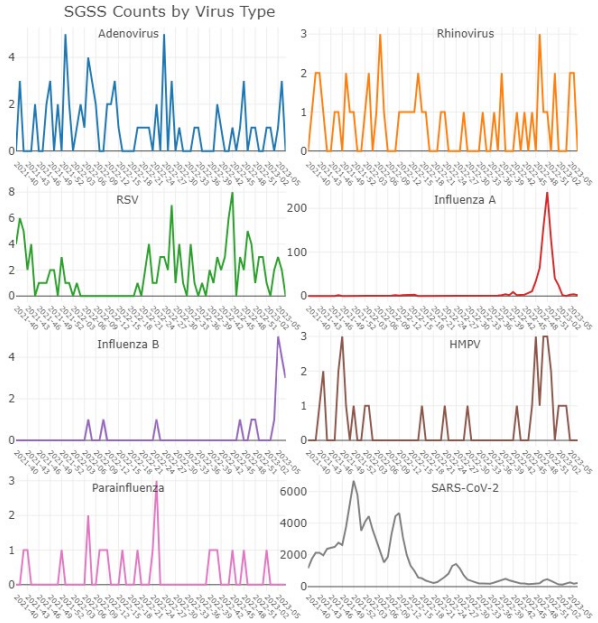
The trust prepared for a high incidence of RSV in children on guidance from UKHSA. Numbers did rise through July/ August but not as many as feared and improvements in the environment on our Childrens Unit enabled isolation of a higher number of young patients. There were no outbreaks reported. See figure 22.

1.10.2. **Influenza A and B**

Influenza did impact both sites with Bournemouth site having outbreaks just before Poole site. There was no evidence of cross transmission through staff or transferring patients and this was thought to demonstrate high numbers of local circulating virus. There was a short, sharp influenza season this year. There was one outbreak at Bournemouth site and two at Poole, see figure 22.

New PCR cartridges were sourced which enabled both microbiology and the SAMBA II service to identify a selection of viruses in a single sample. This was very helpful in diagnosing infectious causes for symptoms.

Figure 22

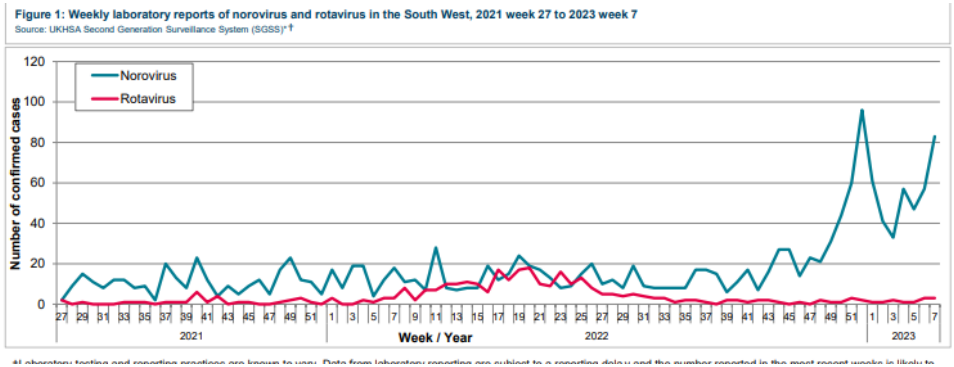


National guidance for managing COVID-19 was amended to cover all respiratory viruses and recommendations returned to pre-COVID measures.

1.10.3. **Norovirus**

During the pandemic, the trust saw a reduced number of outbreaks of other seasonal viruses, assumed to be related to measures in place that contain them and reduce transmission for all pathogens. As with respiratory viruses winter 2022-23 saw the first norovirus outbreak season for some time. Unusually, there were outbreaks, particularly at the Bournemouth site where ward were closed with two outbreaks, some patients having a confirmed respiratory virus and also norovirus. Patients wandering with purpose often featured in these outbreaks. There were five outbreaks at Bournemouth site and three at Poole. As shown in figure 23 Norovirus was higher this season than any other period of the pandemic. This could be explained with reduction of social distancing and the public returning to life as normal.

Figure 23



Findings during the outbreaks are consistent with findings from COVID-19 outbreaks and the outbreak report of 2021-22 is very similar to that of 2022-23 which includes patient movement, prompt identification of outbreak, hand hygiene and PPE, location of bathroom facilities and the impact of patients walking with purpose.

1.11. SARS CoV-2

COVID-19 determined activity of the IPCT throughout 2022-23 with national change advised for the beginning of April 2023, see figure 24. Guidance changes slowed down during the year but included changes to isolation periods, social distancing and PPE. Changes to universal mask wearing were delayed until after the February (see figure 25) surge in cases while other South West organisations chose to step these down earlier. The most significant change in policy came at the end of March 2023 and will be covered in the next report.

Figure 24

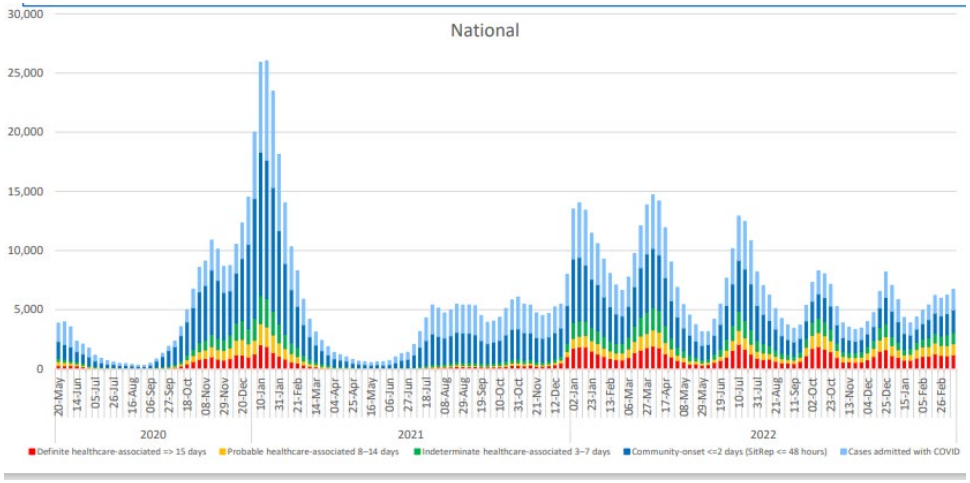
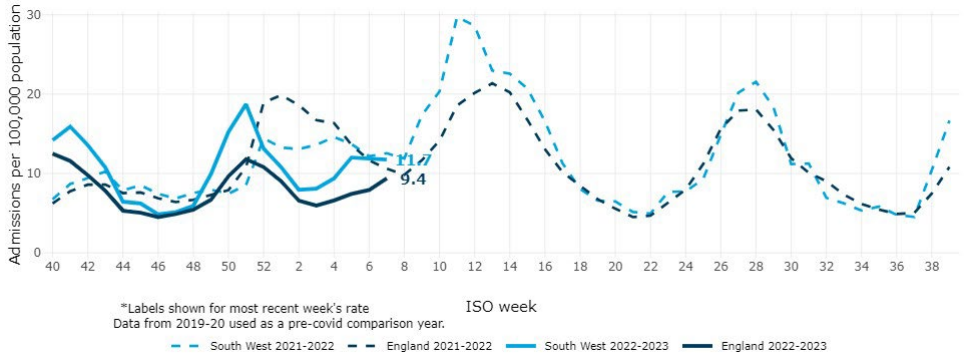


Figure 25



2022-23 saw 20 COVID-19 outbreaks reported at Bournemouth site and 19 at Poole site. High incidence at one site followed from one site to another without any supportive evidence to connect them other than local incidence. This seesaw effect was seen with other organisms, as previously reported. This year's COVID-19 outbreak report was presented to IPG in May 2023 and an action plan developed for all care groups to work with this coming year.

1.12. Mandatory reporting of surgical site infection (SSI)

UKHSA SSI surveillance service (SSISS) mandate surveillance on a limited number of surgical procedures for a minimum of one quarter per year. .UHD are signed up for mandatory procedures carried out in the organisation and deliver 4 quarters per year. At time of writing

this report the 4th quarter for 2022-23 is being submitted. There are other, optional fields that the IPCT recommend the organisation takes part in this coming year.

As shown in Figure 26 trends changed during 2022-23 for repair of neck of femur, previously a low outlier, now a high outlier. The organisation received a letter from UKHSA surveillance service which reminded the organisation that methodology that must include:

- Visiting the wards at least three times a week to liaise with nursing and medical staff and review patient notes and charts for clinical signs of infection
- Daily review of microbiology reports for positive surgical site cultures
- Surgical site wounds identified from a systematic readmission alert system

Trauma orthopaedic surgery assure these processes are in place. There is a national expectation that surveillance includes IPC involvement, which is not the current system for surveillance and will be reviewed in this year's plan.

Figure 26

UHD	Yearly summary data 2021-22	Total operations 2021-22	Q1 2022	Q2 2022	Q3 2022	Q4 2023 Not yet reported
Repair neck of femur UHD	0.8%	710	**2.5%**	1.4%	2.0%	optional
National comparison	1.0%	NA	0.9%	0.9%	0.9%	NA
Knee replacement UHD	0.0%	295	2.2%*	0.0%	0.0%	optional
National comparison	1.1%	NA	1.1%	1.1%	1.0%	NA

Hip replacement UHD	0.0%	329	6.3%*	0.0%	0.0%	optional
National comparison	0.8%	NA	0.8%	0.7%	0.8%	NA

* there are fewer operations in these fields which increases percentage value

It is possible that work to review how the organisation is a low outlier has resulted in becoming a high outlier and audits are now more accurate. This has been supported by IPCT looking at re-admissions via the new ICNet SSIS app and imports of all patients who are re-admitted with post operative wound infections within 30 days of surgery. At time of reporting action taken is:

- Investigation of all post operative infections within SSIS criteria
- A selection of staff in IPCT and orthopaedic teams were invited to attend ICNet training sessions on using ICNet software to report. This was completed but needs further report to gain confidence to discontinue current paper forms.

A theme in orthopaedic surgery has prompted review of skin closure as use of clips adds risk of infection according to data. The surgical care group are to provide a report for IPG. A summary report was distributed for overview in April. The IPC Team will be working closely with the Surgical Care Group to share this data and establish stronger links with the possibility of cross team working to support this.

1.13. Getting It Right First Time (GIRFT) surgical survey

Due to the ongoing pandemic and focus on moving to living with Covid-19, the team have not had the significant time required to support work in this project during the time period with the hope to be able to utilise the experience of a recent secondee to the IPC Team, alongside the theatres team supporting this.

1.14. Hand Hygiene and Saving Lives audit

Hand hygiene audits are undertaken monthly in all clinical areas of the Trust with results collated by clinical audit and made available via the saving lives page of the intranet.

Results are discussed at care group monthly IPC meetings with chair, champion and IPC representative. It is noted that only the current month view is available, and this will be adapted to show rolling rates for awareness of trends and to support action.

The care groups at Poole site need to complete SLA audit reviews before this tool can be viewed effectively. The IPCT have designed a further audit to be included that includes PPE and patient hand hygiene. This is in response to the updated board assurance framework.

Previous endeavours to measure hand hygiene in novel ways had been underway but were unable to be implemented due to demands of COVID outbreak management. It is hoped to work towards this once the team are able to recover and catch up on policy and clinical work and are able to look at the horizon of opportunities.

Below left: shows the IPCT teaching a group of health and social care students from St Peter's School, Southbourne.

Below right: Hand Hygiene Day site swap: cross site working as Poole and Bournemouth based IPCTs found their way around each other's environments to promote WHO Hand Hygiene Day 2022.


Your 5 moments
for hand hygiene
No risk?
WEAR
GLOVES
DON'T

CRITERIA 2
Provide and maintain a clean and appropriate environment

2. Provide and maintain a clean and appropriate environment

2.1. Healthcare Cleaning

Across UHD there are 2 different cleaning services, the Bournemouth site has their own team with Poole covered by an external contract delivered by Mitie. Cleaning contract has been extended for Mitie while the service review is completed.

The organisation has moved over to new national standards for cleaning with introduction and further embedding of a star rating system. Further work to include nursing elements continues.

Poole site report

Figure 30 Star rating report for the Poole site

Number of Areas Achieving													
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
	5 star	113	105	99	86	95	80	74	85	90	86	95	101	**996**
	4 star		4	6	4	2	2	6	5	5	3	4	6	**47**
	3 star		1	1				1	1		1	1	3	**9**
	2 star	1			1				1	1			1	**4**
	1 star			1	1							1		**3**
		114	110	107	92	97	82	81	92	96	90	101	111	

Figure 31 Number of areas audited for the Poole site

Number of Areas Audited (Per Functional Risk Category)														
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
	FR1	47	44	43	39	43	41	39	46	48	38	40	45	
	FR2	30	30	25	32	31	31	27	25	32	34	34	34	
	FR3	3	4	3	1	1	3	1	3		4	1	4	
	FR4	31	25	30	16	12	7	14	18	16	13	18	27	
	FR5	2	1		2	1						3		
	FR6	1	6	6	2	9					1	5	1	
		114	110	107	92	97	82	81	92	96	90	101	111	**1173**

Figure 32 Average monitoring scores for the Poole site

Average Monitoring Score														
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
	FR1 (98%)	99	99	98	99	99	99	98	98	99	99	99	98	**99**
	FR2 (95%)	99	99	99	99	99	99	99	98	99	99	99	98	**99**
	FR3 (90%)	98	99	99	98	92	97	99	97		97	99	99	**98**
	FR4 (85%)	97	97	98	95	95	99	98	97	97	97	95	95	**96**
	FR5 (80%)	94	94		95	99						93		**93**
	FR6 (75%)	99	99	98	99	97					95	97	92	**95**

Figure 34 Terminal Cleans completed for the Poole site

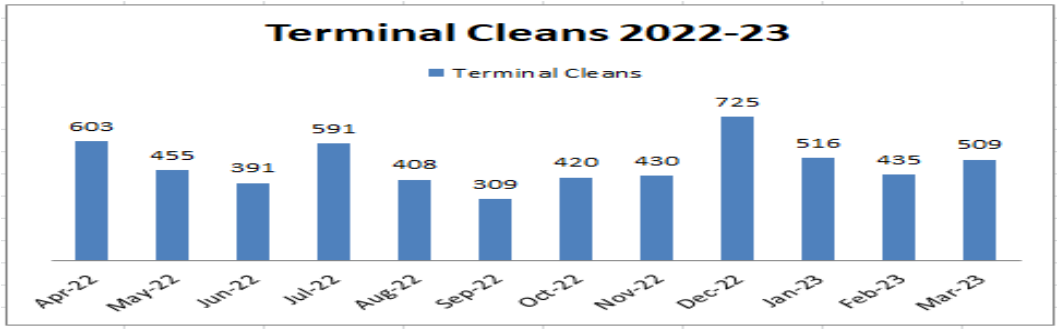
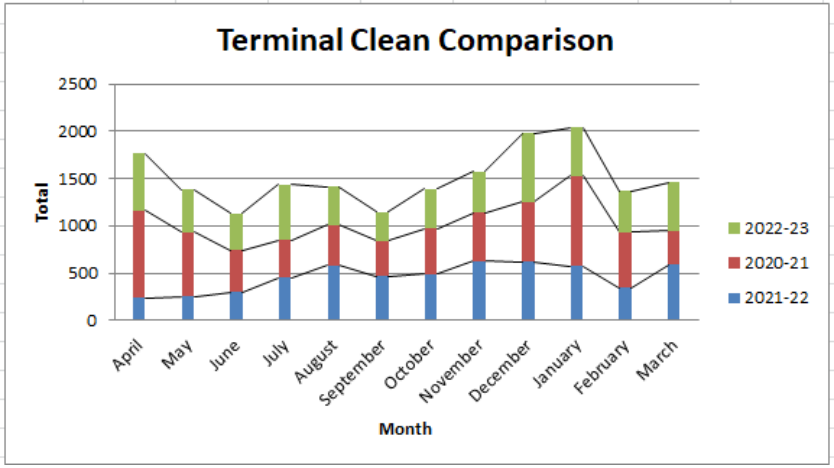


Figure 35 Terminal clean comparison 20/21 vs 21/22 vs 22/23 for the Poole site



The Trust enjoys a very good working relationship with the Mitie contractor and its staff. The team always go above and beyond to support the Trust in its endeavours to keep the site clean and safe for patients, visitors and staff.

2.2. Medical Device Cleaning

Audits carried out across the Trust have identified that attention should be drawn in all areas to the cleaning of these shared devices. The Trust has implemented action plans to address these gaps and has seen the beginnings of improvement, however there is some way to go before these are achieving consistently high standards.

2.3. Patient-led assessments of the care environment (PLACE)

A PLACE led audit was completed at UHD in in 2022, this was led by the Head of Patient Experience and IPC supported the PLACE visits.

2.4. Estates

It is noted that in some areas of the Trust, particularly at Poole site, the age and design of the building and its fabric can pose challenges in cleaning and optimal infection prevention.

There has been no significant change from last year's report. The IPC team continue to work closely on new builds and template changes as part of the merger transformation programme. Established meetings continue and this year has seen the completion of the new barn theatres at the Poole site, due to go live at the time of this report.

Addressing shortfalls in the general environment continues to be a risk assessed process that both teams continue to monitor and discuss. Balancing these requirements against the planned changes for each area and the constant pressure to support patient flow into the organisation has meant that many of these are delayed. There have been ongoing issues with macerator leaks during the year, most of which were user errors.

The ability to ensure there is a decant ward available will be a priority as the trust sees more service moves and considering the transfer of existing equipment into new environments will become a feature for discussion to ensure there is no contamination of new build environments with organisms that flourish through either wet or dry biofilms.

2.4.1. Specialist Ventilation

The Trust has a Ventilation Safety Group that reports into the Infection Prevention and Control Group.

The Group meets on a monthly basis and has supported the assessment against COVID-19 risk assessments required to meet IPC and H&S guidance. The group is supported by the Trust authorised engineer, leads from the estate's teams and clinical representation.

The Trust is continuing to assess the requisite areas for good ventilation using the HSE and HTM guidance as a base line to complete this. The IPC team have one ICN with training in ventilation and plan to send Band 7 staff so that the team are able to extend expertise in the built environment, to support the changes over the next few years.

2.5. Water Safety

Water safety is an important element in the Trust's infection prevention work. Key to maintaining a water supply free from pathogenic bacteria, including pseudomonas and legionella is a system of planned preventative maintenance and monitoring to ensure:

- that all parts of the system are clean (tanks to taps).
- the flow of water is maintained (no dead legs or poor flow/low use).
- the temperature is maintained (hot (min 55°c) and cold (< 20°c)

The IPC team work closely with the Estates team on water quality and engage in policy development and planned sampling of areas. The Trust has a monthly Water Quality meeting chaired by the Associate Director of Estates which is attended by Ban 7 ICN. The water testing programme including assessment of legionella and pseudomonas, is on-going with any positive samples being actively managed.

In 2022-23 a case of healthcare associated legionnaire's disease formally investigated through the serious incident processes with the conclusion that transmission from the environment remained unknown, potentially associated with an ice machine used locally. The ward no longer have an ice machine and the IPC team no longer recommend them for clinical areas.

2.6. Decontamination Services

Decontamination Services comprise distinct areas:

- Sterile Services Department at Alderney
- Endoscopy Decontamination at both sites
- Medical Equipment, Cleaning and Decontamination Unit (MECDU) at Poole

2.6.1 Sterile Supplies Department

The Sterile Services for UHD is now provided on one site, Alderney. This department provides sterile surgical instruments to all theatres, the trust wide wards and departments. The departments continue to work and maintain the standards set in the regulatory requirements (HTM) 01-01 and (HTM) 01-06. All weekly, quarterly and annual testing is up to date.

2.6.2 Endoscopy Decontamination Department

Both sites use their own Endoscopy decontamination services. All weekly testing is conducted by the Trust Engineers and the Endoscopy Technicians. Quarterly and annual testing is conducted by the manufacturer (Getinge). The equipment remains compliant with required standards and has been signed off and approved by the Authorised Engineer (Decontamination) AE (D).

Bournemouth site have accreditation through JAG. (Joint Advisory Group on GI Endoscopy). Both sites receive external audit of standards.

2.6.3 Medical Equipment Cleaning and Disinfection Unit (MECDU Poole)

The MECDU underwent complete refurbishment in 2014 to provide appropriate equipment and workflow for decontamination of equipment including pressure relieving mattresses. All machines are regularly maintained and serviced.

The medical equipment library is set up on the Bournemouth site with the provision to support additional cleaning as and when required. This is particularly focussed on the larger items of equipment such as mattresses that require taken apart to repair/ test and clean before returning into use.

CRITERIA 3
Ensure appropriate antimicrobial use to optimise patient outcomes

Contribution by Antimicrobial Pharmacy Team

3. Ensure appropriate antimicrobial use to optimise patient outcomes

3.1. The AMS activity is managed by the Trust's Antimicrobial Stewardship Group (ASG) which has wide representation from Medical, Pharmacy and Nursing staff with an interest in AMS across specialties.

3.2. The stewardship team also routinely look at all antimicrobial related LERN reports every month to highlight any ongoing issues where improvements may be needed.

3.3. Examples of activity this year include education for clinical staff around correct use on intravenous Vancomycin including a redesign of the drug chart and improved wording in the main policy. This was after feedback from frontline clinical staff.

3.4. We are also currently working on some ongoing projects expected to complete in the next 6 months or so. These include:

1) Establishing a new Outpatient Parenteral Antibiotic Therapy service (OPAT)
2) Transferring the prescribing of Gentamicin from paper charts to the EPMA system
3) Establishing a Dorset ICS wide penicillin allergy delabelling process
4) Investigating what education and training needs are required by frontline clinical staff around AMS and seeking to delivery appropriate E&T to meet these needs.

3.5. A formal multi-disciplinary Antimicrobial Stewardship Group meets 3 - 4 times per year on each site and reports to the medicine's optimisation group, the minutes of the meetings are also sent to the Infection Control Group.

3.6. There is now a Dorset wide AMR group which has not been able to meet as often as required due to the constraints of the pandemic but plans to restart this group are in place

3.7. The medical microbiologists alert clinicians and ward staff when specific organisms or infection are identified including all those which have control of infection implications

3.8. Medical microbiology have an antimicrobial nurse on their staff. They do audits of antibiotic prescribing

Updates on the National Contract for 2022/23 and 2023/24

The target for 2022/23 was a reduction in usage of 4.5% of the Watch and Reserve groups of antibiotics based on the 2018 baseline. Final performance for UHD is shown in the table below. While

2018 **baseline** usage of	2022/23 **Target** usage	2022/23 **Q1** usage	2022/23 **Q2** usage	2022/23 **Q3** usage	2022/23 **Q4** usage
1252 DDD/1000 admissions	1195 DDD/1000 admissions	1283 (7%) DDD/1000 admissions above target	1387 (16%) *thus far* DDD/1000 admissions above target	1358 (13%) DDD/1000 admissions above target	1347 (12%) DDD/1000 admissions above target

Point Prevalence audit data for UHD

The new cross site audit structure is up and running. Data has been collected for the last four quarters across all inpatient areas and will continue on a quarterly basis.

	June 2022	**Sep 2022**	**Dec 2022**	**Mar 2023**
No patients (% total)	337 (36%)	334 (36%)	422 (42%)	283 (34%)
Indication documented	98.5%	97.9%	97.4%	96.8
In line with guidelines	81%	84.7%	86%	85.5
Not in line with guidelines	13.6%	11.1%	9%	10.6
Treatment reviewed within 72 hours	86.5%	95.8%	93.1	94
Duration documented at start	45.5%	39.5%	29.2	37.8

CQUIN updates

CCG5 Treatment of community acquired pneumonia (CAP) in line with BTS care bundle:

Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.

The CAP CQUIN is being led by the Respiratory team. Data was not submitted.

CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+:

Target: 60% of all antibiotic prescriptions for UTI in patients aged 16+ years to be in line with NICE guidance for diagnosis and treatment.

Quarter 22-23	**Number of cases audited**	**Number of cases achieving CQUIN compliance**	**CQUIN target**
Q1	100	51 / 51%	60% not met 40% met
Q2	100	65/ 65%	60% met 40% met
Q3	100	55 / 55%	60% not met 40% met
Q4	100	52/52%	60% not met 40% met
22/23 TOTAL	**400**	**223/ 55%**	**Upper threshold 60% not met** **Minimum threshold 40% achieved**

LERN reports

Antimicrobial related incidents Jan / Feb 23:

Throughout January and February 23 there were a total of 44 LERN reports (20 BH site and 24 PH site) which is a decrease compared to 53 reports in November and December 22. There were 0 LERN incidents resulting in severe or moderate harm, 19 resulting in minor harm (same as for November and December 22) and 25 resulting in no harm.

LERN Themes Jan / Feb 23:

Reductions:

There has been a reduction in LERN reports associated extravasation and with drugs that require therapeutic drug monitoring. There were 0 Vancomycin or Teicoplanin related allergies this report. There has been audit and QIP work conducted by the AMT surrounding Vancomycin prescribing and administration which may account for the reduction.

Increases:

Prescribing in allergy (5), Delayed and missed doses (15) continue to account for the majority of all LERN reports . 4 LERN reports where antibiotics were given to the wrong patient, 4 wrong dose (3 of which were paediatrics), 4 administration, emphasising the importance of following SOPs.

Project work

Based on discussions of the AMT and ASG we are currently working on the following projects:

- Vancomycin prescribing – review of current practice after noting some errors and some odd blood levels reported by the laboratory. This has led to some new wording on the policy and a new Vancomycin prescription chart to help prescribers avoid further errors
- Outpatient antibiotic therapy (OPAT) – plan to establish a formal OPAT service allowing us to treat appropriate patients in an ambulatory setting instead of an inpatient bed. This is likely to start in July 2023 following successful nursing recruitment.
- Penicillin allergy delabelling – a Dorset wide and sector wide project looking to improve penicillin allergy documentation and delabel patients where appropriate to enable us to prescribe these drugs where most useful. This has begun at UHD and the antimicrobial team successfully delabelled (via a penicillin oral challenge) our first patient in December allowing her to receive significantly better and less toxic drugs to treat endocarditis.
- Addition of Gentamicin prescribing onto the EPMA system to reduce the amount of standalone paper charts is use. This is in the final testing phase currently.

CRITERIA 4
Provide suitable, accurate information on infections to service users, visitors and any person concerned with providing further support, including nursing/ medical in a timely fashion

4. Provide suitable, accurate information

4.1. On the Poole site each in-patient ward has a large purpose designed patient safety board which includes Infection prevention metrics. These have been updated during the year to focus on key metrics and include hand hygiene and cleanliness scores.

4.2. The Trust has a range of patient information materials that are made available via the IPCT pages of the Intranet. These have been updated by our IPCT bank support during this year although they remain outstanding with the IPCT to review and present. Information leaflets will be updated on intranet and internet.

4.3. Cross site the Trust is implementing the standards set within the national cleaning manual and each area is displaying the poster for their area with the cleanliness star score.

4.4. Signage is available on the entrances to the hospital around PPE required as a response to recent changes. During outbreaks signage is available for wards to remind people about PPE and hand hygiene. The team have worked in close collaboration with the communications team regarding messaging during the year.

4.5. A Critical Patient Information (CPI) flag is added to the electronic patient record of all patients with specific infections or organisms, e.g., MRSA, MARO, C. difficile, ESBL producing bacteria. This ensures if the patient is re-admitted this information is immediately available to the clinical staff. Staff are prompted to look for the flags through the Electronic Nursing Assessment tools.

4.6. The IPC Team advise GPs in writing when a first isolate of reportable organisms are identified but report all episodes of *Clostridium difficile in response to the increase* in patients with relapses, so the GP is aware. This information is also communicated in writing to patients if the result is obtained after discharge from hospital. A dedicated section of the electronic discharge summary promotes communication of infection related topics.

CRITERIA 5
Ensure prompt identification of people who have or are at risk of developing an infection

5. Ensure prompt identification of people at risk of developing an infection

5.1. Both Microbiology Laboratories have full Clinical Pathology Accreditation status. Tests are provided seven days a week with PCR testing results being available the same day, if sent during laboratory hours.

5.2. The support from the laboratory staff during the pandemic has remained exemplary. The number of additional testing processes and platforms that have been incorporated in business as usual is astounding. However, this has meant that routine testing for many other organisms has stopped or been reduced. It was hoped that during 2022-23 the team would have opportunity to understand how to re-establish existing and updated policy for sampling and screening as appropriate for UHD. This has not happened. At the time of writing this report the team embark on refreshing and merging MRSA screening policy and the laboratory look at how to integrate updated CPE screening policy.

5.3. All infections or organisms identified with control of infection implications are brought to the attention of medical and nursing staff immediately either by the Consultant Microbiologists, Infection Control Nurses or laboratory staff.

5.4. MRSA screening. There remain different approaches within both sites and laboratories. This will be resolved during 2023-24. Current policy requires support from GPs to prescribe decolonisation and departments are finding that GP workload is reducing the number of occasions that this support is available. Further Dorset wide work will be required to review this process.

5.5. CPE screening. In September 2022 UKHSA published an updated framework of actions to contain CPE nationally. This does require some work, as mentioned, to increase patients who are screened on admission. There is some outstanding work anticipated as admission workbooks are not designed to include relevant questions.

5.6. COVID-19 screening. In April 2023, the organisation received updated guidance around COVID management. Screening was adapted in consultation with representatives from nursing, medicine, diagnostics and operations. The policy was changed and communicated widely.

CRITERIA 6
Systems to endure that all care workers (including bank staff & volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

6. Systems to ensure all are aware of process for preventing and controlling infection

6.1. Infection prevention and control is included in all clinical staff job descriptions emphasising that all staff have responsibilities in this area.

6.2. Changes to corporate induction have reduced opportunities for face-to-face learning but maintain e-learning. Hand hygiene competencies are also expected for all clinical staff in their local induction. The whole IPCT acknowledge the importance of first impressions and as a result all staff on duty attend corporate induction to introduce the team and explain the service.

6.3. The IPCT have attended several incidents with the estates team where appropriate action was not optimal in containing spills and contamination, these will be addressed in further training with Estates and Housekeeping teams.

6.4. The IPCT provide and in-put to a variety of formal training programmes including:

- Healthcare assistant training programme
- Mandatory update training (less update for face-to-face training noted)
- Intravenous medication administration course (Poole site only)
- Adhoc topic-based learning across the Trust in response to specific demands

6.5. There is IPCT representation at Essential Core Skills Group.

6.6. IPCT have a team sub-group for education that organises specific adhoc training and national campaigns.

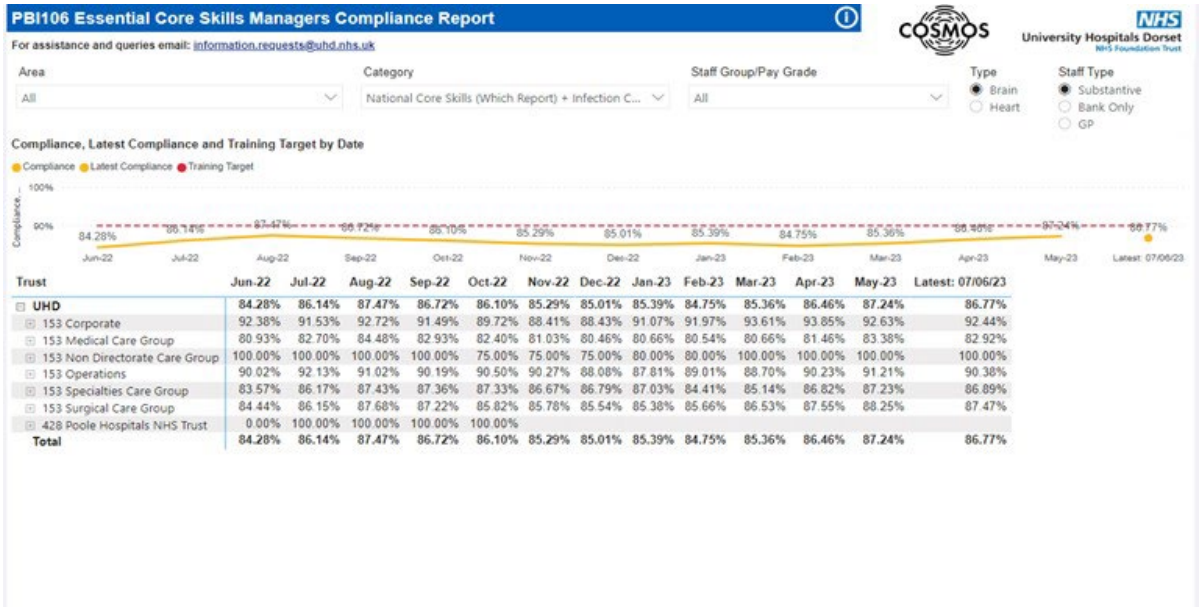
6.7. The IPC Champions support advice and education in the clinical environment. There is a monthly Champions meeting held via MS Teams which provides support and a regular educational presentation, organised throughout the year. This is an active and engaged group although attendance has been challenged with operational issues. Each care group is encouraged to run an annual 'away day' meeting and this year the IPCT supported the Medicine, which was very successful. Surgery also had an away day although at that time COVID incidence did not enable our support with the event.

Figure 29 shows Deputy DIPC at the Medical Care Group Away Day with IC Champions from all sites.

6.8. Compliance with the mandatory update training target of 95% is variable by staff group, see figure 30. By the end of the year this was 87%. However, there is a marked reduction in training compliance within bank staff this year, with a range of 54-57%, and this will be taken forward as action for the ECS group in the coming year. There has been a reduction in compliance with mandatory training seen in

the organisation over this year, thought to be due to acuity, staff shortages and general fatigue post pandemic. IPCT have provided extra training on PPE and hand hygiene for the trust over this period to mitigate where there are areas which are challenged.

Figure 30



PBI106 Essential Core Skills Managers Compliance Report

For assistance and queries email: information.requests@uhd.nhs.uk

COSMOS

NHS University Hospitals Dorset NHS Foundation Trust

Area: All

Category: National Core Skills (Which Report) + Infection C...

Staff Group/Pay Grade: All

Type: Brain / Heart

Staff Type: Substantive / Bank Only / GP

Compliance, Latest Compliance and Training Target by Date

Compliance · Latest Compliance · Training Target

100%

90%

Compliance

84.28% 86.14% 87.47% 86.72% 86.10% 85.29% 85.01% 85.39% 84.75% 85.36% 86.46% 97.24% 86.77%

Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Latest: 07/06/23

Trust	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Latest: 07/06/23
UHD	84.28%	86.14%	87.47%	86.72%	86.10%	85.29%	85.01%	85.39%	84.75%	85.36%	86.46%	87.24%	86.77%
153 Corporate	92.38%	91.53%	92.72%	91.49%	89.72%	88.41%	88.43%	91.07%	91.97%	93.61%	93.85%	92.63%	92.44%
153 Medical Care Group	80.93%	82.70%	84.48%	82.93%	82.40%	81.03%	80.46%	80.66%	80.54%	80.66%	81.46%	83.38%	82.92%
153 Non Directorate Care Group	100.00%	100.00%	100.00%	100.00%	75.00%	75.00%	75.00%	80.00%	80.00%	100.00%	100.00%	100.00%	100.00%
153 Operations	90.02%	92.13%	91.02%	90.19%	90.50%	90.27%	88.08%	87.81%	89.01%	88.70%	90.23%	91.21%	90.38%
153 Specialties Care Group	83.57%	86.17%	87.43%	87.36%	87.33%	86.67%	86.79%	87.03%	84.41%	85.14%	86.82%	87.23%	86.89%
153 Surgical Care Group	84.44%	86.15%	87.68%	87.22%	85.82%	85.78%	85.54%	85.38%	85.66%	86.53%	87.55%	88.25%	87.47%
428 Poole Hospitals NHS Trust	0.00%	100.00%	100.00%	100.00%	100.00%								
Total	84.28%	86.14%	87.47%	86.72%	86.10%	85.29%	85.01%	85.39%	84.75%	85.36%	86.46%	87.24%	86.77%

6.9. Each care group is supported by at minimum two members of the IPCT. The team support meetings, clinical visits, incidents and investigations. During 2022-23 it was hard to establish a specific presence as the team were required to work and direct attention to wards and departments with outbreaks.

Fit testing

During this year the team have been supported by a secondee fit test co-ordinator who we hoped to interview as a substantive post during this year, and the interview slotted into May 2023. This support has continued to enable the IPCT to step back from fit testing and co-ordinating training for most of the year. The entire IPCT support the fit test co-ordinator for influxes in junior doctors and if there is need.

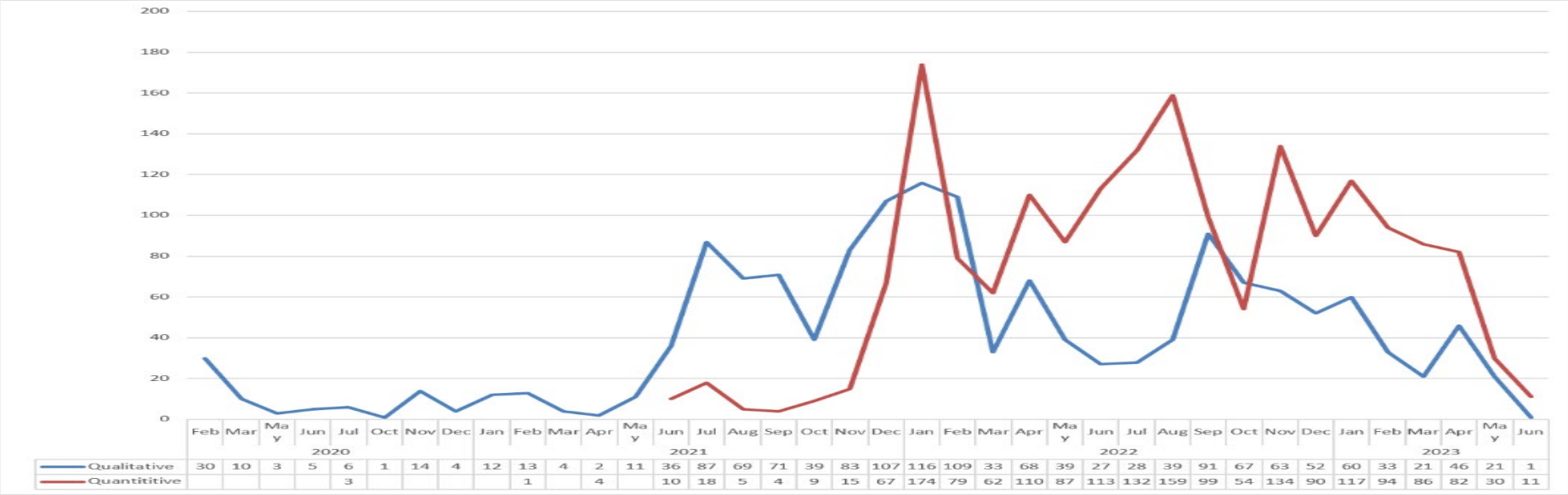
6.10. There are a good number of fit testers and while products have not changed over the year the national pandemic stock will dwindle during 2023 and organisations will swap back to procuring their choice of products. There have been some noted changes to policy. Guidance has changed around the list of aerosol generating procedures (AGPs) and also the number of products each member of staff needs to be fit tested on. It is hoped this will avoid the crisis created at the outset of the pandemic when there was an over-reliance on products that became unavailable. The NIPCM clearly states selection of FFP3 for transmission based precautions in certain situations and this is adopted into trust policy. Guidance on who needs fit testing also changed in August 2022 with a change to resus council recommendations which suggest all wards should have some fit testers, in the case of resuscitation being required.

6.11. The fit test site of the intranet has been fully updated. An electronic fit test register that links with BEAT has been created and now can give us more of an idea on compliance with fit testing although this continues to be developed. Fit tests are a competence for staff on their mandatory training records.

6.12. The organisation purchased a second Portacount machine for performing quantitative fit testing which has enabled the competent fit testers to get more staff through multiple fit tests. See figure 31 which shows the number of fit tests by each method.

6.13. Fit testing has decreased towards the end of the pandemic, at the same time that many of the fit testers are overdue refreshers. This is now covered by HASAT audit with expectations this will support ongoing fit testing in appropriate staff.

Figure 31



CRITERIA 7
Provide or secure adequate isolation facilities

7. Provide adequate isolation facilities

7.1. The Trust has a high proportion of single accommodation on the Poole site, but this is less well provided on the Bournemouth site due to the estate. This has not impacted on many more outbreaks at Bournemouth than Poole but will have a longer-term impact on prevention of transmission. At Bournemouth site there are some long term ICE pods for isolation patients within the bay environment.

7.2. The Infection Prevention and Control Principles policy is available on the intranet and gives details of the necessary transmission-based and standard precautions for infections. It includes details about allocation of cubicles based on priority. There are also infection control policies relating to specific infections together with a Surveillance policy on the intranet. In September 2022 a new National Infection Prevention & Control Manual for England was published by UKHSA and it is hoped this will be linked to within all our policies in the coming year. Importantly it includes an A-Z of pathogens which will offer guidance to wards and departments to include local IC advice, isolation scoring tool and RAG terminal clean request information.

7.3. Whilst in the past it was considered that there were adequate single rooms on the in the Poole site there is a clear difference between single room and an isolation room that has ensuite facilities with appropriate ventilation and antechamber as appropriate to need. The IPCT have representatives supporting the transformation programme and these have included reviewing current and planned building work to ensure we strive to meet the Department of Health target of 70% isolation facilities.

7.4. Overall, the Trust has sufficient single rooms to cope with normal operational workload however, when under pressure from community outbreaks this is stretched particularly in AMU, assessment units, critical care and the emergency departments. This will be continued to be considered in any future service development or reconfiguration.

7.5. Audits carried out post identification of an alert organism that requires isolation often find that patients have had a delayed transfer into a cubicle due to unavailability and a delayed identification. Additional side rooms to support this are key to help us reduce health care acquired infections.

7.6. The organisation has a variety of single rooms, isolation rooms, temporary isolation pods and positive or negative ventilation facilities. New builds and transformation programmes aim to increase the percentage of single rooms and to comply with HTM guidance. At Bournemouth site there are fewer single rooms while at Poole there are more although some have only a patient hand wash basin, shared with staff use as a hand wash basin. These are being reviewed currently.

7.7. The IPCT have continued to work closely with the Clinical Site and Management teams at both sites, to promote flow and minimise the impact of outbreaks on this. This may have led to some secondary outbreaks on two occasions. The IPCT at Poole site plan to teach ICNet to the Clinical Site Team (CMST) with the aim to support them further with patient placement.

7.8. Developed tools such as isolation priority tool and diarrhoea/ vomiting risk assessment continue to be available to clinical staff to help them select the most appropriate patients for isolation facilities

CRITERIA 8
Secure adequate access to laboratory support

8. Secure adequate access to laboratory support

8.1. There is a microbiology laboratory on both sites within the Trust offering a bacteriology, virology (Poole only), mycology and mycobacteriology diagnostic service with access to clinical and infection control advice from the consultant microbiologists.

8.1 Report from Infection Control Doctor.

1. This year we have had the addition of an Infection Prevention & Control section in the UHD Microguide. This section was added in January 2023 to facilitate the Microbiologists & the Clinicians & has been much appreciated by the Deputy Chief Medical Officer, Microbiologists, ITU Consultants & the UHD junior Doctors. It contains a section for Notifiable Diseases & Isolation Precaution Cards.

2. *Candida auris* testing is now aligned to UK guidance.

3. A new, innovative approach of UHD Microbiology & Infection Prevention & Control In-service Education (brief 10-15 minutes teaching sessions) was introduced in 2022 & has been successful in preventing outbreaks of Extremely Drug Resistant Organisms (XDROs) & Pan Drug Resistant Organisms (PDROs). This is extremely beneficial to the Trust as an outbreak with such organisms will not only be difficult to control but also very expensive to treat with a combination of antimicrobials. e.g.: A review of a case estimates about £10,000 to treat a PDRO.

4. The Trust has seen an increase in XDROs but has avoided cross transmission or outbreaks through timely intervention of the Microbiology and Infection Control Teams as well as high quality practice noted in wards and departments managing them.

CRITERIA 9
Have and adhere to policies that will help to prevent and control infection

9. Have and adhere to policies that will help to prevent and control infection

9.1. A comprehensive set of over 30 detailed infection control policies are available to all staff on the hospital intranet with easy access through a link on the front page of the website. Policies requiring updates during the year are included in the work plan. Pandemic pressures have prevented timely updates of policy but at the time of writing this report a comprehensive workplan to align this is underway.

9.2. The new national IPC policy will provide fundamental facts and resources and the team aim to use the A-Z of pathogens (currently under development nationally) to link as many policies as possible to make it simple for staff to access information. There have been no major changes as all services have been focussed on outbreak control and where policies have been amended this has been put into place as appropriate with reference to national guidance.

9.3. In addition to IPCT policies, the antibiotic policies for empirical management of infection in adults and for antibiotic prophylaxis are also available on the intranet. The Micro guide has recently been updated in a working party that included IPCT.

9.4. The trust has an on-site occupational health service that will see and advise staff about infections with liaison with the IPCT.

CRITERIA 10
10. Providers have a system in place to manage the occupational health needs of staff in relation to infection

10.1 The OH service assesses and reviews staff that have had occupational exposure to blood and body fluids including needle-stick injury. This service works closely with IPCT and Risk management in this and other work including promoting education and best safe practice.

10.2 The service has worked closely with the IPCT in areas such as dermatitis and sharps safety as well as the response to COVID-19. There remain on-going concerns that staff continue to have exposure incidents despite ongoing education and active management through the Sharps Safety Group. Exposure incidents are included on the Trust risk register.

IPC Team Work Plan for 2023-24

No	Action	Lead
1.	Post Pandemic, a refresh and review of the ongoing fundamentals of IPC practice, with a specific focus and oversight within the IPC Care Group meetings.	IPC CNS Care Group Leads
2.	IPC framework of education for NHS staff has been published but needs introduction into UHD	Senior IPC Lead
3.	IPC team education framework supporting resilience, professionalism and excellence	Senior IPC Lead
4.	Further updates to A-Z of pathogens	Senior IPC Lead
5.	National Outbreak Policy within National Infection Prevention and Control Manual	IPC Nurse Consultant
6.	Further development of Regional South West IPC collaboration	IPC Nurse Consultant
7.	Further development of Dorset wide IPC collaboration, in particular with integration of Patient Safety Incident Response Framework (PSIRF) for healthcare associated infection (HCAI) surveillance.	Senior IPC Lead / IPC Nurse Consultant
8.	Pathology to work towards electronic solutions for recording LFD test results for accurate reporting of COVID-19 positive results which remains mandatory.	Senior IPC Lead/IT Team
9.	Maintain oversight and compliance with the IPC Board Assurance Framework	IPC Nurse Consultant / DIPC

The coming year promises more national documents for Infection Prevention and Control teams working increasingly in partnership and with the same goals.

UHD IPCT will also aim to undertake the following as part of their continued commitment to IPC practice:

- Refresh all IPC policies. The team plan to continue to develop a framework of 4 basic policies under which appropriate policies sit. Collaboration with other teams to review and improve awareness, eg with practice education team.
- Review all patient information leaflets.
- Review intranet and IC section of internet
- Close working between sustainability group to review single use items and the burden of waste.
- Electronic tool for documentation of indwelling devices with reporting tool for audit and device reduction.
- Review of Aseptic non-touch technique trays as this is gaining national interest.
- Surgical site infection surveillance for a variety of optional procedures. This requires a surveillance staff, based in the IPC team and this year we will develop a business case to demonstrate how this will reduce infections, length of stay and re-admissions.
- Decolonisation and suppression of MSSA for appropriate high risk elective surgery
- Inviting a couple of volunteers to become IPC champions and support the team as able.
- Review of the IPCT resources to consider work programme and embedding roles to support education and training

Summary

Infections in hospital have in general followed the pattern seen in the community and there have not been any significant findings at any one site that have not been seen at both. Commonalities in trends across all organisms, which were higher some months than others also broadly coincided with COVID-19 incidence. Rise in multifactorial bacteraemia's making single source difficult to identify. More time is needed to explore all of these. Closer working with microbiology team is being developed to support this.

It has been another difficult and challenging year for the IPC team, with some successes too. Some colleagues have moved on to other roles and we have had effective recruitment into the team. Career progression and support will be so important to the team and measures to retain staff cannot be underestimated in this climate of vacancy factors in most IPC teams in the country. The team have acted with bravery, resilience and tirelessness.

Thanks also goes to all the teams across UHD for working alongside us, supporting us, and delivering the values the Trust aspires to work and live by.

Figure 32 shows the IPCT at one of the off-site away days for team building.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 9.2.3

Subject:	Infection and Prevention Control – Board of Directors Statement
Prepared by:	Matthew Hodson – Deputy Chief Nursing Officer
Presented by:	Paula Shobbrook – Chief Nursing Officer and Director of Infection Prevention and Control

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The Board of Directors is required to sign and publish an annual statement which reaffirms its commitment to Infection Prevention and Control. The 2023/24 statement is attached.
Background:	The statement details the processes which are in place to meet the duties under The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011). This has been updated to include reference to the CQC essential standards and the Trust's Quality Strategy.
Key Recommendations:	Once approved, the statement will be published on the Trust's website to reaffirm to the public the Board's commitment to Infection Prevention and Control.
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**
Infection Prevention & Control Group	13/07/2023	Meeting has not yet taken place at time of submission of this report.
Quality Committee	18/07/2023	Meeting has not yet taken place at the time of submission of this report.

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

Board of Directors' Statement of commitment to the principles of the Code of Practice for the Prevention and Control of Health Care Associated Infections 2023/24

The successful management, prevention and control of infection is recognised by the Trust as a key factor in the quality and safety of the care of our patients and of those in the local health community, and in the safety and wellbeing of our staff and visitors.

The Board is aware of its duties under The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2011). The Board has collective responsibility for infection prevention and control including minimising the risks of infection.

The Board receives assurance that the Trust has mechanisms in place for minimising the risks of infection by means of the Infection Prevention and Control Group and the Director of Infection Prevention and Control (DIPC). Assurance is provided by performance reports, audit reports, post infection review reports and verbal presentations from the DIPC.

The Infection Prevention and Control Group is chaired by the DIPC. It is a sub-group of the Trust Management Board (TMB). It has terms of reference and produces an annual plan. The Board of Directors receives regular updates via the Trust's Integrated Performance Reporting framework, and an annual Infection Prevention and Control report. The IPC Group reports to the TMB and provides assurance to the Quality Committee.

The DIPC is appointed by the Board and reports directly to the Chief Executive and the Board. The post holder is a member of the Trust Management Board and Quality Committee. The DIPC role is incorporated in the Chief Nursing Officer portfolio and the post holder is assisted in discharging the relevant responsibilities by the Deputy Director of Infection Prevention and Control, Head of Infection Prevention and Control, Infection Prevention and Control Doctor and the Infection Control Team.

The Board is committed to the exemplary application of infection control practice within all areas of the Trust. To this end the Board will ensure that all staff are provided with access to infection control advice with a fully resourced infection control and occupational health service, access to personal protective equipment and training and policies that provide up-to-date infection control knowledge and care practices. Individual and corporate responsibility for infection control will be stipulated as appropriate in all job descriptions with individual compliance monitored annually through the appraisal systems and personal development plans.

The policies in place in the Trust and the arrangements set out above are to encourage, support and foster a culture of trust wide responsibility for the prevention and control of infection in practice, with the aim of continually improving the quality and safety of patient care. This extends to all relevant departments; clinical directorates, clinical support services, estates and ancillary services.

The Trust's policies and practices in respect of infection prevention and control accord with the aims and objectives in national policy and strategy and, in addition, the Trust participates fully in all national mandatory reporting requirements. This is aimed at ensuring the full confidence of the local population in the quality of care the Trust delivers.

July 2023

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 9.2.4

Subject:	Mixed Sex Accommodation Annual Statement 2023/24
Prepared by:	Matthew Hodson – Deputy Chief Nurse
Presented by:	Paula Shobbrook – Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive Summary:	The Board of Directors is required to publish an annual statement which reaffirms its commitment to eliminating Mixed Sex Accommodation which is attached and seeking Quality Committee endorsement. This will then be presented at the public board meeting and published on the UHD website.
Background:	University Hospitals Dorset NHS Foundation Trust remains committed to complying with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, for example in critical care settings such as intensive care and other specialist care areas. We have made some minor amendments to the previous statement highlighted in bold. The Trust implements this commitment in practice through the Same Sex Accommodation and Privacy and Dignity Policies.
Key Recommendations:	Once approved, the statement will be published on the Trust's website to reaffirm to the public the Board's commitment
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**
Quality Committee	18/07/2023	Meeting has not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust

Mixed Sex Accommodation Annual Statement 2023/24

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

We have the necessary facilities to **provide male and female** sleeping areas, toilet and washing facilities. This will mean different things in different hospitals. You could be:

- in a same-sex ward, where the whole ward is occupied by either **a male or female only**
- in a single room, or
- in a mixed ward, where **male and females** are in separate bays or rooms with members of the same **or identified** gender.

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

The trust implements this commitment in practice through the Same Sex Accommodation and Privacy and Dignity Policies. If our care should fall short of the required standard, we will identify this through our internal reporting process, review the reasons, and report it externally to our commissioners.

Our mixed sex accommodation data is regularly reviewed by our Quality Committee and reported to the Board in the public meeting, through the Integrated Performance Report. **UHD remains compliant with the requirements of national reporting.** This is part of our ongoing commitment to delivery of our declaration of compliance.

July 2023

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 9.2.5

Subject:	Annual Complaints Report 2022/23
Prepared by:	Christina Harding- Deputy Head of Patient Experience Laura Northeast - Head of Patient Experience Matthew Hodson Deputy Chief Nurse
Presented by:	Matthew Hodson - Deputy Chief Nurse

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive Summary:	• The Trust procedures to manage concerns and complaints meet statutory requirements. • The complaints procedure was aligned 2021/22, adopting best practice from both sites. • UHD continue to work with the PHSO as an early adopter of the new complaints framework, which includes a focus on Early Resolution of Complaints (ERC). • The number of complaints resolved via early resolution has increased substantially. • The Trust received 984 complaints, of which 483 were formal investigation complaints, 501 early resolution complaints, and 5531 PALS enquiries and concerns during 2022/23. • There have been challenges meeting the acknowledgement times and 55-day response times and actions have been put in place to support this process • Patient Experience is a strategic objective for 2023-24 as one of the Patient First priorities.
Background:	This report is a requirement of the CQC and ICB and draws together the information provided in the quarterly complaints reports during 2022-23 into an annual report. This report will be published on the Trust website.

Key Recommendations:	To note the annual report and recommend to the Trust board final sign off and place on our website page.
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 Regulation 16: Receiving and acting on complaints
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
PEG group TMG	26/06/2023	Presented
Quality Committee	18/07/2023	Meeting has not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust

2022/2023

ANNUAL COMPLAINTS REPORT

2022/2023
ANNUAL COMPLAINTS REPORT

1. INTRODUCTION

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

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

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

2. THE PROCESS FOR MANAGING CONCERNS AND COMPLAINTS

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

- Meets the statutory and regulatory responsibilities.
- Provides a consistent, positive and proportionate experience for complainants.
- Aligns the legacy systems with minimal disruption to services.
- Promotes a culture of learning and ensures complaints are acted on to improve services.
- Achieves or working towards achieving best practice standards (Patient Association 2013; NHSE 2015; Healthwatch 2016; Parliamentary & Health Service Ombudsman, 2020, Care Quality Commission 2022).
- Includes the new Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards Framework currently being piloted nationally. UHD is part of the early adopter group for this work.

The model that was approved in September 2021 was for UHD to align the two legacy NHS Foundation Trusts. This involved:

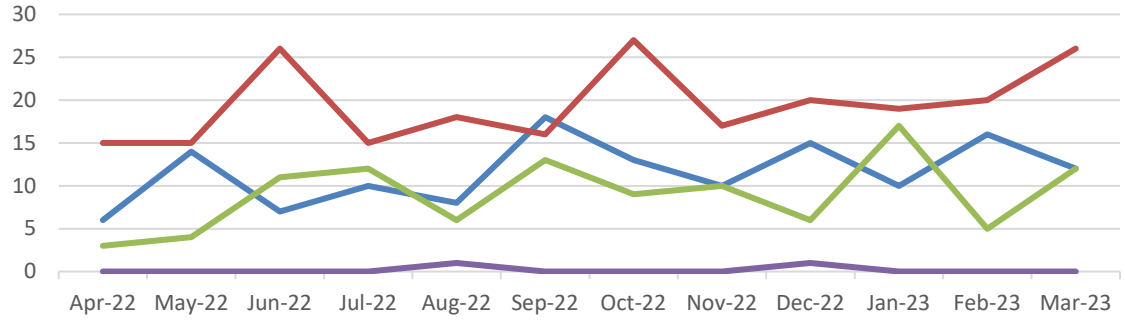
- Early Resolution complaints – complaints that are part of the complaint process but are resolved within 10 working days
- care group investigations and responses
- corporate investigations and complaints – these are the more complex and serious complaints.

3. COMPLAINTS RECEIVED

3.1 The Trust (incorporating single organisation data) received a total of 984 complaints in 2022/2023. This includes the Early Resolution complaints that had not been counted in complaints received previously. However, as they form part of the complaint process their figures are now included.

The Trust managed 483 formal complaints. This is presented as a monthly trend, by care group, in Graph 1.

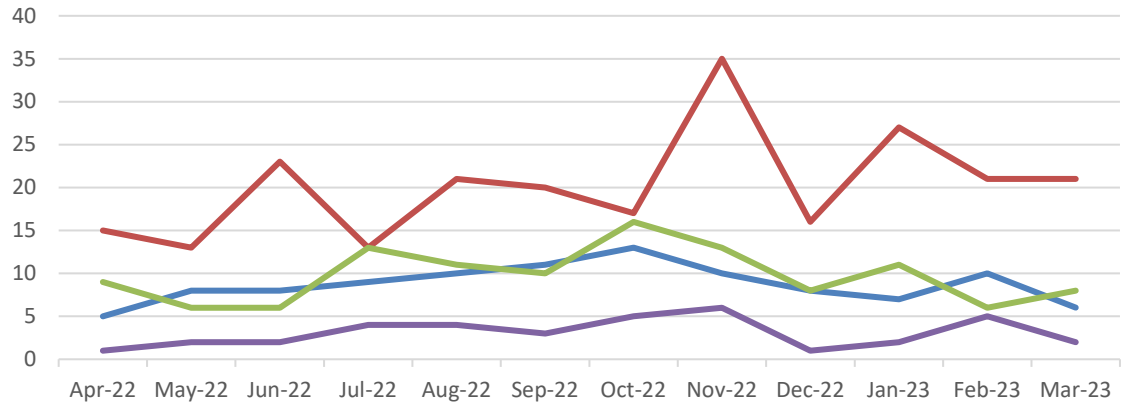
Graph 1: Trend of UHD formal complaints by care group



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Surgical	6	14	7	10	8	18	13	10	15	10	16	12
Medical	15	15	26	15	18	16	27	17	20	19	20	26
Specialities	3	4	11	12	6	13	9	10	6	17	5	12
Other	0	0	0	0	1	0	0	0	1	0	0	0

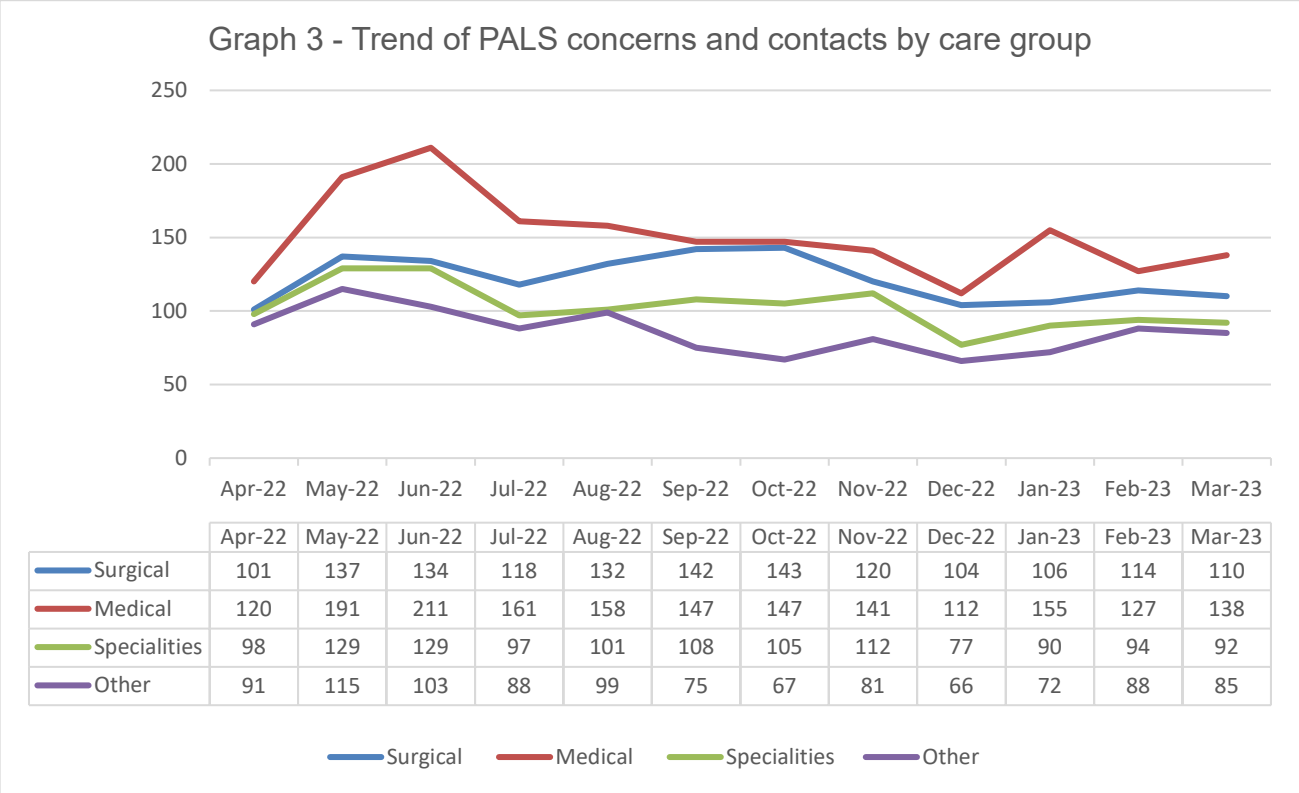
3.2 In addition to the 483 complaints, the Trust also handled 501 early resolution complaints. This has been broken down to the care groups and is shown in Graph 2

Graph 2: Trend of UHD Early Resolution complaints by care group



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Surgical	5	8	8	9	10	11	13	10	8	7	10	6
Medical	15	13	23	13	21	20	17	35	16	27	21	21
Specialities	9	6	6	13	11	10	16	13	8	11	6	8
Other	1	2	2	4	4	3	5	6	1	2	5	2

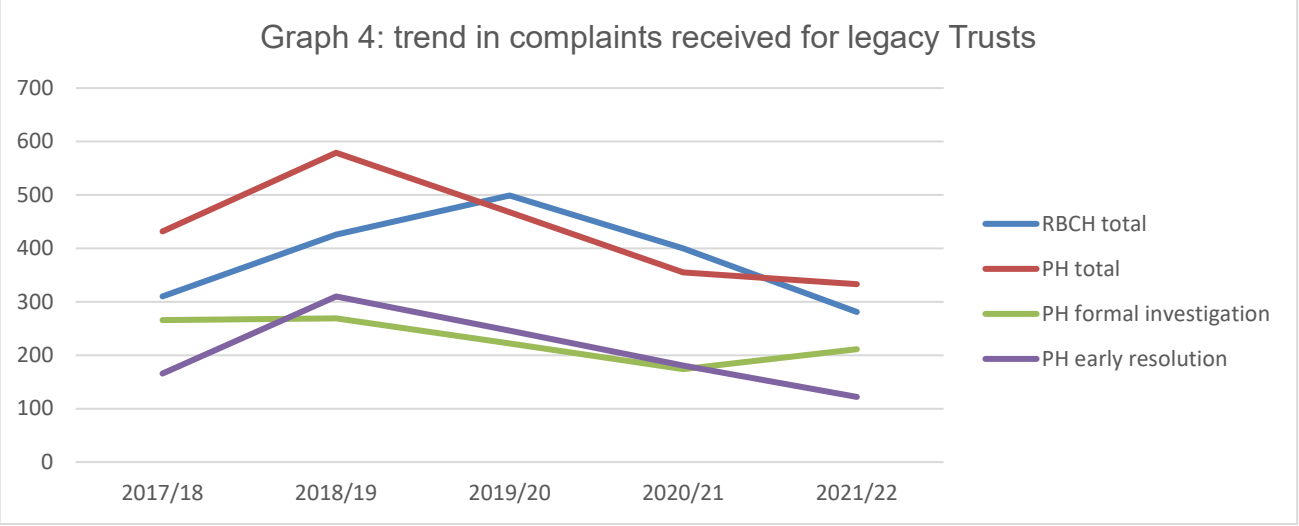
3.3 A total of 5531 PALS concerns, and contacts were processed and responded to in this year, via the UHD Patient Advice and Liaison Service (PALS). This is detailed in Graph 3.

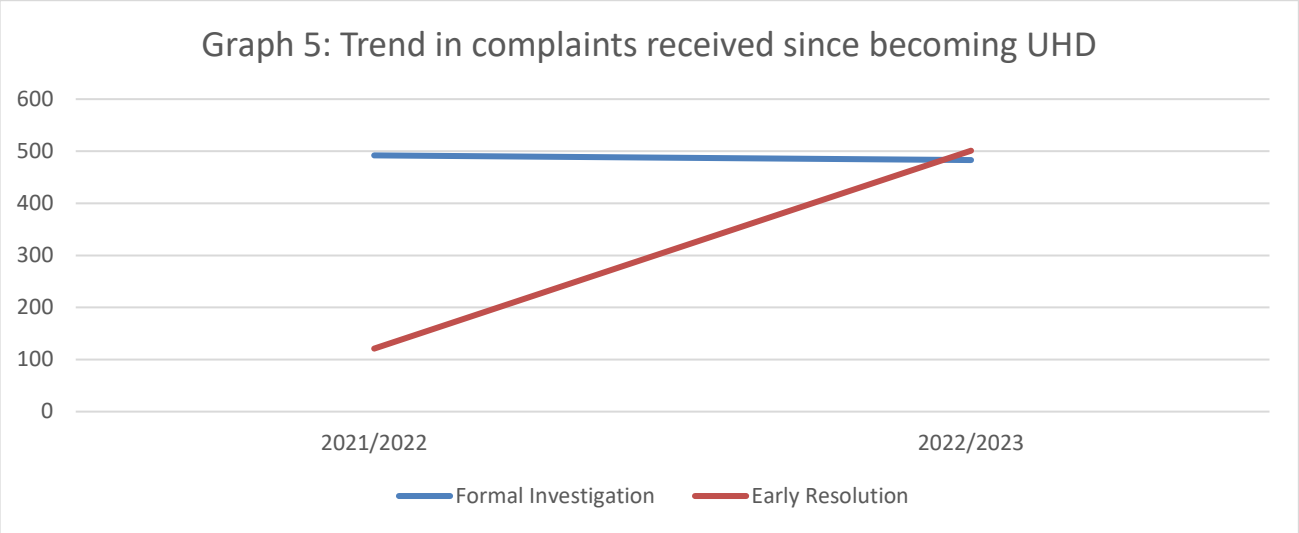


	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Surgical	101	137	134	118	132	142	143	120	104	106	114	110
Medical	120	191	211	161	158	147	147	141	112	155	127	138
Specialities	98	129	129	97	101	108	105	112	77	90	94	92
Other	91	115	103	88	99	75	67	81	66	72	88	85

3.6 The 5-year trend in complaints received can be seen in Graph 4. This showed an increasing number of complaints received, peaking at Poole Hospital Foundation Trust (PH) in 2018/19 and at the Royal Bournemouth and Christchurch Hospitals Foundation Trust (RBCH) in 2019/20. The decrease in 2020/2021 year can be attributed to the COVID-19 pandemic: the overall reduction in activity at the start on the pandemic; the national NHSE pause in complaint handling; and the considerable strong support for the NHS and its staff during this time.

Graph 4 shows the trend in complaints received prior to the merger of the legacy Trusts. Graph 5 shows the trend since the merger, which demonstrates the increase in early resolution complaints since the Trusts merged and became University Hospitals Dorset (UHD).



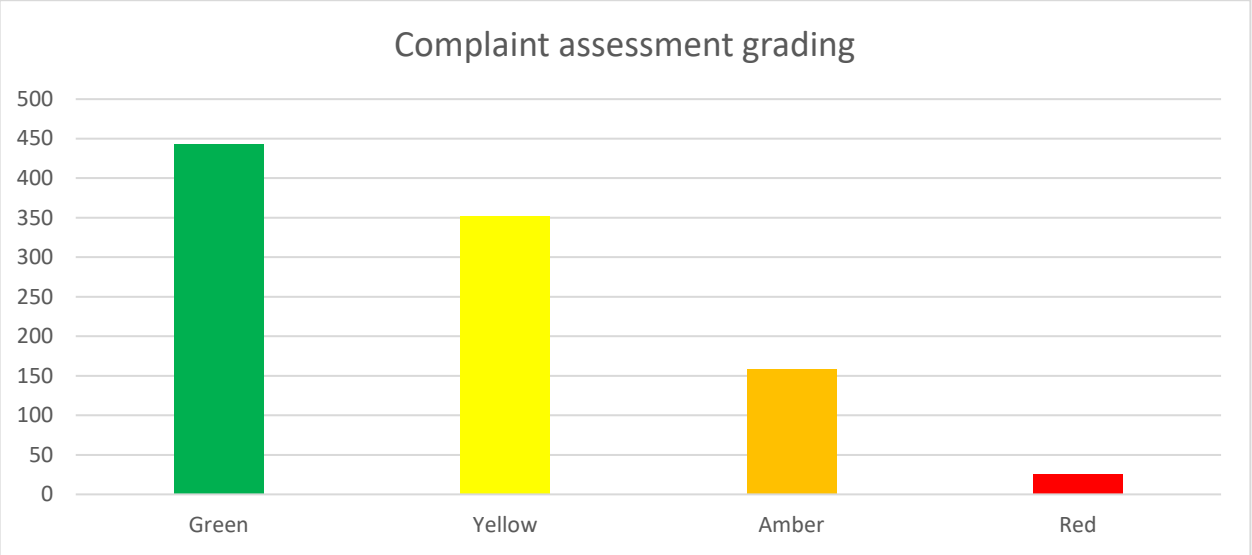


3.7 Table 2 shows the breakdown of persons making a complaint and their method of communication. The low 'In Person' mode of communication reflects the impact of the Covid-19 pandemic and temporary pause on receiving face-to-face PALS callers.

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

Person making the complaint		**Mode of communication**	
Patient	**54%**	Phone	9.8%
Spouse	**10%**	Email	80%
Parent	**10%**	In person	1.2%
Relative / Carer	**1%**	Letter	10%

3.9 Graph 6 shows the breakdown of complaints grading. The Healthcare Assessment Tool (HCAT) was used from April 2021; this is a validated, reliable tool for analysing healthcare complaints about secondary care (Gillespie and Reader 2016). The HCAT breaks down the complaint into three types of "problem", "clinical problems", "management problems" and "relational problems". It then subsequently breaks the complaint down into themes and severity indicators. The complaint severity assessment used at UHD using the HCAT can be located as an appendix of this report



Graph 6: Breakdown of complaints received, by grade

4 RESPONSIVENSS AND PERFORMANCE

4.1 Trust performance is monitored locally (recorded via Datix, an electronic database that enables us to use the information as a reporting tool) and via national KO41a submissions. The data is reported by NHS Digital who through development and operation of national IT and data services help patients get the best care and use data to improve treatment. The information obtained via this collection monitors written complaints received by the NHS regarding Hospital and Community Health Services. This data is published and enables comparison with other Trusts.

4.2 National comparison of the number of complaints received at UHD can be seen in Table 3. The data suggests that UHD is not an outlier when compared with the number of complaints received nationally, but when compared to peer group, who more consistently promote opportunities for early resolution. There is more work the Trust can do in this regard, which is planned for the coming year.

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

4.3 Key performance indicator (KPI) targets are detailed, in tables 4 and 5

4.4 The response timescale was reviewed and as part of the UHD model extended to 55 working days. This was to enable a more thorough review of the complaint and align the investigation processes, to provide a more detailed response to people who unfortunately needed to raise a complaint.

Table 4: complaint handling performance	**Q1**	**Q2**	**Q3**	**Q4**	**Yr end**
Number of complaints received	203	246	276	259	984

% complaints acknowledged within 3 working days (KPI 100%)	73%	79%	88%	82%	81%
% response within 55 day internal target (KPI 75%)	47%	58%	57%	41%	52%
Number re-opened complaint investigations (KPI <10%)	1	4	16	26	47
Complaints under investigation by the PHSO	0	0	2	10	0
PHSO investigations closed (& upheld/partially upheld)	0	0	0	2	0

4.5 The outcome of all closed complaints, by quarter, is shown at Table 5, the numbers will be lower than the information in the previous table as there are complaints received that remain under investigation. The data shows that UHD upholds fewer complaints when compared to the national average. Fewer upheld complaints may indicate fewer incidents where care fell below the expected standard, caution needs to be applied to this conclusion as it could also indicate a lack of robustness within the Trust investigation process. However, it is assuring that the Parliamentary Health Service Ombudsman (PHSO)looks at the way the hospital complaint process investigations are conducted as part of the review. In 2022/23 12 complaints were investigated by the PHSO and 2 upheld or partially upheld. The lower number of upheld complaints at UHD may in part be due to the number of complaints addressed through the Patient Advice and Liaison Service and therefore not included in this data set; the data will continue to be monitored and reported.

Quarter		**Table 5: Outcome of complaints investigated and resolved**					
	Closed	**Upheld**	***National average***	**Partially Upheld**	***National average***	**Not upheld**	***National average***
Q1	203	34 (16.7%)	*26.7%*	94 (46.3%)	*36.5%*	75 (37%)	*36.9%*
Q2	245	36 (15%)	*27.1%*	101 (41%)	*36.4%*	108 (44%)	*36.5%*
Q3	263	44 (17%)	*27.5%*	91 (34%)	*38.4%*	128 (49%)	*34.1%*
Q4	136	32 (13.6%)	*26%*	27 (22.7%)	*38.7%*	77 (63.6%)	*35.4%*

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

5 THEMES AND LEARNING FROM COMPLAINTS

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

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

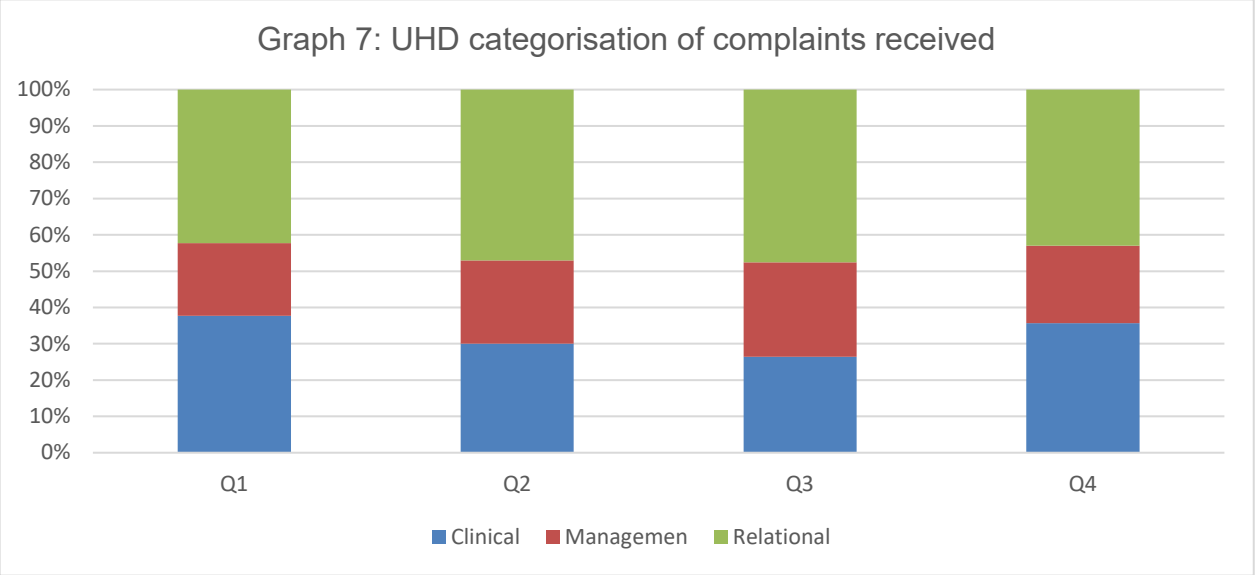
5.3 The data collected from complaints is analysed to help identify themes and emerging trends. The themes are extracted from the complaint narrative, taken from the perspective of the patient or their representative.

5.4 From 01 April 2021, the tool used for theming complaints was aligned and the grouping of complaint themes based on the HCAT tool; 3 over-arching categories, 9 themes and beneath this, over 50 sub-themes. A summary can be seen at Table 6.

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

Table 6: UHD complaint theming: categories and themes

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



5.6 The data, by complaint category is shown by quarter in Graph 7. The top 3 complaint themes, by category, by quarter are shown in Table 7 overleaf, identifying consistency in many of the top themes reported at Trust level. It is recognised that reporting themes and sub-themes by directorate or specialty will generate more relevant and useable data for tends, learning and improving. This detail will be available in the complaints dashboard, supported by the informatics team for 2022/23.

5.7 Moving forward into 2023/24 patient first will be implemented across the Trust with a drive to put patients first in all aspects of their care. This will include using wider patient feedback such as the Friends and Family Test (FFT) and Have your say feedback to understand the perspective of our patients, their family and carers.

Currently it is felt that we do not get enough valuable and useful feedback from our patients and on review it has been identified that:

- Not all patients are asked to comment on their care
- Not all teams across the Trust have access to enough patient feedback to make improvements
- There is not always evidence of learning or continuous improvement as demonstrated in the complaint trend at the Trust

Our aim is to substantially improve our standing in the “overall experience” section in all CQC national surveys of NHS Acute Hospital Trusts over the next three years. Increase FFT and Have your say feedback rates. This will be supported by every clinical area using the data to show continuous improvement.

Whilst this is a longer term plan, once this is in place we should see a reduction in PALS concerns and complaints being raised.

Table 8: 2022/23 TOP COMPLAINT THEMES, BY QUARTER		
Complaint category	**Quarter**	
CLINICAL **Quality** eg. Clinical standards **Safety** eg incidents, staff competencies **Effectiveness** eg procedural outcomes	Q1	• Error - diagnosis • Inadequate examination and monitoring • Clinical skills and conduct
	Q2	• Inadequate examination and monitoring • Error - diagnosis • Clinical skills and conduct
	Q3	• Clinical skills and conduct • Error - other • Team work
	Q4	• Clinical skills and conduct • Substandard care; neglect – personal care • Inadequate examination and monitoring
MANAGEMENT **Environment** eg facilities, equipment, staffing levels **Systems & processes** eg bureaucracy, waiting times, accessing services **Well led:** eg leadership and decision	Q1	• Delay – access (outpatient) • Discharge • Documentation / records
	Q2	• Discharge • Trust administration and bureaucracy • Delay in accessing emergency / urgent care
	Q3	• Discharge • Administration and bureaucracy • Documentation / records
	Q4	• Discharge • Administration and bureaucracy • Delay in procedure or referral
RELATIONAL **Communication & listening** eg not acknowledging information given **Attitude** eg behaviour **Dignity& respect** eg caring and patient rights	Q1	• Communication absent • Communication breakdown • Caring and compassion
	Q2	• Communication absent • Communication breakdown • Caring and compassion
	Q3	• Communication breakdown • Caring and compassion • Communication absent
	Q4	• Communication breakdown • Caring and compassion • Communication absent

6 CONCLUSIONS & RECOMMENDATIONS

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

6.2 The Trust has received 483 complaints, 501 early resolution complaints and 5531 PALS enquiries and concerns during 2022/23. This is an increase in the number of complaints received from 2021/22, which is a reflection of the fully merged systems and teams. There continues to be a significant increase in the cases managed in the PALS service.

6.3 A national comparison of complaints received (NHS Digital) shows that UHD is not an outlier with regards to the number of complaints received but reiterated some opportunity to increase the volume of early resolution complaints which has been realised in 2022/23.

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

6.5 The Trust also underperformed with the final response timescale of 55 working days. This in part can be attributed to the high clinical demand on our staff that were needed to have input into the responses. A shift to a corporate team investigation and responses should start to minimise these delays and an improvement should start to be seen in the next year.

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

Appendix A: 2022/23 examples of learning from upheld complaints

Further examples of learning from complaints:		
Complaint	**Action/Learning**	**Status of learning**
Patient information leaflets regarding post-surgery discharge care and given to patients on their discharge lacked detail and could be more clear	Surgical matron has reviewed the leaflets, and these have been updated, with clearer and more specific advice. The 'Information Following General Anaesthesia' leaflet has also been updated.	We now have a named individual for patient information at the Trust and have secured short term funding for support with this.
Concerns raised regarding lack of updates from ward when father in law was an inpatient at Bournemouth Hospital	Complaint has been shared with staff anonymously for learning and staff training has been revisited with regard to communication	Completed
Concerns raised as mother of patient found a needle and syringe left in a cubicle in the Emergency Department, and the way in which it was handled.	Staff members were identified, and additional training has been given regarding sharps safety and their disposal. Apologies given to patient and her mother.	Completed training
Patient and his father were upset by the manner of the doctor when they saw him in clinic. They were also unhappy that they had not yet receive the results of a recent MRI	The feedback regarding communication was passed on to the locum doctor for reflection. Another consultant reviewed the MRI results and wrote to the patient and the GP with the findings. A further appointment with an alternative consultant was offered.	Completed
A local GP raised concerns that there were delays in the pathway when trying to admit patients their patients to the Royal Bournemouth Hospital in emergency situations	There is now a dedicated Emergency Admissions Team which answers calls across the whole Trust and continuous work is undertaken to improve the service further. Feedback from GPs have already noted improvements and quicker responses.	Completed
Concerns raised that a taxi organised by the hospital did not take the patient directly to his door, and left him at the end of a long driveway	The Transport Manager contacted the Taxi company with whom UHD holds a contract, which includes safely delivering patients to their front door. The taxi company have spoken to the driver involved and will also remind all drivers of their responsibility towards patients when they hold their driver	Completed

	awareness and feedback meetings. Sincere apologies were made to the patient.	
Concerns were raised that a leaflet on the UHD website containing sleep advice for children was outdated	The leaflet was removed and will be updated. Therapy Services have also implemented a new system to ensure all patient information is reviewed at set intervals.	We now have a named individual for patient information at the Trust and have secured short term funding for support with this.

Appendix 1

PATIENT EXPERIENCE TEAM

COMPLAINT ASSESSMENT - SEVERITY CATEGORY

Category	Theme	Severity Indicators		
CLINICAL	Quality & Effective-ness	**1. Low severity**	**2. Medium severity**	**3. High severity**
		Delay changing dirty bedding	Patient dressed in dirty clothes	Patient left in own waste in bed
		Isolated lack of food or water	Nothing to eat or drink for one day	Patient dehydrated/ malnourished
		Wound not dressed properly	Seeping wound ignored	Infected wound not tended to
		Rough handling patient	Patient briefly without pain relief	Force feeding baby, resulting in vomiting
		Patient monitoring delayed	Patient not monitored properly	Discharge without sufficient examination
		Patient not involved in care plan	Aspect of care plan overlooked	Failing to heed warnings in patient notes
		Patient left with some scarring	Patient required follow-up operation	Patient left with unexpected disability
	Safety	**1. Low severity**	**2. Medium severity**	**3. High severity**
		Slight delay in making diagnosis	Clinician failed to diagnose a fracture	Clinician misdiagnosed critical illness
		Slight delay administering medication	Staff forgot to administer medication	Incorrect medication was administered
		Minor error in recording patient progress	Delay noticing deteriorating condition	Onset of severe sepsis was not identified
		Not responding to bell (isolated)	Not responding to bell (multiple)	Not responding to heart attack
		Minor misunderstanding among clinicians	Test results not shared with clinicians	Failure to coordinate timecritical decision
		A minor error filling-out the patient notes	Clinician overlooked information (eg, previous experience of an illness)	Clinician overlooked critical information (eg, serious drug allergy)

Category	Theme	Severity Indicators

MANAGEMENT	**Environment**	**1. Low severity**	**2. Medium severity**	**3. High severity**
		Noisy ward surroundings	Patient was cold and uncomfortable	Fleas, bed bugs, rodents Patient relocated due to bed shortage
		Patient bed not ready upon arrival	Patient placed in bed in corridor	
		Dirt and cigarette ends on main floor Parking meter not working	Blood stains in bathroom A temporary malfunction in an IT system	Overflowing toilet, faeces on floor Medical equipment malfunctioned
		Midwife repeatedly called away	Specialist not available	Severe staff shortages
		Argument between patients	One patient bullying another patient	Patient assaulted by another patient
	Systems & processes. Well led	**1. Low severity**	**2. Medium severity**	**3. High severity**
		Difficulty phoning healthcare unit	Waited in emergency room for hours	Unable to access specialist care
		Non-urgent medical procedure delayed	Medical procedure delayed	Acute medical procedure delayed Emergency phone call not responded to
		Phone calls not returned	Complaint not responded to	
		Appointment cancelled and rescheduled	Chasing departments for an appointment	Refusal to give appointment
		Visiting times unclear	Visiting unavailable	Family unable to visit dying patient
		Patient notes not ready for consultation	Patient notes temporarily lost	Another patient's notes used as basis for consultation

Category	Theme	Severity Indicators		
RELATIONAL	**Listening**	**1. Low severity**	**2. Medium severity**	**3. High severity**
		Staff ignored question Patient's dietary preferences were dismissed	Staff ignored mild patient pain Patient-provided information dismissed	Staff ignored severe distress Critical patient-provided information repeatedly dismissed
		Question acknowledged, but not responded to	Patient anxieties acknowledged, but were not addressed	Patient pain acknowledged, but no follow through on pain relief

Communication	**1. Low severity**	**2. Medium severity**	**3. High severity**
	Short delay communicating test results Patient received incorrect directions Staff did not communicate a ward change	Long delay communicating test results Patient received conflicting diagnoses Staff did not communicate care plan	Urgent test results delayed Patient given wrong test results Dementia patient discharged without the family being informed
Dignity, respect & staff attitude	**1. Low severity**	**2. Medium severity**	**3. High severity**
	Staff spoke in condescending manner Private information divulged to the receptionist Staff member lost temper Unclear information for consent Lack of privacy during discussion	Rude behaviour Private information divulged to family members Patient intimidated by staff member Consent was obtained just prior to a procedure, giving no discussion time Lack of privacy during examination	Humiliation in relation to incontinence Private information shared with members of the public Patient discriminated against Do-not-resuscitate decision without obtaining consent Patient experienced miscarriage without privacy

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May 2023

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BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 26 July 2023

Agenda item: 9.4

Subject:	Annual Review of Committee Effectiveness
Prepared by:	Ewan Gauvin, Corporate Governance Manager Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Committee Chairs

Strategic Objectives that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Assurance
Executive Summary:	A review of each Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team to support the Committees) by scrutinising the agendas and minutes meetings which took place between 1 April 2022 and 31 March 2023. The reports evidence how the Committees have discharged their respective responsibilities, recognising that new terms of reference were adopted in January 2023.
Background:	The NHS Foundation Trust Code of Governance advises that the Board of Directors should undertake a formal and rigorous evaluation, not only of its own performance, but also that of its committees.
Key Recommendations:	To review the Committee Annual Reports.
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**
Charitable Funds Committee	04/05/2023	Approved for presentation to Board.
People & Culture Committee	10/05/2023	Approved for presentation to Board.
Quality Committee	16/05/2023	Approved for presentation to Board.
Finance & Performance Committee	17/07/2023	Approved for presentation to Board.
Audit Committee	13/07/2023	Approved for presentation to Board.

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