University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 24 May 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 24 May 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 24 May 2023

Time	Item		Method	Purpose	Lead
13:15	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	2	Declarations of Interest	**Verbal**		**Chair**
	3	Patient Story	**Verbal**	**Discussion**	**CNO**
13:30	**4**	**MINUTES AND ACTIONS**			
	4.1	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 27 March 2023	**Paper**	**Approval**	**Chair**
	4.2	Matters Arising - Action List – *(none outstanding)*	**Verbal**		**Chair**
13:35	**5**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
	5.1	Trust Chair's Update	**Verbal**	**Information**	**Chair**
	5.2	Chief Executive Officer's Report • Update • ICB Minutes – 2 March 2023	**Paper**	**Information**	**CEO**
13:50	**6**	**INTEGRATED PERFORMANCE REPORT AND RISK**			
	6.1	Board Assurance Framework (Close/sign-off previous year's framework)	**Paper**	**Assurance**	**CSTO**
	6.2	Board Assurance Framework (Approve annual framework)	**Paper**	**Approval**	**CSTO**
	6.3	Risk Register Report	**Paper**	**Review**	**CNO**

	6.4	Integrated Quality, Performance, Workforce, Finance and Informatics Report *Questions to the Executive Team by exception*	**Paper**	**Assurance**	**Execs**
14:20	**7**	**STRATEGY AND PLANNING**			
	7.1	Annual Operational Plan	**Paper**	**Information**	**CSTO**
14:30	**8**	**QUALITY AND PEOPLE**			
	8.1	Mortality Report	**Paper**	**Assurance**	**CMO**
	8.2	Guardian of Safe Working Hours Report	**Paper**	**Assurance**	**GSWH**
14:40	**9**	**COMMITTEE CHAIRS' REPORTS**			
	9.1	Finance and Performance Committee – Chair's Reports – April and May 2023 • Annual SIRO Report	**Paper**	**Assurance**	**Committee Chair**
	9.2	Quality Committee – Chair's Reports – April and May 2023	**Paper**	**Assurance**	**Committee Chair**
	9.3	People and Culture Committee – Chair's Report – May 2023* • Gender Pay Report *(for approval)*	**Paper**	**Assurance**	**Committee Chair**
	9.4	Population Health and System Committee – Chair's Report – April 2023	**Paper**	**Assurance**	**Committee Chair**
	9.5	Audit Committee – Chair's Report – May 2023* • Availability of Resources and Systems for Financial Compliance *(for approval)* • Certification of Governance *(for approval)*	**Paper**	**Assurance**	**Committee Chair**
	9.6	Charitable Funds Committee – Chair's Report – May 2023*	**Paper**	**Assurance**	**Committee Chair**
14:55	**10**	**GOVERNANCE**			
	10.1	Enabling Accountability Framework	**Paper**	**Approval**	**COO**
	10.2	Freedom to Speak Up: • Annual Report • Policy	**Paper**	**Approval**	**FTSUG**
	10.3	Training of Governors	**Paper**	**Approval**	**Chair**
	10.4	Terms of Reference: • Finance and Performance Committee • People and Culture Committee	**Paper**	**Approval**	**Chair**

		• Quality Committee and Committee membership			
	11	**ITEMS FOR INFORMATION**			
	11.1	Seal of Documents Register	**Paper**	**Information**	**CoSec**
15:05	**12**	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 21 May 2023 to company.secretary-team@uhd.nhs.uk		**Receive**	**Chair**
	13	Any Other Business	**Verbal**	**Discussion**	**Chair**
	14	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 26 July 2023 at 13:15.			
	15	**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	**16**	**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 (May 2023)

Quarterly Reports

- Quality Impact Assessment Overview Report
- Guardian of Safe Working Hours Report

Annual Reports

- Annual Complaints and Patient Experience Report
- Annual CQC Report
- Quality Assurance for Responsible Officers and Revalidation
- Annual Health and Safety Report
- Annual Organisational Audit Report

- Workforce Race Equality Standards Report
- Workforce Disability Equality Standards Report
- Committee Annual Reports

AGENDA – PART 2 PRIVATE MEETING

15:30 on Wednesday 24 May 2023

Time	Item		Method	Purpose	Lead
15:30	**17**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	18	Declarations of Interest	**Verbal**		**Chair**
15:35	**19**	**MINUTES AND ACTIONS**			
	19.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 26 April 2023	**Paper**	**Approval**	**Chair**
	19.2	Matters Arising – Action List	**Paper**	**Review**	**Chair**
15:40	**20**	**UPDATES**			
	20.1	Chief Executive Officer's Update • CQC • New Hospitals Programme	**Verbal**	**Assurance**	**CEO**
	20.2	Committee Chairs' Reports: • Annual Report – Financial Statements • Annual Governance Statement *(for approval)* • Capital and revenue amounts proceeded with at risk *(for approval)*	**Paper**	**Information**	**Committee Chairs**
	20.2	CQC Update	**Verbal**	**Information**	**CNO**
15:55	**21**	**QUALITY AND PEOPLE**			
	21.1	Serious Incident Report	**Paper**	**Review**	**CMO**
	21.2	Risk Register	**Verbal**	**Review**	**CNO**
16:05	**22**	**STRATEGY, TRANSFORMATION AND FINANCE**			
	22.1	Financial Risks	**Paper**	**Information**	**CFO**
	22.2	Hip and Knee Prosthesis	**Paper**	**Approval**	**CFO**

	22.3	Use of Seal: Pharmacy Leases	**Paper**	**Approval**	**CSTO**
	22.4	Immunotherapy Toxicity Service	**Paper**	**Approval**	**CFO**
	23	Any Other Business	**Verbal**		**Chair**
	24	Reflections on the Board Meeting	**Verbal**		**Chair**
	25	**Date and Time of Next Standing Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 26 July 2023 at 15:30.			
17:00	**26**	**Close**	**Verbal**		**Chair**

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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 Monday 27 March 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
	Stephen Mount	Non-Executive Director
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy & Transformation Officer
	Cliff Shearman	Non-Executive Director
	Paula Shobbrook	Chief Nursing Officer
	John Vinney	Associate Non-Executive Director *(until BoD 060/23)*
	Ruth Williamson	Acting Chief Medical Officer
In attendance:	Robert Bufton	Public Governor
	Sharon Collett	Lead Governor
	Katherine Curley	Care Quality Commission Inspector
	Yasmin Dossabhoy	Associate Director of Corporate Governance
	James Donald	Associate Director of Communications
	Trudi Ellis	Senior Matron *(until BoD 057/23)*
	Cllr Beryl Ezzard	Appointed Governor
	Rob Flux	Public Governor
	Elayne Goulding	Project Support Officer *(from BoD 060/23)*
	Paul Hilliard	Public Governor
	Ewan Gauvin	Corporate Governance Manager
	Marjorie Houghton	Public Governor
	Judith May	Associate Director of Operational Performance and Oversight
	Keith Mitchell	Public Governor
	Patricia Scott	Public Governor
	Jeremy Scrivens	Public Governor
	Gemma Short	Midwife
	Diane Smelt	Public Governor
	Susanne Surman-Lee	Public Governor *(from agenda item 9.1)*
	Kani Trehorn	Staff Governor
	Michele Whitehurst	Deputy Lead Governor
Public attendees:	2 members of the public attended	

BoD 050/23	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting. He introduced Judy Gillow who would be joining the Trust as a Non-Executive Director in April 2023 and also introduced Katherine Curley from the Care Quality Commission.

	Outlining that as usual, papers would be taken as read, he commented that there would be particular discussion during the course of the meeting on certain items such as the Integrated Performance Report and CQC Inspection Reports. Apologies were received from: • Mark Mould *(represented by Judith May)*. • Caroline Tapster. The meeting was declared quorate.
BoD 051/23	**Declarations of Interest** No existing interests in matters to be considered were declared. In addition, no further interests were declared.
BoD 052/23	**Patient Story** Paula Shobbrook introduced the Patient Story welcoming Trudi Ellis, a Senior Matron at the Trust. Trudi Ellis introduced the story of Naomi, who was unable to attend in person but was keen that her story be shared. Naomi was admitted to the Trust towards the end of 2022, following a significant deterioration in her mental health combined with a number of physical health concerns. These required a joined-up approach from acute and mental health services. Naomi had a prolonged stay within the Trust due to her health complexities as a result of which she came into contact with a number of services across the organisation. Whilst ensuring a holistic approach, there was considerable focus upon improving Naomi's nutritional intake and understanding from her the different approaches that she would find helpful. A video of Naomi was presented to the meeting where she relayed her story. The special support given to her by one of the Trust's volunteers, Mary, was of particular note. Naomi had produced an inspirational guide to support patients admitted to the Trust's hospitals and had given permission for her story not only to be shared with the Board but with staff at the Trust's upcoming Mental Health Action Day. Paula Shobbrook highlighted the role of the Trust's volunteers, the mealtime companion being a very important role, supporting patients and the teams. The Board NOTED the Patient Story and thanked Naomi for her moving story.
BoD 053/23	**For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 25 January 2023** A proposed amendment to minute BoD 12/23 was proposed by Philip Green: "*The transformational aspects of estates would be a standing monthly item*" to instead read "*The improvement aspects of estates would be a standing monthly item*". Subject to this amendment being made, the minutes of the Board of Directors meeting held on 25 January 2023 were APPROVED as an accurate record.
BoD 054/23	**Matters Arising – Action List** **BoD 073/22 –** *Annual Board Effectiveness Report* – This would be presented at the meeting. Action CLOSED.
BoD 055/23	**Trust Chair's Update** Rob Whiteman provided the Trust Chair's Update highlighting: • It was a busy period for the National Health Service. The NHS in England was heading for its financial year end, with a reported overspend of potentially £6 billion. This was having an impact on

	planning for 2023/24. The Trust's budget had been considered by the Board on a number of occasions. As Trust Chair, he had been holding various meetings at a Dorset system level about financial forecasting for the following year and how best the Trust should construct its budget. He extended his thanks to Siobhan Harrington and Pete Papworth for their work on this. • He thanked managers and staff across the Trust for the effective manner in which the industrial action had been handled to try and mitigate the risks of disruption. • He had met Chairs from provider trusts across the Dorset system as well as Chairs of provider trusts across the country, particularly in relation to their approach to financial planning. He had also met with directors of NHS England in relation to workforce and delayed discharges. The Trust wanted to continue to work with the joint Chief Executive and Chair of Dorset Healthcare and Dorset County hospitals, whom he had been pleased to meet. The Board NOTED the Trust Chair's Update.
BoD 056/23	**Chief Executive Officer's Report** Siobhan Harrington presented the Chief Executive's Report highlighting: • The Trust was emerging from a very challenging winter and she thanked all staff, volunteers and the public for their support during what had been a challenging time. There had been considerable disruption as a result of the industrial action, which appeared likely to continue. • She expressed her pride at the incredibly caring staff at the Trust and the progress being made on the Trust's operational plan. • Peter Wilson would be joining the Trust as Chief Medical Officer the following week. • Within the staff survey results, there was good news in relation to how staff were feeling. 45.6% of staff had responded to the survey, with this demonstrating engagement and people caring about improvements at the Trust. • The Trust had no patients waiting more than 104 weeks, this being the result of considerable work across all teams and a focus on reducing waits for patients. The Trust was on trajectory to meet its performance on 78 weeks. • The Trust was continuing to improve and focus upon its governance and risk management across the organisation. • Adding to her report, she referred to requests for expression of interest having been issued for a GP to work with the Trust's leadership. • Urgent and emergency care flows had been challenging but walking through the Trust's departments, the care from staff for all patients across urgent and emergency care was astounding. • There were 70 patients across the Trust with Covid. As could be seen from the Integrated Performance Report, there had also been some cases of norovirus. • The Trust was on track to meet its financial plan for 2022/23, with some challenges in relation to the recurrent nature of the plan. • The Care Quality Commission (CQC) inspection reports had made for difficult reading. However, staff were tremendous. Having worked through a pandemic and through the merger, the staff were working to make improvements across the organisation. The Trust was working on and welcomed a commitment to continuous and relentless focus on improvement and delivering a consistent standard of high care. The Board and Executive Team were very committed to this.

	• Referencing Patient First in her report, she summarised that this was a quality improvement approach across the whole Trust and was the way the Trust would operate. It would be a significant culture change, this being a year of transition. • Recruitment was an issue across all trusts in England but the Trust was making progress including with some significant investment having been made into staffing. • The next round of industrial action with junior doctors would be 11 to 15 April 2023, with planning and discussions with staff underway. • In April 2023, changes would be made in cardiology and stroke which would deliver better outcomes for patients. • Thanking Ruth Williamson for having been Acting Chief Medical Officer, she commented upon her having been a great colleague and member of the team. • The Trust had won an HSJ partnership award for its partnership with Legal and General in relation to Beales and outpatients. Adding to her report, she provided an update on the flood that had occurred at Poole Hospital during the preceding weekend. Business continuity plans had been implemented but with minimal disruption to activity that morning. Patients were all safe. Separately, there had been an oil incident in Poole Harbour but no impact at the hospitals had yet been seen. Councillor Beryl Ezzard clarified that the incident related to reservoir fluid, releasing water or saline containing a relatively low content of crude oil. It was being managed with a view to it being contained as far as possible. The Board NOTED the Chief Executive Officer's Report.
BoD 057/23	**Integrated Quality, Performance, Workforce, Finance and Informatics Report (IPR)** Presenting the operational performance aspects of the IPR, Judith May highlighted: • It had been a challenging month for the emergency and urgent care pathways, with the impact of industrial action. • In relation to cancer performance, the report reflected the position in January 2023 which was the latest published data. An improvement was being seen in February 2023 in the faster diagnostic performance, which was above 70% in February 2023. • After the end of February 2023, an improvement was also being seen in relation to ambulance handovers and reduction of the mean time within emergency departments. Referencing the number of Covid patients highlighted by Siobhan Harrington, Paula Shobbrook commented upon: • The national high levels of C.Diff, with high rates within Dorset. The Trust was working closely with the regional and national teams. The wider implications of C.Diff were being reviewed. • The number of patients coming into the organisation with pressure damage. When patients were coming in, a thorough skin assessment was conducted. • The focus upon falls and falls prevention. • The increase in the number of family and friends tests responses. Increased early resolution with complaints was being seen.

Ruth Williamson drew attention to the inequalities monitoring within the reporting. Work was in progress to consider outpatients unable to attend appointments, there being a differential between different community groups.

Cliff Shearman referenced being encouraged by the health inequalities data, noting that it was early and would be positive to see how it developed. Further to the discussions at the Quality Committee about babies with APGAR scores less than seven at 5 minutes, he suggested that Paula Shobbrook provide an update to the meeting on this. She outlined that a report had been received from the Director of Midwifery with further work to be undertaken. However, the Quality Committee had been assured that there were wider key performance indicators (KPIs); from a patient safety perspective, there were not concerns. Part of the matter related to ensuring consistency in applying the APGAR score.

Referencing the fractured neck of femur action plan In the IPR and the improvement that had been seen, but this having been impacted by industrial action, Cliff Shearman asked for an update on the current position. Responding to this, Paula Shobbrook confirmed that the data as at the date of the meeting was:

- Fractured neck of femurs to theatres within 36 hours of admission was 94% of patients, with the national average being 58%.
- The number of patients within 36 hours of being fit was 92.3%.
- The number of patients which were overall trauma cases that had been to theatre within 48 hours of admission of being fit was 99.2%.

She summarised that these KPIs were monitored every day, with the level of detail going down to the number of patients waiting for theatre capacity and numbers of outliers. There was a full suite of KPIs monitored to make sure patients were at the heart of what the Trust did.

Rob Whiteman enquired whether the Trust was up to date on where Paula Shobbrook would expect it to be on the fractured neck of femur action plan. She referenced that this was not a new action plan, with the actions having been in place for a long time. There had been a number of discussions through the Quality Committee and she was pleased to see progress in the outcomes for patients. Cliff Shearman responded that it had been a positive surprise to hear the data that she had reported. Challenge had been raised at Quality Committee about it for some time and it would be important for the position to be sustained. There were other factors about delivery and quality of the service which would need to be considered going forward.

Referencing a Dorset level Non-Executive Directors' workshop attended by some of the Trust's Non-Executive Directors with ICS colleagues, Pankaj Davé asked Judith May whether the Trust was contributing to and utilising the information from the Dorset system level performance dashboards. She confirmed that the Trust was very involved with working across the system in the development of the dashboards, contributing information and daily looking at implications across the organisations with the ICS. Ruth Williamson added that she looked at the data in the Dorset DiiS each day, which could be viewed thematically. Judith May had complete extensive work particularly on inequalities. It was also being used to compare the Trust with other providers and to seek to learn from them. Siobhan Harrington and Rob Whiteman also commented upon the strength of the tool.

In relation to the Informatics report in the IPR, Peter Gill highlighted:

- The considerable reduction in the past year in the average waiting time on the IT service desk, with many "Plan Do Study Act" and continuous improvement cycles having been led by Verity Cook in the service.

	• The use of artificial intelligence in breast screening. Pete Papworth presented the Finance section of the IPR. Karen Allman drew attention to the following in relation to Workforce: • The successful recruitment of international midwives. In addition to the first four offered that were due to join by the end of May 2023, a further eight were due to join the Trust in subsequent months. • The importance of the management module for understanding staff survey information, which linked to Patient First, listening to staff and action planning at local levels. • Considerable work on the electronic staff record establishment data cleanse was ongoing. • Since the IPR report had been written, the Trust had been shortlisted for a national award for the Make a Difference Award for health and wellbeing support. The Trust had been shortlisted, one of eight organisations in the public sector not for profit on health and wellbeing support for staff and the difference that had made. The Trust was the only NHS organisation that had been shortlisted. Siobhan Harrington highlighted the position in the IPR relating to patients who were medically ready for discharge (MRFD). The Trust had been visited in February 2023 by Lesley Watts, the National Senior Responsible Officer for discharge who had spent two days with the Trust's access team, walking around wards, observing the board rounds and in the emergency departments. A subsequent system meeting had been held, as a result of which demand and capacity across the Dorset system was being fully considered. In addition, a new local discharge to assess model was coming into place. Also, within the Trust, an internal focus on pathway to support patients within the Trust's own control to get home. In relation to MRFD patients, Rob Whiteman enquired how much was attributable to needing more capacity and how much was as a result of the Trust's own processes where it could discharge more quickly. Siobhan Harrington confirmed that there was real time information available, with Judith May adding that this information was actively looked at and discussed at several points during each day through hospital flow meetings. Cliff Shearman had looked at the number of virtual appointments being offered and noted that these had dipped. There had been a national group looking at virtual appointments. He enquired whether the number of virtual appointments was due to patients not choosing them or absence of suitable technology. Responding to this, Judith May outlined that from an operational perspective, this was a trend being seen nationally with the numbers declining, although there was month on month variation. The promotion of virtual appointments remained part of the Trust's outpatient transformation and would be comprised within the plan going forward into next year. Ruth Williamson added that as part of the outpatient transformation, the Trust was working to increase patient initiated follow up (PIFU), such that a patient would not need to have a virtual appointment booked but could contact the Trust. The aim of this was to reduce activity of relatively low value and to make sure that contact with patients was when and what they needed. PIFU reduced the number of booked outpatient appointments but increased the availability of appointments to suit patient needs, therefore fitting within an overall strategy. The Board NOTED the Integrated Performance Report.
BoD 058/23	**Risk Register Report** Paula Shobbrook presented the Risk Register Report, with the risks having been discussed at the Quality Committee.

	In relation to Risk ID 1738 – Radiotherapy Eclipse Treatment Planning System Failure – Peter Gill summarised that Eclipse was the 3D modelling software used by the radiotherapy team to plan treatment. It was a high consuming piece of software and the technology stacks upon which it sat needed to be upgraded. The upgrade was being planned. As a result of it not having been upgraded, the software jumped from time to time, requiring additional quality assurance which had been put in place. The matter was being escalated to ensure that the upgrade took place as quickly as possible. Cliff Shearman referenced that there had been a detailed discussion at the meeting of the Quality Committee about the risk. However, the timeframe for the upgrade had not been established. Peter Gill responded that he estimated that it would be within the next two months. The various suppliers would need to come together and go through the upgrade and minimise the downtime for the service during the upgrade. The Board APPROVED the Risk Register Report.
BoD 059/23	**CQC inspection reports** Cliff Shearman, as chair of the Quality Committee, summarised that there was considerable information in the CQC inspection reports that needed to be digested. The sentiment from the Quality Committee was that it was a great disappointment to receive the reports and the implications. There were areas where the Trust needed to do things better; however, it was important to bear in mind that within the organisation over 60,000 patients had been treated in the last month. It was important to have the energy to address the issues. While there were national challenges such as with staff morale there were also local issues, most if not all of which the Trust had identified and discussed such as fractured neck of femur. He had been impressed with the energy and enthusiasm of people in the organisation to tackle the issues. It was important that the organisation learned how to translate awareness into strategies, which then resulted in quicker resolution of concerns. Adding to this, Philip Green agreed that the reports had been a challenging read, there was learning to be taken from them and many areas of improvement had already been identified to the Quality Committee and to the Board as appropriate. Actions were already in hand to improve upon them. It had been pleasing to see in the reports the kind and compassionate care provided by staff recognised and the open reporting structure. The theme of staff shortages ran through all the reports and it was therefore essential that the caring and professional approach of staff was recognised, many of whom were exhausted after three years of pandemic and the extreme operational pressures which still continued. The Trust had the opportunity to improve and, in many cases, had already initiated actions. It was encouraging to know of the positive response from staff to the actions identified and that they were looking forward to re-welcoming the CQC to demonstrate the improvements made. Paula Shobbrook provided an overview of steps already undertaken: • The action plan for maternity services had been returned on 24 April 2023 in line with the timescales from the CQC. The national maternity CQC inspection team had undertaken the inspection of maternity services. • The static call bell system was being put in when the CQC visited with significant work from the Trust's estates team in making sure that the system was responsive in the manner in which the midwives wanted it to be. It was fully functional: she and Siobhan Harrington had tested it. The midwives were extremely pleased with the new call bell system.

	This had been one of the "must do" actions, the other being in relation to the triage service. • At the time of the inspection, the Trust was moving its triage services and consolidating them on the Poole site. The team from the Bournemouth site had moved and were in the triage service at the front door. The latest data set was that 96% of women were seen in 15 minutes. Paula Shobbrook had been in the maternity unit in Poole hospital on 23 April 2023 and had witnessed an emergency in triage where everything had been managed well and with a very positive outcome. • She reiterated that staff wanted the CQC to re-inspect and had also relayed to her the support received from members of the public. Appropriate data was available to demonstrate the progress being made and to provide assurance. • Considerable work was being undertaken in relation to incident management and ensuring consistency across the organisation. It was important for people to feel safe and to speak up. The Trust was working with the ICB from whom some positive feedback had been received and the Trust had invited the maternity safety support program team to work with it. • Areas which were disappointing in the report were consistency of documentation. She cited the example of crash trolleys having been checked but with the need for positive documentation of this being in place. Siobhan Harrington positively commented upon the cultural aspects of staff. The areas the reports highlighted included governance, risk and having a more strategic approach from the Board. She had seen a "can do" approach, which would be used to galvanise improvement over the next three to five years. The Trust had a unique opportunity with the staff, the buildings and the Board to get to outstanding. Rob Whiteman requested that Paula Shobbrook thank staff on behalf of the Board. Their response to the inspections had been first class. However, there were lessons that the Board would need to consider including leadership, strategy, improvement and governance. Appropriate time and commitment would need to be given to those and for the Board to be forward looking. He invited Katherine Curley to add any comments, who did not have any comments to make. The Board NOTED the CQC Inspection Updates.
BoD 060/23	**Staff Survey** Karen Allman presented the Staff Survey report. Philip Green asked whether improvements made in staff survey results formed part of individuals' objectives. Karen Allman confirmed that it was not a standardised part of the staff survey but could be considered. Siobhan Harrington added that as part of the accountability framework, it would be important to be clear about the expectation of improvements in the staff survey with Care Groups. The staff survey results were discussed in performance meetings with them. Richard Renaut reflected upon the additional layers of data granularity now available enabled more focus on variation across the organisation. In addition to improving communications and engagement, integration of teams where there were or would be site moves going forward would be important. The Board NOTED the Staff Survey Report 2022.

BoD 061/23	**Update from the Council of Governors** Sharon Collett, Lead Governor, provided an update from the Council of Governors including recent engagement activity. An Understanding Health Talk with over 100 attendees had been held, where an outstanding presentation was given by Dr Amy Pharoah, consultant in Palliative Medicine. It had been a good quality event with high levels of satisfaction from attendees; her thanks were extended to Keith Mitchell and other Governor colleagues for this. A community event in Corfe Castle was being held on 27 April 2023. Governors had been very interested in the assurance reports presented by Committee Chairs at the joint Board and Council of Governors Development Session, giving them further opportunity to hold Non-Executive Directors to account. Also central to the session had been a presentation on Patient First. Following the change in approach to Governors observing Committee meetings, a glowing account of the work of the Quality Committee had been received from a Governor who had observed one of its meetings. The Board NOTED the Update from the Council of Governors.
BoD 062/23	**Integrated Care Partnership Strategy** Richard Renaut presented highlights from the Integrated Care Partnership Strategy. The Board NOTED the Integrated Care Partnership Strategy.
BoD 063/23	**Annual Operational Plan** Introducing Richard Renaut's presentation of the Annual Operational Plan, Rob Whiteman commented upon the Board having had a number of discussions about the plan including at a recent Board Development Session. Presenting the Annual Operational Plan, Richard Renaut outlined that the majority of the text would remain as currently drafted, with some non-material changes to be made. Work was ongoing in relation to the financial settlement through the ICS and regionally. As a result of that, the activity and the workforce and quality metrics may be adjusted. Unlike previous years, while the plan set out in the chapters what the Trust aimed to undertake, there was a significant amount of work to focus upon a smaller number of high impact changes. The Trust would not be able to achieve everything that it wanted to in one year. In the Part 2 meeting of the Board, additional time would be needed for the Board to discuss the smaller focused high impact areas. On behalf of the Non-Executive Directors, Rob Whiteman confirmed that they welcomed the approach; their experience and insight was that if the Trust could phase and focus on fewer items in the first year, success was more likely. The three recommendations referenced in the paper were made to the Board, subject to in the second bullet point the date being amended from "end of March 2023" to "April 2023". The Board APPROVED the recommendations made to it in relation to the Annual Operational Plan as set out in the report, subject to the amendment to the date in the second bullet point as referenced above.
BoD 064/23	**Finance and Performance Committee: Chair's Report** Philip Green presented the Finance and Performance Committee: Chair's Report, inviting Pete Papworth to introduce the annual going concern statement.

	Pete Papworth presented the annual going concern statement report. The Board NOTED the Finance and Performance Committee Chair's Report and APPROVED the assessment of going concern.
BoD 065/23	**Quality Committee: Chair's Report** Inviting Cliff Shearman, Chair of the Quality Committee to present the Quality Committee: Chair's Report, Rob Whiteman referenced that the assurance included the Mortality Report which was in the Reading Room and would be presented to the Board on a quarterly basis. Cliff Shearman added that the process of the Chair's Report was maturing and it was visible how areas of work were followed up in subsequent Committee meetings. He drew attention to the Morecombe Bay report, highlighting that it was an important read which he commended to everyone, including aspects in relation to the whole organisational performance. The Quality Committee had its first deep dive, following on from the changes in the Committee format which, going forward, would include deep dives. In addition, Cliff Shearman and Paula Shobbrook were meeting on 4 May 2023 for their first visit, as part of the rollout of Board member visits to units and teams. The Board NOTED the Quality Committee Chair's Report.
BoD 066/23	**People and Culture Committee: Chair's Report** Pankaj Davé, Chair of the People and Culture Committee referenced key matters for the Committee including workforce morale. A challenge remained with retaining staff; it was important to manage both recruitment and retention to create capacity for staff to become involved in improvement and transformation activities. The Board NOTED the People and Culture Committee Chair's Report.
BoD 067/23	**Audit Committee – Chair's Report** John Lelliott, having chaired the meeting on behalf of Stephen Mount presented the Audit Committee: Chair's Report. He added that the Committee wanted to ensure that there was not duplication in the work being undertaken by internal audit and the local counter fraud specialist in 2023/24. Themes and trends in the risk register had been considered, the most consistent being resources and capacity. The Register of Compliance with Licence Conditions and Code of Governance had been considered and were being presented to the Board for approval. The Board NOTED the Audit Committee Chair's Report and APPROVED the Register of Compliance with Licence Conditions and the Register of Compliance with the Code of Governance.
BoD 068/23	**Annual Board Effectiveness Report** Rob Whiteman presented the Annual Board Effectiveness Report, which was APPROVED by the Board. He thanked two long standing Non-Executive Directors who would be standing down at the end of September 2023, Philip Green and Stephen Mount, and welcomed the new Non-Executive Directors who would be joining the Trust.
BoD 069/23	**Population Health and System Committee Terms of Reference** Rob Whiteman presented the draft Population Health and System Committee Terms of Reference, noting that these may change over time and would be kept under review. Richard Renaut added that particularly with Patient First, as the Trust reviewed its key priorities and as part of the Trust's well led work, alignment of Committees to objectives would be critical.

	The Board APPROVED the Population Health and System Committee Terms of Reference.
BoD 070/23	**Independence of Non-Executive Directors** Rob Whiteman presented the Independence of Non-Executive Directors report outlining that it was a collective and individual statement on each of the Non-Executive Directors' behalf confirming their independence. Each Non-Executive Director present confirmed that it was a representation of their individual and collective view, with Caroline Tapster having also confirmed her agreement. The Board APPROVED the Independence of Non-Executive Directors report.
BoD 071/23	**Nursing Establishment Review** Paula Shobbrook presented the Nursing Establishment Review report. Summarising that there had been discussion about it at the People and Culture Committee, she highlighted: • The overall work in relation to monitoring safe staffing across the Trust, recognising challenges nationally but noting the real time daily monitoring to ensure patient safety. From a responsiveness perspective, staff were moved around the organisation to support patients. This was not how the Trust wanted to work going forward, but the approach was mitigating risk. • Page 251 of the meeting materials referenced the successful recruitment of fantastic internationally educated nurses. The Trust had met targets set by NHS England. Paula Shobbrook conveyed to the Board the contents of the note she had received from the Chief Nursing Officer for England commending the Trust on its work in relation to internationally educated nurses. It was positive to note that internationally educated midwives were also joining the team at the Trust. The Board NOTED the Nursing Establishment Review report.
BoD 072/23	**Questions from the Council of Governors and Public** Carrie Stone, Public Governor, had submitted the following question to the Board in advance of the meeting: *Having read the paper and the CQC report regarding Maternity Services, firstly I am sure medical and midwifery staff must be devastated and I hope they are all receiving the appropriate support from the Chief Medical Officer and Chief Nursing Officer. I note the inspection report refers amongst other issues, to known risks e.g. the emergency call bell system. This is not the only example, but leads me to ask whether the risks and issues identified by the CQC had previously been identified by the Board/Quality Committee, did they appear on the Risk Register, were they rated appropriately and how were they mitigated? I also note the CQC found little evidence of continuous learning. Given the number of maternity reports nationally, how will the Board assure itself that continuous learning will be evidenced in the future?* Paula Shobbrook outlined that she, Siobhan Harrington and others had been meeting with all of the team, including midwives and wider obstetrics, both face to face, virtually, at weekends and in the evenings. This had been very well received. In relation to the question about whether the risks were known and discussed at the Quality Committee, she referred to the discussions earlier in the meeting. The work being undertaken to tighten up processes and reporting from the Trust's predecessor organisations and changes to the governance across the organisation were occurring. The Board would receive

	assurance of continuous learning from the enhancements to the Board reporting, governance and risk management. Diane Smelt, Public Governor, had submitted the following question to the Board in advance of the meeting: *The AECC, which provides diagnostic imaging, was rated as requires improvement when it was last inspected by the CQC in May 2022,* *safe, responsive and well led were rated as requiring improvement but they did not rate effective in diagnostic and screening services.* *The report highlighted several important issues and said that staff "did not receive all of the training they needed to keep patients safe or receive training that would enable them to support people who lacked capacity to make decisions about their care". The report also said that they "did not always control infection risk well".* *As the College provides diagnostic imaging services on behalf of the Trust and the local health system, can an assurance be given that our Officers are satisfied that the services provided by the College are now effective and safe for our patients and that the issues highlighted by the CQC have been actioned.* Responding to the question, Ruth Williamson referenced Anglo European Chiropractic College (AECC) being a higher education institute, but which had been conducting some ultrasound and other diagnostic studies for the Trust. Ruth Williamson had discussed the CQC report with Leslie Haig who had agreed to share the AECC action plan with the Trust. She had been informed that it had been signed off by the CQC in November 2022 with no outstanding actions. Diane Smelt, Public Governor, had submitted the following question to the Board in advance of the meeting: *The waiting times for cataract surgery at the Eye Unit at Royal Bournemouth Hospital are extremely long. Patients in other parts of the country are being referred by ophthalmologists to a private provider who offer patients treatment on the NHS within 6 weeks. I am aware of such a company in Poole who offer cataract surgery on the NHS so is it possible for the Board to give an assurance that this alternative service has been considered with a view to reducing waiting times for our patients.* Ruth Williamson confirmed that the Trust did use that service. There was some primary care direct access alternative to NHS providers to support the NHS cataract service. It was not suitable for all patients; the providers tended to select patients who did not have additional needs. For example, where patients required sedation or anaesthesia, they could not be dealt with in that community setting. The Trust had been undertaking some consistent work within the Getting It Right First Time team. The Trust was seeking to reduce the number of patients waiting by increasing productivity within its own operating lists. Diane Smelt, Public Governor, had submitted the following question to the Board in advance of the meeting: *Agenda item no 11.1 - contains a statement under the "fit and proper persons" provisions in paragraph B2.2, which states that both Directors and Governors receive a DBS check on appointment. Governors only have a standard DBS undertaken and not an enhanced one, but I am unsure which one is undertaken in relation to Non-Executive Directors. If Directors only have a standard DBS undertaken, I am wondering how this allows them to visit wards and talk to patients under the new arrangements?* *I understand that all Trust volunteers and staff, who are patient facing, are required to have an enhanced DBS and to comply with certain medical*

	standards prior to entering a ward in any official capacity, to talk to patients. This has caused problems in the past when Governors, who are not volunteers, have wanted to speak to patients on a ward or undertake surveys. A decision was therefore made some time ago that Governors who wanted to visit wards had to become volunteers and have an enhanced DBS and a medical screening. *In view of this, can an assurance be given that in order to keep our patients safe, this practice of having an enhanced DBS and a medical screening applies to all directors as well, as they become more active within our hospitals and visit wards.* Karen Allman explained that there were a variety of different levels in relation to DBS screening and wanted to confirm that in relation to medical screening this meant pre-employment medical, occupational health screening. This was conducted for everyone upon joining the organisation pre-employment. For Board members an enhanced DBS check took place. Rob Whiteman mentioned that two other questions had been received half an hour before the meeting from Keith Mitchell, Public Governor. The first of these was: *Governors have been advised to give the following answer when answering questions from members of the public about increased journey times to Bournemouth ED.* *'Impact on all three hospitals and journey times were modelled and showed an overall weighted increase of one minute travel time'* *What do you think the reaction to this answer will be from residents in Swanage, Corfe and Wareham?* Richard Renaut outlined that this had been through significant detail through judicial review as Keith Mitchell would be aware, with substantial information shared with both the public and elected representatives. He would liaise with Keith Mitchell separately about the specific wording and how it was used. The short takeaway was that having had both expert national independent review, there was a very strong case about the lives that would be saved as a result of the clinical services review, which had been through the courts. This was about positive change for everyone although there would be counterviews to that. The Trust could be quite confident about the ambulance service, local GPs and the national independent review panel supporting it. He would provide detailed information if needed. Adding to this, Rob Whiteman referenced the Trust's duty of candour and if there were research evidence that suggested the journeys may be marginally greater, then such information should be made available to the public. Keith Mitchell clarified that, in his opinion, it was definitely the correct thing to do. His point was more in relation to the approach to communication with the public. The second question received from Keith Mitchell, Public Governor was: *Hopefully everyone recognises the value of staff governors to the governing body. What action is being taken to fill the vacant positions and what action is being taken to support staff governors who have to miss meetings and events due to work pressures?* Rob Whiteman referred to him having been asked about this at the meeting of the Council of Governors. His view previously was that the Trust did not want to give time off for being a staff Governor because public Governors were volunteers and there should be parity. However, the number of people coming forward for staff Governor roles was less than the Trust would want. He and Siobhan Harrington would re-visit the support given to staff Governors both in terms of people carrying out the role and also having flexibility through interested individuals trying out the role on a taster basis to encourage more interest.

	Kani Trehorn, staff Governor raised that in the Patient Story, Naomi had referenced challenges with mental health staffing during bank holidays and enquired whether the Board would look into this. Paula Shobbrook responded that this had been reflected in the Trust's risk register; she and Mark Mould were working with directors from Dorset Healthcare regarding the staffing. From a nursing perspective, meetings were being set up between the Trust's and Dorset Healthcare's senior nurses to work through how to support more fully. Kani Trehorn raised a second question in relation to support provided to staff working on action plans from her experience at Poole hospital. Paula Shobbrook confirmed that the Executive Directors were working alongside teams to make sure that the action plans were supported as a team effort.
BoD 073/23	**Any Other Business** Rob Whiteman asked that the Board note that the meetings of the Board in January 2024 would commence at 9:00 for the Part 1 meeting and 11:15 for the Part 2 meeting. John Lelliott reported that there had been a very successful March for Men event on 25 April 2023, which was well attended by staff, governors and sponsors. Rob Whiteman thanked everyone for their contributions to the meeting. There was much to be proud of at the Trust. The staff were remarkable and it was a privilege to serve a wonderful community. The Trust needed to celebrate that which was good but not be defensive or complacent about the CQC judgments having highlighted areas for improvement. The Trust was working hard and progressing against those areas already, with more to do. The responsibility fell upon the Board to do this and Board members were sorry for the staff and for the public that some of the judgments had been difficult. The Board took responsibility to make sure that the staff and public received the services that were richly deserved.
BoD 074/23	**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 24 May 2023 at 13:15 via Microsoft Teams.

CHIEF EXECUTIVE'S REPORT
MAY 2023

As we have moved into May after exiting another round of industrial action, I would like to again express my thanks to all the staff and volunteers of UHD. Without fail our staff have expertly managed the demands of the recent strikes, ensuring the safety of our patients and staff through their commitment and support. Recognising that Team UHD has been through five waves of Covid-19 as well as unprecedented industrial action, demonstrates the resilience and strength of our UHD colleagues. I'd also like to encourage all our staff to access support around their well-being which will help them remain resilient through these challenges.

This May was historic, with the coronation of King Charles III and a well-deserved additional bank holiday for those lucky enough not to be rostered. Again, as we ensure that our patients are cared for, another thank you to those who worked during the Coronation bank holiday weekend.

Activity has remained high during April 2023 with 33,319 patients seen in our outpatients department and an additional 7,426 virtually. We carried out 1060 day-case procedures, supported the birth of 316 babies, attended 13,051 patients in ED, and started more than 197 patients on their radiotherapy journey. We also cared for 238 people at the end of their lives.

1 NATIONAL UPDATES

1.1 The Hewitt Review

The review was set up to consider review the oversight and governance of integrated care systems (ICSs). It covers ICSs and the NHS targets and priorities for which integrated care boards (ICBs) are accountable.

The review has identified six key principles, that will enable ICSs to create the context in which they can thrive and deliver. These are:

- collaboration within and between systems and national bodies;
- a limited number of shared priorities;
- allowing local leaders the space and time to lead;
- the right support, balancing freedom with accountability; and
- enabling access to timely, transparent and high-quality data.

It has also been recognised that the NHS operates more as a National Illness Service rather than National Health Service and despite best efforts Dorset, along with many ICSs, have to date not devoted the same amount of time, energy and money to the causes of poor health as to its treatment. This is recognised by the Dorset ICS and underpins the five Year Joint Forward Plan objectives.

1.2 NHS England, NHS Digital and Health Education England Merger

On 28 March 2023 NHS England adopted responsibility for all the activities previously undertaken by Health Education England and NHS Digital. This includes ensuring that the healthcare workforce has the right numbers, skills, values and behaviours to support the delivery of excellent healthcare and health improvement to patients and the public. It also includes running the national IT systems which support health and social care,

and the collection, analysis, publication and dissemination of data generated by health and social care services to improve outcomes for patients.

NHS England will now change the way it works and how support for local systems and providers is provided. The changes link in with the Hewitt Review findings where space must be created to allow systems to lead locally. A new NHS England operating framework identifies the new ways of working and is available here.

1.3 Covid Pandemic

On 5 May 2023 the World Health Organisation announced that Covid-19 is no longer a global health emergency. However, the WHO has been careful to state that the virus will remain active and will still be changing and ultimately causing deaths. New variants are also expected with potential for new surges in cases and deaths. Whilst this announcement is undoubtedly good news, our current approach within the NHS remains the same. Our thoughts are with staff and families who have lost loved ones over the last three years.

1.4 Delivery Plan for Recovering Access to Primary Care

On 9 May 2023 the Delivery Plan for recovering access to primary care, which outlines the commitment to tackle the 8am rush in General Practice by making it simpler and easier to get help. The plan includes:

- Empower patients to manage their own health including the NHS App, self-referral pathways and increased services available through community pharmacies;
- Implement Modern General Practice Access to tackle the 8am rush, provide rapid assessment and avoiding asking patients to call back to make appointments;
- Build capacity through additional staff and flexibility in staff types;
- Cut bureaucracy and reduce workload between primary secondary care.

There are implications for UHD within the plan, including secondary care providing onward referrals, provision of fit notes, call/recall systems and clear points of contact.

1.5 NHS @ 75

On 5 July 2023, the NHS will turn 75 years old. This significant milestone is an opportunity to reflect on the past and look ahead to the future. The NHS Assembly is now drawing together collective insights on the NHS today, taking stock of recent lessons and highlighting future opportunities and challenges.

Patients, carers, staff, and the wider health and care community are being asked to share their thoughts, which will be shared with NHS England ahead of the 75th Birthday. At UHD we will be asking staff for their insights to feed into the process.

Further information is included in a blog, written by Co-Chairs of the NHS Assembly, Professor Sir Chris Ham and Professor Dame Clare Gerada here.

The deadline for comments is Friday 26 May 2023.

2 WITHIN DORSET

2.1 Actions following the ICP Strategy

Jenni Douglas-Todd and Patricia Miller gave a presentation at the Trust's Board Development Session on the ICS Strategy and how the Trust could support delivery;

In addition, the Trust held its inaugural meeting of its new Population Health and System Committee.

2.2 Dorset Provider Collaborative

The Dorset Provider Collaborative held a virtual workshop to review terms of reference and the workplan for the year ahead. There was a clear commitment to prioritise a number of areas to deliver improvements for patients and providers in year this year. A more detailed report will be bought to a future Trust Board meeting. I will be chairing the Provider Collaborative Board this year on behalf of the providers in Dorset.

2.3 ICS People Plan

The ICS People Plan was presented to the NHS Dorset ICB and aims to support the five ICS transformation priorities and provide solutions to current pressure in the health and care system. The people plan covers the health, care and voluntary community sector (VCS) workforce and aims to provide the right people in the right place at the right time.

This is a development from the 2017-2022 plan and now includes the core purpose of ICBs to improve outcomes in population health, tackle health inequalities, increase productivity, value for money and support broader economic and social development.

Following ICB Board approval an implementation plan with timescales will be developed collaboratively and the proposed system people operating model will be refined.

3 PERFORMANCE

All staff at UHD have continued to work to ensure our patients are kept safe during a very busy period, including both Easter bank holidays and several periods of industrial action.

3.1 Urgent & Emergency Care and Flow

UHD has reported against the national pilot UEC standards since 2019, however from this month we will return to reporting against the organisation 4-hour safety standard. We launched the 4-hour safety standard campaign with our communications team earlier in the year to ensure all staff are aware of this change and that they have an important part to play in delivering the 4-hour standard.

March and April 2023 remained very busy with long waits in our Emergency Departments for beds. Pressure on our Emergency Pathways has meant that UHD has remained at OPEL 4 frequently during the first part of the year. We have worked closely with the whole health and care system across Dorset, focussing on discharge and admission avoidance to alleviate the pressures within the emergency departments. We cancelled some elective operations in April-May in response to both industrial action and bed pressures. We are working hard to reschedule any patients who were impacted by these cancellations and have continued to keep opened additional capacity across the trust.

We are working with system partners to reduce the number of patients in UHD beds that are waiting for discharge. With Dorset ICB we have reinstated the local Discharge to Assess model (D2A) which enables patients to leave hospital for care assessments rather than remain in hospital, this has begun to reduce the number of patients medically fit in hospital. The number of commissioned beds outside of hospital currently supporting this model has been increased to 36.

Internally, we have run a Multi-Agency Discharge Event (MADE) during the last week of April and first week of May. This focused on c90 patients on our Complex Care Wards and has seen significant changes to complex plans and increased discharge rates. Analysis of the actions and building them into current workflow and escalation processes is taking place.

A reduction in the number of patients in beds who no longer require the level of medical care the hospital provides, has contributed to reducing bed pressures, crowding in the emergency departments and overall bed occupancy.

The Trust delivered a further reduction in ambulance handover delays in April with 17% of ambulances waiting for more than 60 minutes; this is a fall of 3%. The average handover time also fell at both Bournemouth and Poole.

3.2 Elective and Cancer Care

As mentioned in the previous update, we reached a key milestone in February to have no patients on the waiting list who have been waiting over 2 years for treatment, other than where the patient has chosen to wait – this has been maintained. Our ability to maintain progress on eliminating waits over a year and a half has been impacted by a 4-day period of industrial action in April (Junior Doctors).

A total of 1,958 cancellations were made, including:

• 65 inpatients (of which, 15 are P1/P2)

• 244 day cases

• 1,649 outpatient appointments

Rescheduling cancelled patients affected the capacity for routine elective patients to be booked in during the months of April and May, including long waiters. The number of patients waiting over a year and a half subsequently increased to 112 at the end of April compared to 96 at the end of March. Teams are focused on minimising these waits by the end of June 2023, alongside actions to eliminate 65 week waits by March 2024.

May sees the new Barn Theatres opening at Poole with the first patient scheduled on 30 May 2023. The barn theatre complex will increase our access to laminar flow theatres and increase the Trust's flexibility to list trauma cases across all its theatre capacity.

We are maintaining our position as the best performing Trust in the South West for diagnostics and the Community Diagnostics Centre (CDC) programme within the ICB continues to gather momentum.

We continue to make progress on delivery of cancer improvements and March's published national performance confirmed that UHD met the Faster Diagnosis standard which is the time from referral to diagnosis and the standard is 28 days. The last time the Trust met this standard was August 2021. Performance against the 62-day standard,

time to treatment, also increased to 65.4% (Target 85%) and the Trust continues to perform above the national average.

4 ACCOUNTABILITY FRAMEWORK

Within the papers you will find our refreshed and strengthened accountability framework and internal governance map. We continue to refine and will continuously improve our governance and will be seeking additional assurance from external colleagues on our work so far.

5 FINANCE

Operational pressures continued through April, exacerbated by the period of Industrial Action, placing significant pressure on staffing budgets. In addition, energy inflation continued to run higher than the national planning assumptions used to inform the budget. Collectively, these factors contributed to an adverse variance of £0.9 million during April.

The targeted financial savings of £1.3 million were fully achieved during April. To date; full year financial savings of £14.5 million have been identified against a target of £33.3 million. Identifying and developing further savings plans to mitigate this shortfall is the immediate 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 April, the Trust has committed capital expenditure of £5.3 million against a plan of £16.6 million representing an underspend of £11.3 million reflecting the phasing of actual expenditure.

The Trust is working with partners within the Dorset ICS to refresh its medium-term financial strategy.

6 PATIENT FIRST

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

Phase 1 was completed at the end of January 2023 and the Readiness Assessment report shared with our senior leadership team in February 2023. This feedback, combined with our recent national staff survey results are now influencing the development of our Trust vision and objectives (True North) based on the Patient First approach and more specifically, Phase 2: Strategy Development. As a result, five key strategic themes have been agreed:

- Patient Experience
- Quality [Outcomes and Safety]
- Our People
- Sustainable Services
- Systems and Partnerships

These will guide where we apply our continuous improvement effort at UHD.

In June 2023 we will start our training programme Patient First for Leaders, to ensure all our senior leadership team and their direct reports [circa 150 staff] have the right improvement tools and coaching skills to support our frontline teams. We will then confirm our roadmap for further cascade to all managers and supervisors who have line management responsibilities for staff.

We are continuing a 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'm really encouraged by the feedback so far and the ideas we are sharing together at these events. This month, we are also visiting Maidstone and Tunbridge Wells NHS Trust, an exemplar organisation who have adopted a similar approach within the NHS.

7 WORKFORCE

The Royal College of Nursing (RCN) took official strike action from 8pm Sunday 30 April to 11.59pm on Bank Holiday Monday 1 May 2023. A total of 36 staff took strike action across UHD on Sunday 30 April, and 83 on 1 May. The BMA (British Medical Association) have also given notice of a ballot from the 15 May to the 27 June for consultant medical staff regarding the pay award for 2023/24.

A decision has been taken by the NHS Staff Council to accept the pay offer made by the government to Agenda for Change staff in England. The additional payments for the previous pay year (2022/23) will be paid as a non-consolidated lump sum, and the new salary rates for this year (2023/24) will take effect from 1 April 2023. Talks are taking place between trades unions and the government to try to avert further industrial action.

We have seen a reduction in the turnover rate across the Trust over the last few months and the joining rate is consistently higher which is pleasing. The rolling 12-month turnover had dropped to 13.8 % and the sickness rate has dropped to 5.76%. The mandatory training has also improved to 87.98% and it is good to see this performance improvement in our metrics.

7.1 Staff Monthly Excellence Awards

We continue to receive nominations for our monthly awards the following staff were awarded their gold pins for excellence following nominations by staff, patients and volunteers:

- The Infection Prevention and Control Team;
- Dr Robert Sawdy, Obstetrics & Gynaecology;

- Evan Bano, Thomas Garcia, Ramsey Aguilar, Marlon Caoiol, Domestic Services Team, Emergency Department, Royal Bournemouth Hospital

8 TRANSFORMING OUR BUILDINGS

Our preparation for integrating and reconfiguring our services across our three sites is progressing strongly. Highlights include:

- The stroke and cardiac pathway changes have been made, where services have moved to one site and are now providing faster access and saving lives;
- Poole theatres for trauma surgery are opening from June 2023;
- The Topping Out Ceremony of the BEACH building at the Royal Bournemouth Hospital site will take place on 19 May 2023;
- We have received approval for the enabling schemes for 2023-24 of the New Hospital Programme (NHP);
- Approval of the road link to the Wessex Way A338 at the Royal Bournemouth Hospital;
- Supporting teams coming together as part of the preparations for the planned and emergency hospitals.

9 INTEGRATED CARE BOARD (ICB)

I attended the ICB meeting which took place on 2 March 2023. The approved minutes of the meeting are attached.

Minutes of the meeting of the ICB Board – Part 1 - Public
of NHS Dorset
Thursday 2 March 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)	ICB Non-Executive Member
	Philip Broadhead (PB)	Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East) (nominated deputy for Drew Mellor)
	Cecilia Bufton (CB)	ICB Non-Executive Member
	Jonathon Carr-Brown (JCB) (virtual)	ICB Non-Executive Member
	Dawn Dawson (DD)	Acting Chief Executive Dorset Healthcare NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West)
	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)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Graham Farrant (GF)	Chief Executive, Bournemouth, Christchurch and Poole Council
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Leesa Harwood (LH)	ICB Associate Non-Executive Member
	Nick Johnson (NJ) (virtual)	Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust
	Karen Loftus (KL) (virtual)	Chief Executive, Community Action Need
	Matt Prosser (MP)	Chief Executive, Dorset Council
	Ben Sharland (BS) (virtual)	Primary Care Participant
	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:		
	Lucy Compiani (LC) (for ICBB23/046)	Practice Educator
	Liz Beardsall (LBe) (minutes)	ICB Company Secretary
	Cara Southgate (CS) (for item ICBB23/053)	Acting Chief Nursing Officer, Dorset Healthcare NHS Foundation Trust

	Sarah Tilbury (ST) (for item ICBB23/046)	Head of Workforce Expansion and Professional Development
	Natalie Violet (NV)	Business Manager to the ICB Chief Executive
Observing:		
	Jane Ellis	Programme and Project Specialist, NHS Dorset
Public:		
	2 members of the public in attendance Plus members of the public via Livestream	
Apologies:		
	Sam Crowe (SC)	Director of Public Health Dorset (participant)
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Manish Tayal (MT)	Interim Non-Executive Member

ICBB23/042 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from Sam Crowe, Siobhan Harrington and Manish Tayal. The Chair welcomed Cllr Phil Broadhead, the new Leader of Bournemouth, Christchurch and Poole Council (BCP), to the meeting.

ICBB23/043 Conflicts of Interest

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

ICBB23/044 Minutes of the Part One Meeting held on 5 January 2023

The minutes of the Part One meeting held on 5 January 2023 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 5 January 2023 were approved.

ICBB23/045 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.

ICBB23/046 Staff Story: Lucy Compiani – Nursing Times Practice Educator of the Year

The ICB Chief People Officer introduced the Staff Story, and welcomed Lucy Compiani and Sarah Tilbury to the meeting. Lucy was recently awarded Practice Educator of the Year by the Nursing Times for her work in clinical placement expansion for nursing in primary care.

The Board watched a video regarding Lucy's work, including how expanding clinical placement work in primary and social care enhances an individual's skills and understanding of services, provides an entry route into primary and

social care nursing, and improves workforce retention. The video included positive feedback from a practice manager and a student who had benefitted from Lucy's work as a practice educator.

The Board thanked Lucy for her interesting presentation and congratulated Lucy on her award.

The Board noted the challenges to supporting learners including culture, physical aspects including estate and support for learners due to limited GP capacity. Areas of greatest need, promotion of health and care careers, on-boarding of staff and retention by providing a positive learner experience, and supporting individuals during transition and in the early years were discussed.

There was a need to continue to build on the existing collaborative working in this area, but it was important that expansion was not to the detriment of quality of the student experience. There was a real opportunity to promote placements, such as creating videos with apprentices to showcase the programme to young people.

The Board thanked Lucy and Sarah for their work and their presentation.

ICBB23/047 Chief Executive Officer's Report

The ICB Chief Executive Officer (ICB-CEO) introduced the previously circulated CEO's Report, which was taken as read. Key items were:

- £150 million of increased funding for mental health services
- Increasing concerns about an escalation of industrial action, noting the good work by NHS organisations in manging strike days to date
- NHS England (NHSE) had published the delivery plan for recovering urgent and emergency care services
- PWC working with the system on Place development with a view to running a shadow format from October
- The Hewitt Review was coming to its conclusion with the aim of publishing the report on 15 March
- From July NHS Dorset will take on the role of lead commissioner for the region for ambulance commissioning. There had been good improvements in performance over the last few weeks and SWAST were being supported to make further improvements.

The Board discussed the need to consider the cumulative effect of industrial action, and the challenges this would present to performance and the transformation agenda. Delivery of the NHS planning guidance and the ICP strategy, and the ongoing work around transformation plans were also discussed.

The Board welcomed the move to use the Executives and Deputies Meeting as the main operational decision-making forum for the ICB.

The Chair thanked the ICB-CEO for her report.

PM left the meeting.

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

<u>Items for Decision</u>

ICBB23/048 There were no items for decision.

Items for Noting/Assurance/Discussion

ICBB23/049 Quality Report

The ICB Chief Nursing Officer (ICB-CNO) introduced the previously circulated Quality Report, which had been discussed in detail at the February Quality and Safety Committee (QSC). The main issues included:

- Challenges around the Urgent and Emergency Care (UEC) Pathway and patient flow. Support was being provided to the wider system and, following visits to the providers, a new streamlined discharge pathway was planned for implementation on 1 April
- Work was still ongoing on Initial Health Assessment (IHA) performance
- An update was provided on Oliver McGowan Learning Disability and Autism Training
- Good progress was being made in meeting the NHS patient safety strategy
- The ICB was compliant with the Chief Nursing Information Officer (CNIO) requirements, and a Dorset network of CNIO's had been established
- Feedback from Dorset System Quality Group to QSC included the UEC pathway, workforce, system beds, and refugee hotels
- Dorset County Hospital were the only Trust nationally to be ranked 'Much Better Than Expected' in the 2022 national maternity survey recently published by the Care Quality Commission.

The Board discussed the markers for measuring the success of the revised UEC pathway, and workforce and bed capacity in the system. The robust serious incident framework was noted.

Jonathon Carr-Brown joined the meeting

It was highlighted that the VTE Risk Assessment data in the Quality Report was dated 2022. The ICB-CNO offered to check if this date was correct and if so, why was the reporting a year in arrears.

ACTION: DSi

The Board discussed the revised UEC pathway, noting the importance of not inadvertently increasing pressure on primary care. The revised pathway should reduce the complexity of the discharge process and enable the system to better understand the issues within the pathway. The process can then be re-evaluated over time. It was noted that there were similar issues that needed addressing in mental health services and similar visits to those undertaken to Dorset County Hospital (DCH) and University Hospitals Dorset (UDH) would be carried out at Dorset HealthCare (DHC).

Louise Bate left the meeting

Resolved: the Board noted the Quality Report.

ICBB23/050 Performance Report

The ICB Chief Operating Officer (ICB-COO) introduced the previously circulated Performance Report. The main issues included:

- There were zero 104 week waiters predicted for the end of March, and the Board thanked the providers for their hard work on achieving this
- The number of patients waiting more than 78 weeks at University Hospitals Dorset (UHD) was forecast to be 123 across four specialties at 31 March 2023. These were due to capacity issues and the Trust was working towards reducing this figure. Dorset County Hospital (DCH) were reporting zero patients waiting at the end of March 2023
- In diagnostics, activity recovery was generally good but challenges remained in endoscopy, echo cardiography and audiology
- No Criteria To Reside patients, which had been as low as 300 and as high as 360, were now at 340. Focused work from October had managed to stem the increase but there was not yet a sustained reduction
- Category 2 mean ambulance response times had not been compliant with the target of 18 minutes since May 2021.

The Board discussed the changes which were required to current information technology systems to support Patient Initiated Follow Ups, the issues underlying ambulance response times and how these could be addressed, and the potential impact of planned industrial action on performance.

The Chair thanked the ICB-COO for his report.

Resolved: the Board noted the Performance Report.

ICBB23/051 Finance Report

The ICB Chief Finance Officer (ICB-CFO) introduced the previously circulated Finance Report regarding the financial position of both the ICB and ICS NHS providers as at December 2022 (Month 9), and provided a verbal update on the current financial position in month 12.

The Board had previously reconfirmed the plan to deliver a breakeven position for year end, and the ICB and NHS providers remained confident that this would be achieved. However it had required £60 million of non-recurrent money for Dorset's breakeven position to be reached. It was noted that 14 of 42 ICBS would not reach a breakeven position this year. The plan for the coming financial year would be discussed in the Part Two Board meeting.

The Chair thanked the finance team and the provider CFOs for their hard work in reaching a breakeven position for the financial year.

The Board questioned the pressure of agency spend, noting that Dorset County Hospital and Dorset HealthCare were holding a relatively flat position. It was noted that the system was in a good position to meet the planning guidance on agency spend, however the system continued to work on reducing agency costs.

The Board discussed the impact of industrial action on activity and finance. It was noted that the costs relating to the junior doctors' strike was not yet quantifiable but the priority remained safe coverage. The need to understand the triangulated impact of industrial action, in relation to activity, quality and

finances was discussed. The Board requested an update on the financial impact of the industrial action at the next meeting.

ACTION: RM

Resolved: the Board noted the Finance Report.

ICBB23/052 NHS Dorset ICB Operating Model

The ICB Chief Operating Officer introduced the NHS Dorset ICB Operating Model. The model had been co-designed with the ICB workforce. The model set out 'how we work'. The model was built on the system values, relevant legislation, the four ICB aims, and the national context set by the NHS operating model. The model set out the role of the ICB in the system context, what the ICB planned to achieve and how it planned to achieve this, and the governance and decision-making mechanisms. The model would evolve over time and would be underpinned by an implementation pack for the teams. The next step was to design an operating model for the system.

The Board welcomed the Operating Model, noting that it was concise and clear. The Board raised the following in relation to the model:

- Transformation and how this fits into the model
- Consideration of what services could be outsourced or shared
- Supporting decision making in the short term which serves the long term, mechanisms for working and decision making across units, and the importance of reserving matters for decision where appropriate
- The need for better integration of the slide regarding those groups sitting under the System Executive Group, but noting that this would segway into the System Operating Model and that this structure would be refined once the Operating Plan and priorities were in place
- The need to bring the Provider Collaboratives and Place into the decision-making structure, noting that the ICB Board would need to work through where these sit after the development phase
- The importance of Quality Impact Assessments and Equality Impact Assessments in decision-making.

PM rejoined the meeting

Resolved: the Board endorsed the Operating Model.

ICBB23/053 Quality and Safety of Mental Health Inpatient Services

Cara Southgate Acting Chief Nursing Officer, Dorset Healthcare NHS Foundation Trust (DHC) joined the meeting to introduce the previously circulated report on the Quality and Safety of Mental Health Inpatient Services. At the Board's request, the report provided an update on the previous report which detailed DHC's response to the letter from Claire Murdoch, National Director Mental Health.

The paper outlined the key actions in relation to all workstreams, including safeguarding of care, Freedom to Speak Up arrangements, Advocacy provision, workforce, culture and leadership, hearing and acting on the patient voice, including lived experience peers and restrictive interventions.

The next steps were completing the actions identified within timeframes set out in the action plan and providing evidence and assurance that actions had been embedded into practice.

The Board thanked the Acting Chief Nursing Officer DHC for the report which provided the Board with assurance regarding the actions. The Acting Chief Executive Officer DHC confirmed that progress would be monitored through DHC's governance processes.

The ICB Chief Nursing Officer noted that the report offered assurance on those patients in NHS facilities. She offered to liaise with the ICB Chief Commissioning Officer to consider how similar assurance could be provided to the Quality and Safety Committee regarding adults and young people in external placements.

ACTION: DSi and DF

The Chair thanked the Acting Chief Nursing Officer DHC and Acting Chief Executive Officer DHC for the report.

Resolved: the Board noted the report on the Quality and Safety of Mental Health Inpatient Services.

ICBB23/054 Eating Disorder Service Update

The Acting Chief Executive DHC introduced the Eating Disorder Service Update which was requested by the Board following the Quality Report at the January meeting. The report provided background for the current waiting times for patients to access the Dorset All Age Eating Disorder Service (DAEDS), with a particular focus on Children and Young People (CYP) and the recovery plan being implemented to resolve the current issues and achieve national and local referral to treatment (RTT) targets.

The COVID pandemic had a significant impact on mental health, especially for young people, as evidence in the recently published National Audit Office report. There was a surge in demand for the service following the pandemic (para 2.4). There was a recovery trajectory in place. Recovery was being managed by active management of the waiting list, partnership working with the voluntary sector, and two-year non-recurrent funding from NHS Dorset to support the recruitment of a number of fixed term posts to recover the service position, clear the waiting list and achieve the RTT metrics. A new purpose-built inpatient and day patient unit for Adult Eating Disorders was due for completion in February 2023.

Dean Spencer left the meeting

The Board discussed the use of transformation work in getting 'upstream' of the current issues and the need to accelerate the speed of change, the need to consider the role of prevention in relation to eating disorders, the issues underpinning retention challenges, the proposed new children's psychiatric unit, the role of voluntary sector in providing a first line of response, the need for consideration to the given to the support and signposting available for those whose referrals were rejected by the service. It was noted that this linked into the work that would be reported on in the next paper on children and young People mental health services.

Nick Johnson and John Beswick left the meeting

Resolved: the Board noted the Eating Disorder Service Update.

ICBB23/055 Children and Young People (CYP) Mental Health Services Update

The ICB Chief Commissioning Officer introduced the update on Children and Young People (CYP) Mental Health Services.

Louise Bate rejoined the meeting

Mark Harris joined the meeting and spoke to the previously circulated presentation which covered the current challenges across the local Child and Adolescent Mental Health Services (CAMHS) offer, the immediate actions to address challenges and an overview of the joint health and social care transformation programme for children and young people's mental health. The transformation project would be led jointly across both Places, using the Thrive framework and focused on 'no wrong door' and co-production. The implementation date for the project was March 2024, but the presentation outlined the other initiatives and projects which were underway or would be put in place prior to this date.

The Board welcomed the direction of travel, noting the Clinical Commissioning Committee's endorsement of the plan and the ICB Chief Commissioning Officer's confidence that the programme would deliver change. The Board discussed:

- the pace of change and whether this could be increased
- the need for a focus on prevention and resilience, noting the work that was already underway with schools, and the links to work in the adult sector on family support and expansion of perinatal mental health services.
- the need for cultural development work to wrap around the programme, the impact this would have on the successful delivery of the programme and the important of taking the time to embed this cultural change
- the importance of noting the range of conditions encompassed by mental health and the need to consider the impact of wider determinants and not to over-medicalise
- the challenges being created by ADHD/ASD assessments of children undertaken by private providers, noting that there was a separate workstream underway regarding assessment and treatment, with a focus on access to support without a diagnosis.

Ben Sharland and Paul Johnson left the meeting

Resolved: the Board noted the Children and Young People (CYP) Mental Health Services Update.

Items for Consent

There were no items for consent.

ICBB23/056 Questions from the Public

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

ICBB23/057 Any Other Business

Cllr Phil Broadhead, Leader BCP Council, raised the issue of collective use of assets and the possibility of using government grants available to local authorities to support investment for partners. It was noted that the ICB Chief Finance Officer (CFO) would lead on the next stage of the estates and capital plan. Use of capital across the system was not a current workstream but the ICB-CFO would work with local authority colleagues to develop this.

The Board welcomed Matt Prosser's, CEO Dorset Council, report that the first housing round-table had taken place and he would bring updates back to the ICB Board as appropriate.

ICBB23/058 Key Messages from the Meeting

The Chair summarised the key messages from the meeting as:

- The value that clinical placements add, and the importance of continuing to support these, using mechanisms such as long-arm supervision.
- The need for information to underpin important discussions e.g. No Criteria To Reside, and the workforce enablers for each report
- The Board noted the impact of COVID on mental health, welcomed the assurance provided on local services and welcomed the programme of work on Children and Young People's services. The Board expressed a commitment to deliver on these services and to deliver thriving communities.

ICBB23/059 Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 4 May 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

ICBB23/060 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:

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

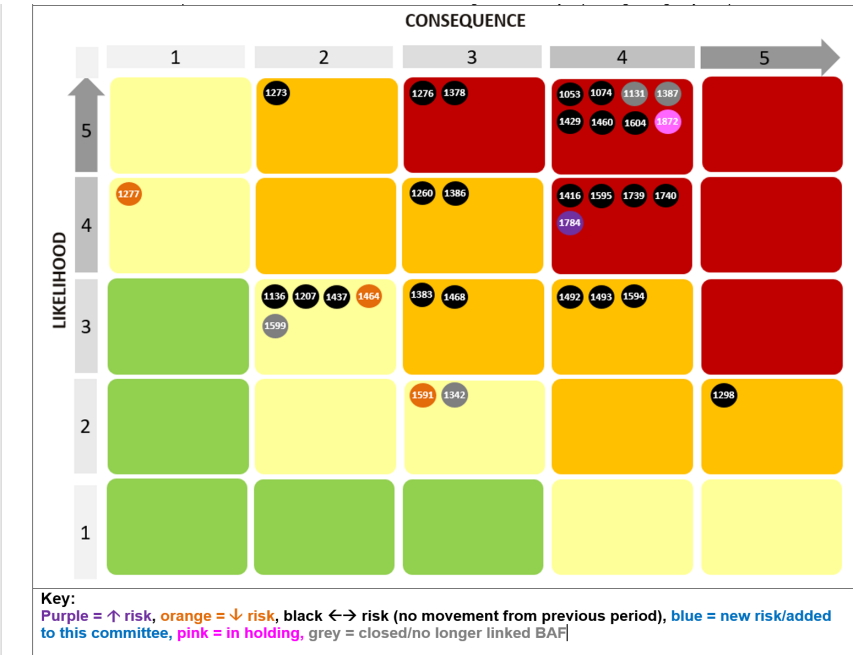
Meeting Date: 24 May 2023

Agenda item: 6.1

Subject:	Q4 Board Assurance Framework
Prepared by:	Jo Sims, Associate Director Quality Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic Objectives that this item supports/impacts:	Continually improve quality ☐ Be a great place to work ☐ Use resources efficiently ☐ Be a well led and effective partner ☒ Transform and improve ☐
BAF/Corporate Risk Register: (if applicable)	All
Purpose of paper:	Assurance
Executive Summary:	The 2022/23 BAF for the Trust is linked to the Board Objectives agreed at the Board of Directors meeting in May 2022. In accordance with the Trust's Risk Management Strategy the Board Assurance Framework for the Trust will be reviewed quarterly at the Audit Committee. The Q4 report (1 January 23 – 31 March 2023) provides full details of the risks linked to the Board objectives. The table below provides a Q4 summary:

	Q1	Q2	Q3	Q4	Refs:
New BAF Risks added in Quarter	3	0	1	0	
BAF Risks rated 12-25 in Quarter	20	21	22	13	
BAF risks increased in Quarter		2	0	0	
Downgraded BAF Risks in Quarter	1	3	1	3	1277,1464,1342
Closed BAF Risks in Quarter	5	4	3	6	1599,1131,1387,1740,1739,1342

	Q4 Heat Map:  Work is currently underway to review the process for agreement and monitoring of the Board objectives, associated KPI and BAF for 23/24. (See separate paper)
Background:	The Board Assurance Framework is a systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.
Key Recommendations:	To note for information.
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	16/05/2023	Meeting not yet taken place at the time of submission of this report.
Audit Committee	18/05/2023	Meeting not yet 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 Annual Objectives 2022-23
Summary - Quarter 4

Objectives 2022/23

1 To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience

2 To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best

3 To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets

4 To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people

5 To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community

Ref	Specific Objective	BAF Risk Executive Lead	Risk Ref.	Risk Title	Risk Lead	Qtr 1 Rating	Qtr 2 Rating	Qtr 3 Rating	Qtr 4 Rating	Consequence	Likelihood	Rating	Movement	Last Update	Monitoring Group	Target risk rating
1.1	To deliver wide range of Patient Safety Quality Priorities, using a quality improvement (QI) approach:	Chief Strategy & Transformation Officer	1600	If we do not deliver the Trust's QI and Innovation Strategy there is a risk that the Trust will not improve outcomes or deliver efficiencies in line with the Trust's values of being an improving organisation	Betts, Alan - Deputy Director of Transformation	⇩ Closed from RR 4								[05/05/2022] QI priorities agreed for 2022/23 at TMG - ongoing delivery of QI strategy with no new risks identified. **RISK CLOSED**	Transformation Committee	0
1.1.1	Deliver quality priority - **managing the deteriorating patient**	Chief Medical Officer	1605	Managing the deteriorating patient - if the Trust is unable to develop a unified policy and process for the monitoring, escalation and management of a deteriorating patient then there is a risk to patient safety and patient outcomes.	Williamson, Ruth - Acting Chief Medical Officer	9	⇩ Closed							[04/05/2022] Good progress on a number of workstreams with DIVA project, IV fluids and TEP management now live. Communication with ITU imminent and 2222 calls will go live in August when new doctors hand over Work continues on safe medical staffing model	Quality Committee Quality Governance Group	
1.1.2	Deliver quality priority - **standardised safety checklists**	Chief Medical Officer	1599	If unable to embed culture for use of safety checklist process for all interventional procedures undertaken across UHD then risk of never events occuring with potential harm to patients and regulatory action from CQC. Risk that variable application across UHD and lack of standardisation across sites for same specialities, including staff training, will impact on compliance and culture .	Williamson, Ruth - Acting Chief Medical Officer	9	9	9	⇩ Closed				⇩ Closed	31/3/23 **Closed by acting CMO**. There were no never events between August 2022 and march 2023. The never event in march 2023 (retained swab) was identified before the patient left theatres as part of the final swab count. Immediate remediation was possible. The final post procedure check mitigated the human error in the pre closure swab count.	Quality Committee Quality Governance Group	
1.1.3	Deliver quality priority for 2022/23 - **acute kidney injury/dialysis management**	Chief Medical Officer														
1.1.4	Deliver quality priority for 2022/23 - **blood glucose management**	Chief Medical Officer														
1.1.5	Deliver quality priority for 2022/23 - **the deteriorating patient in ED**	Chief Medical Officer	1605	Managing the deteriorating patient - if the Trust is unable to develop a unified policy and process for the monitoring, escalation and management of a deteriorating patient then there is a risk to patient safety and patient outcomes.	O'Donnell, Alyson - Chief Medical Officer	9	⇩ Closed							[08/08/2022] This risk has been closed as reaching target grading (in line with policy). Policy and QI group established. RISK CLOSED	Quality Committee Quality Governance Group	0
1.1.6	Deliver quality priority for 2022/23 - medical/pharmacy communication	Chief Medical Officer														
1.1.7	Improve against **Stroke pathway quality standards**	Chief Operating Officer	1468	Stroke Outreach Team Staffing. If there not an appropriate uplift to the staffing profile for UHD Stroke Outreach Team then there is a risk to patient safety	Gower, Morwenna - Stroke Service Manager	9	9	9	9	3	3	Moderate	⇔		Stroke Governance Group	2
1.1.8	Improve against **Trauma pathway quality standards**	Chief Operating Officer	1277	Risk that Trauma Patients on non-trauma wards receive a reduce level of specialist input due to lack of trauma nursing, therapy and dedicated medical cover. Increased impact on ED performance standards due to lack of Trauma Capacity.	West, John - General Manager, Trauma and Orthopaedics	9	9	9	3	3	1	V Low	⇩	[31/2/23] Risk to very low now because of the good work that has been undertaken within our directorate at pulling patients off of outlier wards in a timely matter. The awareness by the teams knowing that we have patients in other directorates has also played a a positive role.	Trauma and Orthopaedics Governance Group	3
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	1136	High level of qualified staff vacancies (24.6%) across the trauma wards, leading to risk to the quality of care to patients. Inability for the nursing bank office to provide substantive replacement staff for each vacant shift resulting in agency usage impacting available skill mix. ward nursing staff report increased workload and delays in care delivery.	West, John - General Manager, Trauma and Orthopaedics	6	6	6	6	2	3	Low	⇔	31/3/23 outlier numbers reduced but risk remains unchanged	Trauma and Orthopaedics Governance Group	3
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	1439	Risk that lack of capacity to admit routine Orthopaedic Patients for their surgery creates inability to maintain or recover RTT position. This may lead to more complaints around compromising wellbeing of patients attributable to deteriorating access and waiting times. Operations may be cancelled when unable to maintain ringfenced bed base to meet GIRFT requirements.	West, John - General Manager, Trauma and Orthopaedics	10	6	⇩ **Closed**					⇩ **Closed**	[28/10/2022] risk has achieved target grading and has been closed	Trauma and Orthopaedics Governance Group	0
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients - Risk of failure to achieve the NHFD standard that no more than 15% of patients have to wait longer than 36hrs post admission to undergo their surgery following a #NoF. Evidence shows that if patients wait more than 36hrs post injury for a #NoF they will have a worse outcome and longer recovery.	West, John - General Manager, Trauma and Orthopaedics	15	15	15	15	3	5	High	⇔	[31/3/23] updated action plan, improved performance (>50%) No change to risk.	Trauma and Orthopaedics Governance Group	2

Ref	Specific Objective	BAF Risk Executive Lead	Risk Ref.	Risk Title	Risk Lead	Qtr 1 Rating	Qtr 2 Rating	Qtr 3 Rating	Qtr 4 Rating	Consequence	Likelihood	Rating	Movement	Last Update	Monitoring Group	Target risk rating
1.1.8	Improve against Trauma pathway quality standards	Chief Operating Officer	1207	T&O Medical Staffing Shortage at Junior and Middle Grade Level	West, John - General Manager, Trauma and Orthopaedics	9	6	6	6	2	3	Low	⇔	[31/3/23] no change to risk rating	Trauma and Orthopaedics Governance Group	2
1.2	**Improve the safety and experience of emergency patients and their flow**, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partner and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer	1131	Current challenges around patient flow and capacity due to increased demand, delays in external discharge and bed closures have become increasing difficult to manage and presents risk to patient safety	Sophie Jordan - Associate Director - Operations, Flow and Facilities	20	20	20	0	0	0	0	**Closed**	[31/3/23] Risk superseded by 1872 which incorporates both 1387 and 1131. Risk closed.	Finance and Performance Committee	
1.2	Improve the safety and experience of emergency patients and their flow, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partner and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer	1387	Demand & Capacity: Demand will exceed capacity for acute inpatient beds	Sophie Jordan - Associate Director - Operations, Flow and Facilities	20	20	20	0	0	0	0	**Closed**	[31/3/23] Risk superseded by 1872 which incorporates both 1387 and 1131. Risk closed.	Finance and Performance Committee	
1.2	Improve the safety and experience of emergency patients and their flow, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partner and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer	1053	Lack of capacity for elective & non elective activity and risk to patient harm due to LLOS and NRTR patients	Jones, Jackie - Associate Director Partnership Integration and Discharge	20	20	20	20	4	5	High	⇔	Some improvement in P1-3 discharges, successful ICB Community Hospital MADE event and commencement of D2A model/bed capacity saw some improvement in our NC2R delays. However, this remains variable and the outputs of change actions are yet to be evidenced sustainably, therefore, the risk score currently remains at 20. This will be closely reviewed as April/May sees a significant focus on the following: new Chief Medical Officer priority, UHD MADE event focusing on LLOS, Estimated Date of Readiness rollout supported by medical and clinical team engagement, continued development of D2A model, continued work to improve Health of the Ward data capture/reporting to support focus on opportunities for improvement. Note, shadow monitoring is in place following changes to HotW to identify any impact. [31/3/ 23] Discussed at Quality Committee and risk score of 20 approved. Noted that also supports the CQC 'Must' actions (Medical Care Group).	Finance and Performance Committee	6
1.2.1	Also **improve the responsiveness and quality of Urgent and Emergency Care (UEC) as measured by a reduction in 12 hour waits in ED** towards zero, minimisation of handover delays and same day emergency care outcomes supported by implementation of the UEC 10 Point Action Plan	Chief Operating Officer	1460	Ability to meet new UEC National Standards and related impact on patient safety, statutory compliance and reputation.	Higgins, Michelle - General Manager - Urgent and Emergency Care	20	20	20	20	4	5	High	⇔	31/3/23 Focused work continues, however 4 hour performance remains c50% for Type 1 attendances. COO meeting with Care Groups 4/4/23 to agree ongoing governance for performance and breach/exception analysis and actions/delivery.	Operations and Performance Group	6
1.3	To **design and transfer outpatient services with a Digital First offer, improving access to care**, diagnostics strategy delivery, reducing travel times, and through effective completion of care pathways	Chief Operating Officer	1464	Re-designing outpatient services for future demand Risk that the Trust fails to respond to the challenge of changing models of outpatient care in line with National trend information relating to population growth and aging population needs. Developing innovation and new models of care is essential to future-proof access to relevant clinical intervention and advice in a timely way.	Jose, Darren - Deputy Group Director of Operations (Specialties)	9	9	9	6	2	3	Low	⇩	31/3/23 Re-structure complete however, unable to progress new working hubs due to electronic referral management processes at present IT live project in progress to support the necessary IT integration between eRS to ePR system current status - eGrading form for testing beg April.	Finance and Performance Committee	4
2.1	To continue to engage with staff at all levels to ensure we maintain focus and realise the **Health, Wellbeing and Covid-recovery needs** and priorities of all our people, investing in appropriate provision of holistic interventions and resources. To engage with staff so that they feel valued and listened to and to strengthen our compassionate and inclusive culture, acting on staff culture champions recommendations and demonstrating success through the national staff survey	Chief People Officer	1493	Absence, Burnout and PTSD - Risk of medium and lon	Carla Jones Deputy Director of Workforce & Organisational Development Deborah Matthews Director of Improvement and OD	12	12	12	12	4	3	Moderate	⇔	31/3/23 Risk rating to be reviewed at the next meeting of WODG (19/5/23) with a view to downgrading in light of the actions which have been completed and the substantive recruitment to the PSC and MSK posts within OH.	Workforce Strategy Committee	4
2.2	To support teams in coming together to operate as a single team across UHD sites, embedding our values and behaviours, policies and processes and to identify talent and raise performance and staff engagement across the Trust as measured by an improvement staff integration survey	Chief People Officer													0	0

Ref	Specific Objective	BAF Risk Executive Lead	Risk Ref.	Risk Title	Risk Lead	Qtr 1 Rating	Qtr 2 Rating	Qtr 3 Rating	Qtr 4 Rating	Consequence	Likelihood	Rating	Movement	Last Update	Monitoring Group	Target risk rating
2.3	To deliver the **Trust's People Strategy** by developing effective and responsive People services, policies and practices for each stage of the employee cycle. This will include workforce planning recruitment and retention, training and education, employee relations, temporary workforce and workforce systems	Chief People Officer	1492	Resourcing Pressures - Staffing. Risk of significant resourcing pressures in the remainder of the Covid 19 pandemic and recovery period due to limited number of trained front line staff, likely increase in turnover as soon as the pandemic eases and limited pipeline of new recruits which is also impacted by the uncertainty around retaining EU employees and continuing to recruit from the EU.	Irene Mardon - Deputy Chief People Officer	12	12	12	12	4	3	Moderate	⇔	31/3/23 Momentum being maintained in recruitment of Internationally Educated Nurses to meet our objective of 80 new starters in the next 8 months. International recruitment has also commenced or in planning stage for Midwifery, Radiotherapy and Theatres. Significant focus on addressing our HCSW WTE vacancy rate, which was reported as 227.5 WTE . With funding support from NHSI we continue to run Saturday Open Day events and review process for an improved applicant experience following each one. Activity and development of contracting, terms and conditions for new roles, trainees, various level apprentices and short or long term BU Partnership roles and placements continues.	Workforce Strategy Committee	4
2.4	To champion **Equality, Diversity and Inclusion across UHD** through positive action and promote initiatives which continue to improve results against workforce equality standards (eg WRES and WDES)	Chief People Officer													0	0
2.4.1	Implement the National Patient Strategy requirement to develop a just culture across UHD as part of a ICS workforce plan	Chief People Officer													0	0
2.4.2	Define and agree measures to monitor implementation of inclusive leadership, equal opportunities in career development and endorsement of staff networks	Chief People Officer													0	0
3.1	Agree and deliver a sustainable budget, including delivery of the Trust Cost Improvement Programme. **This includes realising the opportunities identified in the Getting It Right First Time (GIRFT) and Model Hospital benchmarking data**	Chief Medical Officer	1416	GIRFT and Model Hospital Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision.	Helen Rushforth - Head of Productivity & Efficiency	16	16	16	16	4	4	High	⇔	[31/3/23) Reviewed, no change	Finance and Performance C	6
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	1594	Capital Programme Affordability (CDEL) - Risk that the agreed capital programme will not be affordable within the ICS capital allocation (CDEL) resulting in operational and quality/safety risks and a delay in the reconfiguration critical path.	Papworth, Pete - Chief Finance Officer	12	12	12	12	4	3	Moderate	⇔	[31/3/23] The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same.	Finance & Performance Committee	6
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	1595	Medium Term Financial Sustainability -Risk that the Trust will fail to deliver a financial break-even position resulting in regulatory intervention, an unplanned reduction in cash and the inability to afford the agreed 6 year capital programme.	Papworth, Pete - Chief Finance Officer	16	16	16	16	4	4	High	⇔	[31/3/23] The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same.	Finance & Performance Committee	6
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	1740	ICS at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit, a reduction in cash and regulatory intervention	Papworth, Pete - Chief Finance Officer	20	16	16	0	0	0	0	**Closed**	31/3/23 Closed at Year end	Finance & Performance Committee	0
3.1.1	**Agree and deliver a sustainable budget**, including delivery of the Trust Cost Improvement Programme.	Chief Finance Officer	1739	Financial Control Total 2022/23 - Trust at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit and a reduction in cash available to support the capital programme.	Papworth, Pete - Chief Finance Officer	20	16	16	0	0	0	0	**Closed**	31/3/23 Closed at Year end	Finance & Performance Committee	0
3.2	To deliver a Covid restoration programme that reduces the elective backlog, increases activity to pre-pandemic levels and returns waiting times and waiting patient numbers towards the national standards	Chief Nursing Officer	1383	Given the nature of the novel coronavirus, there is a risk that patients and/or staff could contract hospital acquired covid-19 infection as a result of inadequate or insufficient infection prevention and control processes and procedures, which may not be known due to evidence base available at the time of the pandemic	Bolton, Paul - Lead Nurse for Infection Prevention and Control	9	9	9	9	3	3	Moderate	⇔	31/3/23 Risk score, actions and controls to be reviewed when new guidance is released (due imminently).	Quality Committee Infection, prevention & control group	6
3.2	To deliver a Covid restoration programme that reduces the elective backlog, increases activity to pre-pandemic levels and returns waiting times and waiting patient numbers towards the national standards	Chief Operating Officer	1342	The inability to provide the appropriate level of services for patients during the COVID-19 outbreak - There is potential for this outbreak to create a surge in activity with resultant pressure on existing services. Risk to personal health if staff contract Covid-19 Risk to the organisation relating to staffing gaps (medical, nursing, AHP, ancillary) due to social isolation requirements and sickness. Risk of Covid-19 positive patients presenting to main hospital services causing risk from spread of infection	Sophie Jordan - Associate Director - Operations, Flow and Facilities	16	16	16	6	0	0	0	**Closed**	Risk closed in it current form as we are not in a Covid pandemic and are able to provide appropriate levels of services to our patients whilst we live with Covid.	Quality Committee Infection, prevention & control group	0
3.2.1	**Deliver a Covid restoration programme for elective patients**	Chief Operating Officer	1074	Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2020/21 are not met There is a risk that there will be patient harm from delayed pathways, NHSI/E regulatory challenges and premium expenditure requirements if the RTT related targets for 2020/21 are not met, namely: 1) Total waiting list to be no greater than Jan 2020 2) No 52 week waiters 3) RTT delivers to agreed operational plan trajectory for 2020/21 4) Recognise RTT standard is 92% (national NHS constitution target) and should be delivered where possible	Judith May, Associate Director of Operational Performance, Assurance & Delivery	20	20	20	20	4	5	High	⇔	[31/03/2023] Zero 104ww maintained in February. Reduction in 78ww expected to deliver below trajectory of 123 by end of April. Total waiting list increasing - drivers include impacts of industrial action in Q4. RTT performance reducing due to growing waiting list, increasing the denominator, and reduction in overall activity in Q4 due to industrial action.	Finance and Performance Committee	6

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3.2.1	Deliver a Covid restoration programme for elective patients	Chief Operating Officer	1439	Risk that lack of capacity to admit routine Orthopaedic Patients for their surgery creates inability to maintain or recover RTT position. This may lead to more complaints around compromising wellbeing of patients attributable to deteriorating access and waiting times. Operations may be cancelled when unable to maintain ringfenced bed base to meet GIRFT requirements.	John West - General Manager, Trauma Orthopaedics, Surgery PH Site	10	6	**Closed**					⇩ Closed from RR 6		Finance and Performance Committee, Operations and Performance Group	6
3.2.2	**Covid restoration programme for cancer patients**	Chief Operating Officer	1386	Cancer waits - Risk of patient harm from delayed pathways, risk to compliance with CWT standards. Risk may be increased if unable to recruit and retention of key clinical staff (oncologist and histopathologists) in particular in sub specialisation areas that rely on a single handed practitioner.	Lake, Katie - General Manager - Corporate Cancer Services	12	12	12	12	3	4	Moderate	⇔	31/3/23 Further improvement in CWT performance. A/w system confirmation of priority actions on 5/4/23. Action plan detailing assurance will be added to this risk once confirmed.	Finance and Performance Committee	4
3.2.3	**Deliver a Covid restoration programme for diagnostic patients**	Chief Operating Officer	1348	Covid related pause to Dorset Bowel Cancer Screening Programme and potential diagnostic delay	Lister, Alex - Group Director of Operations (Medical Care Group)	6	⇩ Closed from RR 6							[03/05/2022] Diagnostic wait standard achieved for April at 100%. RBH rooms are now back open following ventilation work and all planned insourcing weekends delivered. No further actions required at this point. RISK CLOSED	Finance and Performance Committee, Operations and Performance Group	0
3.2.3	Deliver a Covid restoration programme for diagnostic patients	Chief Operating Officer	1574	Breast screening backlog - There is currently a significant backlog with 20,000 women waiting for breast screening in Dorset and just 3.9% of women eligible are being offered screening. If this continues women will present later with breast cancer as 7-10% of every 1000 patients screened have cancer detected early. The earlier the condition is found the better the prognosis and the less likely the patient is to need major surgery and treatments such as chemotherapy	Mandy Tanner - Radiology General Manager	16	⇩ Closed from RR 16							[24/06/2022 Predicted to reach recovery September 2022. Following external inspection in 2019 increase in staffing levels recommended but business cases not supported. No vacancies achieved without increase in staffing. RISK CLOSED.	Finance and Performance Committee, Operations and Performance Group	0
3.2.4	**Deliver a Covid restoration programme for emergency care patients**	Chief Operating Officer	1429	Ambulance handover delays - If we cannot assess and move patients into ED clinical areas from the Ambulance queues within 15 minutes then there is a risk of harm to patients in the queue or community. See attached PDSA documents. There is also a risk to organisational performance standards and reputation	Lister, Alex - Group Director of Operations (Medical Care Group)	16	20	20	20	4	5	High	⇔	31/3/23 Marginal reduction in Ambulance Handover delays in March. key system workstreams to be focused on were Data Quality, Corridor Care and next steps as well and ED delivery plans	Finance and Performance Committee, Operations and Performance Group	3
3.2.4	Deliver a Covid restoration programme for emergency care patients	Chief Operating Officer	1460	Urgent and Emergency Care (UEC) performance There is a potentional risk to patients waiting in excess of National Standards	Lister, Alex - Group Director of Operations (Medical Care Group)	20	20	20	20	4	5	High	⇔	31/3/23 Focused work continues, however 4 hour performance remains c50% for Type 1 attendances. COO meeting with Care Groups 4/4/23 to agree ongoing governance for performance and breach/exception analysis and actions/delivery.	Finance and Performance Committee, Operations and Performance Group	6
3.3	**To update and deliver our Green UHD Strategy and Plan** - including reducing our carbon footprint, improving air quality and make more sustainable use of resources	Chief Strategy & Transformation Officer	1446	Sustainability Strategy If we do not deliver the Trust's Sustainability Strategy there is a risk that the Trust will not either measure or reduce it's carbon footprint	Edwin Davies - Associate Director Capital and Estates	4	⇩ Closed from RR 4							04/05/2022 RISK CLOSED, on trajectory for sustainability	Sustainability Committee	0
4.1	To improve partnership and engagement with staff, governors, patients, local people and key stakeholders	Chief Strategy & Transformation Officer													0	0
4.1.1	Implement a communication and engagement plan, delivered over the year	Chief Strategy & Transformation Officer													0	0
4.1.2	Further develop our BU partnership and tangible benefits	Chief Strategy & Transformation Officer	1601	If we do not continue to develop the partnership with Bournemouth University it may lead to a failure to fulfil our potential as University Hospital which may mean we don't continue to attract staff and research opportunities as a leading University Hospital	Betts, Alan - Deputy Director of Transformation	4	⇩ Closed from RR 4							[05/05/2022] BU Programme in year 2, recent presentations by BU and UHD at respective Boards, no new risks identified and systems and processes in place to continue to deliver BU partnership. RISK CLOSED	Transformation Committee	0
4.1.3	Host the Dorset Innovation Hub on behalf of Dorset partner supporting spread of proven innovations	Chief Strategy & Transformation Officer													0	0
4.2	Work with partners to address Health inequalities and improve population health management, preventing ill health and promoting health lifestyles	Chief Executive	1603	The risk is establishing the Statutory ICS by April 2022 in a way that has effective governance and relationships that deliver against the 4 ICS objectives:- - improving population health and healthcare; - tackling unequal outcomes and access; - enhancing productivity and value for money; and - helping the NHS to support broader social/economic development) Failure to achieve the above leads to UHD being unable to fulfil its requirements and regulatory compliance.	Renaut, Richard - Chief Strategy and Transformation Officer	4	⇩ Closed							[01/09/2022] ICS established by July 1st with most executive posts filled. Further work required by ICS in order to effectively discharge statutory duties with provider collaborative work at minimum levels. Loss of organisational memory and further internal restructuring could hamper delivery of duties. There could remain an ongoing risk regarding the effectiveness of the ICS in discharging statutory duties however the recommendation is to close this current risk given the successful establishment of the ICS.	Board of Directors	0
5.1	Develop the reconfiguration plan to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for new estate and new models of care	Chief Strategy & Transformation Officer	1602	Risk that In year delays to the critical path programme can lead to costs increasing by £0.5m a month. Complexity of the programme and external approvals required for capital expenditure generate the likelihood	Killen, Stephen - One Acute Network - Programme Director	8	Closed							[02/08/2022] Risk now closed As this risk focused on FBC approval and associated in year delays if Wave 1 STP funding/deliverables went off track, this is now under control and can be closed. A new timeline risk associated with critical path deliverables has now been opened	Transformation Committee	0

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5.1	Develop the reconfiguration plan to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for **new estate** and new models of care	Chief Strategy & Transformation Officer	1260	There is a risk that we are unable to maintain the Trust estate in line with Clinical and regulatory requirements. Risk to staff and patient safety and risk of regulatory action if statutory breaches identified. Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling	Edwin Davies - Associate Director Capital and Estates	12	12	12	12	3	4	Moderate	⇔	[30/03/2023] Extensive work ongoing to comply with regulatory bodies. CQC maternity call bells action plan has been completed. 2 x fire authority surveys completed with only minor suggestions. Fire escape plans in place. 30+ sets of fire do0rs replaced. 25% (1500 breaches) fire compartmentation work complete. £5.45m of capital funding allocated in 23/24 will su	Quality Committee	4
5.1.1	**Develop the reconfiguration plan** to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for new estate and new models of care	Chief Strategy & Transformation Officer	1604	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds	Killen, Stephen - Programme Director	20	20	20	20	4	5	High	⇔	31/3/23 Issue remains the same. Review in April	Quality Improvement and Digital Information Group Transformation and Innovation Committee	8
5.2	W**ork with system partners in establishing the Dorset ICS** and within that develop the Dorset provider collaborative	Chief Executive	1603	The risk is establishing the Statutory ICS by April 2022 in a way that has effective governance and relationships that deliver against the 4 ICS objectives:- - improving population health and healthcare; - tackling unequal outcomes and access; - enhancing productivity and value for money; and - helping the NHS to support broader social/economic development) Failure to achieve the above leads to UHD being unable to fulfil its requirements and regulatory compliance.	Renaut, Richard - Chief Strategy and Transformation Officer	4	**Closed**							[01/09/2022] ICS established by July 1st with most executive posts filled. Further work required by ICS in order to effectively discharge statutory duties with provider collaborative work at minimum levels. Loss of organisational memory and further internal restructuring could hamper delivery of duties. There could remain an ongoing risk regarding the effectiveness of the ICS in discharging statutory duties however the recommendation is to close this current risk given the successful establishment of the ICS.	Board of Directors	0
5.3	**Implement the UHD Digital Transformation Strategy**	Chief Informatics & IT Officer	1298	There is a risk that we fail to maintain and develop the Trust IT services in line with clinical and operational requirements	Gill, Peter - Chief Information & IT Officer	10	10	10	10	5	2	Moderate	⇔	From Sep 2022 to Jan 2023 there were been monthly outages of the EPR - this had led to the creation of a specific risk register entry (1805) on this topic	Information Governance Group	8
5.3	Implement the UHD Digital Transformation Strategy	Chief Medical Officer	1378	Lack of Electronic results acknowledgement system - A lack of an electronic results acknowledgement system for requested clinical tests is a risk to patient safety and could result in missed diagnosis and suboptimal treatment.	Ayer, Dr Ravi - Consultant Radiologist and Clinical Director	9	15	15	15	3	5	High	⇔	[31/03/2023] This was discussed at the recent clinical governance group in the light of publications from the academy of royal colleges and RCR regarding referrers responsibilites. The current systems for tracking results demonstrate unwarranted variation and the timeframe of implementation of a new EPR means that unless further controls are in place this will remain a significant risk. A T&F group is proposed to consider a central results management team resource to ensure that results are appropriately directed and acted upon	Information Governance Group	4
5.3.1	**Progress digital transformation and play an active part in the key Dorset transformation plans programmes**	Chief Informatics & IT Officer													0	0
5.3.2	**Progress a Digital Dorset Shared Service**	Chief Informatics & IT Officer	1434	Delays to the implementation of the Dorset Care Record	Hill, Sarah - Assistant Director IT Development	6	6	⇩ **Closed**					⇩ **Closed**	[08/08/2022] This risk has been closed as reaching target grading (in line with policy) [04/08/2022 Pathology testing delayed due to resource issues in Pathology - due to commence at the end of August. Document feed being developed.	Information Governance Group	0
5.3.3	Procure and implement the Strategic Integrated Imaging Service: a digital diagnostics image sharing platform for Dorset	Chief Informatics & IT Officer														
5.3.4	**Create the Strategic Outline Case and Outline Business Case for the Dorset Electronic Patient Records system**	Chief Informatics & IT Officer	1756	There is a risk that the Graphnet CareCentric EPR degrades in its functionality and performance over the next 3 to 5 years	Hill, Sarah - Assistant Director IT Development	12	12	⇩ **Closed**					⇩ **Closed**	[19/08/2022] Closed - open in excess of 60 days without being made live	Information Governance Group	0
5.3.5	**Ensure that the IT infrastructure and BAU support services are fit for purpose** with minimal down-time and the technical layers are subject to a rolling stock replacement programme	Chief Informatics & IT Officer	1273	Cyber Security Risks, Threats and Vulnerabilities- There are risks related to cyber security that, potentially, can affect the resilience of the Trust's IT systems and data. This could adversely affect all trust business.	Martin Davis, IT Security Manager	10	10	10	10	2	5	Moderate	⇔	[31/3/23] This is an ongoing risk to remain open due to the ever-present risk of a threat or vulnerability, both known and unknown, being used to affect the resilience of the Trust's IT systems and data. There have been no incidents or additional risks or mitigations to change the current risk rating.	Information Governance Group	5

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5.3.5	Ensure that the IT infrastructure and BAU support services are fit for purpose with minimal down-time and the technical layers are subject to a rolling stock replacement programme	Chief Informatics & IT Officer	1437	There is a risk of total outage of the computing services at RBCH if the single point of failure of electrical supply fails	Gill, Peter - Chief Information & IT Officer	6	6	6	6	2	3	Low	⇔	31/3/23 The physical move of the 2nd CaMIS box is being scheduled and the work required clarified to go ahead with this move.	Information Governance Group	1
5.3.6	Achieve a **compliant Data Protection and Security Toolkit submission**	Chief Informatics & IT Officer	1591	Information Asset Management.There is a risk of data loss and/or service interruption as a result of the inadequate management of the large suite of Information Assets that contain Personal Identifiable Data.	Camilla Axtell - IG and Data Protection Officer	12	12	6	6	3	2	Low	⇔		Information Governance Group Quality Improvement and Digital Information Group Transformation and Innovation Committee	4
5.1	Develop the reconfiguration plan to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for **new estate** and new models of care	Chief Strategy & Transformation Officer	1784	Critical Path Management. There is a risk that inter-programme dependencies (eg. Beach, NHP, Decants) will impact negatively on the overall delivery of the Programme. Given the size, scope and complex funding streams of the overall programme, there are numerous projects, moves and decants that combine to form the Critical Path and the cumulative impact on this is high. Failure to manage progress and dependencies, identify & manage associated risks & issues and set realistic start / finish dates may delay completion and impact on other tasks. As a consequence, a delay to tasks and Projects along the Critical Path will delay the overall Programme end date	Killen, Stephen - One Acute Network - Programme Director			16	20	4	5	High	⇔	No further update. Review end of April.	Transformation Committee	8

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

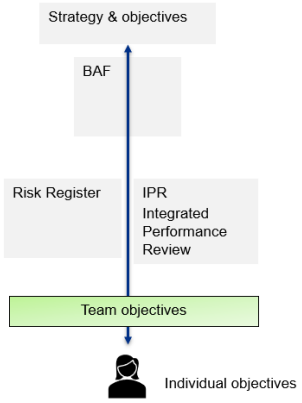
Agenda item: 6.2

Subject:	Board Assurance Framework (BAF) 2023/24
Prepared by:	Richard Renaut CSTO
Presented by:	Richard Renaut CSTO

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☒ Use resources efficiently ☒ Be a well led and effective partner ☒ Transform and improve ☒
BAF/Corporate Risk Register: (if applicable)	Oversight of the whole BAF
Purpose of paper:	Assurance
Executive Summary:	Proposed approach to updating the BAF process, including: • 9 strategic objectives and BAF risks proposed • Alignment of executive leads & assurance committees • Proposed template • Develop the approach over the next cycle of meetings, including closer aligning with IPR and risk register.
Background:	The BAF approach for 2023/24 has been developed as part of the planned work to review and strengthen governance across UHD. This process is being enhanced to provide a continually improving set of assurance for achieving the Trust objectives. The proposed approach will take several cycles of meetings to refine as feedback improves the BAF, creates common understanding and strengthens our "well led" approach. This will include re-focusing committee agenda time, to allows greater focus by the Board on strategy and deployment, and assurance. The approach used builds upon the governance review and enhancements already implemented as well as the Board Development workshop in February 2023, the Patient First work underway especially for strategic aims, and the UHD Annual Plan. Good practice has been drawn from NHS Providers, the Good Governance Institute (GGI), CQC Well led, and review of other Trusts' BAFs. The purpose of a BAF is described in the NHS Providers Foundations of Good Governance report:

"The trust board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisational objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The trust board achieves this, primarily through the work of its committees, through use of audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives."

Organizational alignment to ensure delivery of the objectives can be simplified and visualized as:



Board does less, better & is forward looking.

The BAFs main focus is on achieving organizational objectives. However high risks (12 and above) from the risk register and significant variances from the IPR will continue to be reviewed by the committees and Board. From a strategic viewpoint Committees and the Board will continue horizon scanning so that the strategic and external risks can also enter either via the risk register, or via the annual plan and strategy updates. Likewise risks that cover more than one committee's remit and there is not an obvious lead committee, or are Trust-wide, will be considered by the Board of Directors.

The Trust is implementing Patient First, and as such is in a year of transition with the programme. The Board has reviewed and supported the approach of more focused, strategic set of goals and annual objectives. These are set out in the Annual Plan.

Subject to approval, the annual objectives are being developed into plans, under an exec lead, with the monitoring committees already being established (see Appendix 1). Approval is sought for the continuing this approach.

Of note it is proposed that the Finance and Performance Committee (FPC) continues to be the lead monitoring committee for constitutional standards, but that the new

	Population Health & Systems Committee will receive assurance on reducing inequalities. The other area of note is that the reconfiguration programme lead monitoring committee will also be FPC, but that – in line with its Terms of Reference approved by the Board in January 2023, the People and Culture committee will have a key role of "*monitoring major workforce transformation programmes, including to obtain assurance that no such programme has an unforeseen adverse impact on workforce or on the performance of the Trust*", "*monitoring delivery of staff engagement plans to ensure there are clear communication channels across the organization which provide staff with key information during the transformation of services*" and "*monitoring the provision of training and development and implementation of solutions which deliver a skilled, flexible modernized workforce improving productivity, performance and reducing health inequalities."* The 5 strategic goals are being developed with "Strategic A3s" which provide "root cause problem solving" approaches which is core to the Patient First methodology. These are listed in the reading room as Appendix 2. They are being constantly developed as part of the continuous improvement process. 7 BAF risks are identified and will be tracked through the year. The delivery of the two major change programmes (for Patient First and reconfiguration) complete the BAF risks as 8&9. Following agreement of the above a draft "BAF risk on a page" can be developed. A template is attached as Appendix 3, based upon good practice exemplar from an Outstanding trust. Board member views are sought as to whether to adopt this or amend. The UHD populated templates will then be developed for the next cycle of Board meetings. A Datix (risk register) entry of each BAF risk will also need to be created, and these should be updated monthly. Over time individual risk register entries may also be linked to the BAF strategic objective risks, but this is not immediately necessary as high scoring risks are already reported to Committees. Wider alignment with Board governance can then occur with updated risk register entries, refined Integrated Performance Report (IPR) focusing more on the Key performance indicators (KPIs) and greater committee time and scrutiny on the clear and concise reporting of progress against the objectives.
Key Recommendations:	1. Note the updated BAF approach, and approval of the strategic aims. 2. To agree the 9 BAF risks at Appendix 1, including exec lead and lead assurance committee. 3. To seek Board member views whether any other strategic risks, not covered in the risk register already, should be added to the BAF.

	4. To comment on the template for BAF risks, and if adopted to prepare these for the next cycle of Board meetings 5. To start aligning the Board, Committees, IPR and Risk register reports around the 23/4 strategic objectives.
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**
Board seminars on BAF and strategic objectives	01/04/2023	Updated on BAF roles and importance of Strategic objectives, which are set out in the Annual Plan.
Audit Committee	18/05/2023	Meeting not yet 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 ☐

Appendix 1 **UHD Board Assurance Framework 2023/4**

Strategic Objectives	BAF Risks 1-9	2023/24 Trust objectives (SMART)	Lead exec & Assurance Ctte
Systems working & partnership	1. Risk of not meeting the patient national constitutional standards for Planned care 2. Risk of not meeting the patient national constitutional standards for Emergency care (both while reducing inequalities in outcome and access and improving productivity and value).	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 zero non admitted patients above 52 weeks by March 2024]. To achieve 76% of patients treated within 4 hours through the emergency care pathway by March 2024.	1. COO & FPC 2. COO & FPC
Our People	3. Risk of not significantly improving staff experience, engagement and retention over the next 3 years [and not being in NHS Staff Survey results top 20% of comparator trusts].	All wards / departments taking action to improve their 2022 National Staff Survey results, by March 2024. Overall 2023 NHS Staff Survey results: • Staff Engagement Score > 7/10 • Staff Morale Score > 6/10 • Q23c: I would recommend my organisation as a great place to work > 62% • People Promise 'We are safe and healthy' > 6/10 To achieve a 13% staff turnover rate by March 2024.	3. CPO & P&C
Patient Experience	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.	Family and Friend Test (what our patients say) • Feedback rates increases from baseline in all service over the next year. • Is in top 20% rated 'good' over a 3-year period • Every ward / clinical service has access to monthly Have Your Say survey information and data by March 2024.	4. CNO & QC
Quality (Outcomes and Safety)	5. Risk of not improving hospital mortality (and being in top 20% of trusts in the country for HSMR over the next 3 years).	To reduce HSMR over the next 18 months [Sept 2024]. To reduce moderate/severe harm events on a trajectory of	5. CMO & QC 6. CMO &QC

	6. Risk of not reducing moderate/severe harm patient safety events through development of an outstanding learning culture.	30% fewer by 2026/7, through developing a learning culture.	
Sustainable Services	7. Risk of not returning to recurrent financial surplus from 2026/27.	To reduce the recurrent underlying deficit over a 3-year period [Closing balance of £20m by March 2024].	7. CFO & FPC
Patient First Programme	8. Risk of not successfully and sustainably adopting the Patient First approach across UHD.	To deliver Year 1 of transitioning to the Patient First approach including all staff attending a 'Let's have a Conversation' session and encouraged to identify improvements in their ward / department.	8. CEO & P&C
One Team *"Patient Ready" for Reconfig*	9. Risk of not integrating teams and services, and then reconfiguring to create the planned and emergency hospitals.	For every service to have an agreed plan to integrate and start delivery so they are "move in" and "patient ready" for the future	9. CSTO & FPC/P&C

Appendix 2 : Strategic A3s for Trust objectives

(see reading room)

Appendix 3 : Template for BAF risk on a page (based on East London FT)

BAF Risk 5	If the Trust fails to effectively plan for, recruit and retain people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy
Strategic Priority	Improved staff experience
Review Date	10 December 2021
Executive Lead	Chief People Officer
Lead Committee	Appointments & Remuneration Committee

Risk Score 2021/2022							
Residual	Apr/May	Jun/Jul	Aug/Sept	Oct/ Nov	Dec/ Jan	Feb/ Mar	Target
16	16 ↔	16 ↔	n/a	16 ↔			9

Context

Covid
- With the new variant being announced the Trust is stepping up its communications and refreshing guidance previously released.
- Trust continues to highlight the infection control protocols to keep our staff, service users and patients safe

Remote working:
- Future of Work Group has been re-established led by COO

Workforce planning, recruitment and retention:
- Significant workforce planning challenges for CAMHS Tier 4 and MHS within NEL and BLMK
- Additional resources recruitment agreed to determine what corporate support is needed to meet demand. Resourcing and Medical Education/Medical Staffing teams have been prioritised given the levels of activity
- Continue to develop our GPs bank following transfer in of Leighton Road/Caudwell Road GP practices
- Plans to roll out the Picker pulse survey which will run quarterly for three quarters of the year and then the annul staff survey

Training:
- Reverted BLS and PMVA training to run face to face and Covid compliant; remaining training is virtual
- Trust online induction programme and local induction programme launched

Long service awards: second year with 230 people eligible; delayed due to capacity

Gaps in Control or Assurance
- New post created and recruited to lead on workforce planning; start anticipated winter 2021
- Recruitment & Retention Group amended to reflect recruitment across all professions
- Bank Expansion Group which reviewed the structure of the Bank and to recruit into Bank was completed. However, given the demands in terms of Bank, the Group is being reformed with revised terms of reference and membership. Also in scope is a review of Bank rates in order to make this competitive
- Project focusing on agency recruitment initially focusing on doctors, now being broadened across all staff groups. A project manager is being recruited to. This role will process map all recruitment processes and will make recommendations as to change ideas.
- QI project focusing on the experience of new starters with a specific approach on the Smart cards and access to digital on day 1 of starting in role.

Progress

What's going well inc future opportunities	What are the current challenges inc future risks	How are these challenges being managed
Staff recognition, wellbeing and support: • Salad Money commissioned to help staff • Hardship fund to support staff/service users • Online webinars continue to support shielding staff • Considering trauma informed approach to services/corporate functions to support wellbeing agenda around wider determinants of health • ELFT people plan being revised to support refreshed Trust strategy **Mass vaccination:** putting in place mechanisms to support longer term view **DBS:** significant progress made with backlog; Policy changed recheck period from 3 to 5 years **Mandated vaccination of all staff:** **Cost of living pay increases for non-AfC staff**	**Workforce planning and recruitment:** • Significant workforce planning requirement (CAMHS Tier 4 and MHS in NEL and BLMK) • Challenge to continue to support staff wellbeing and teams • **Cauldwell Medical Centre dispute:** holding up organisational change process which is causing anguish for staff and affecting morale	• New post to lead on workforce planning created and recruited to • Recruitment & Retention Group covers all professions • Bank Expansion Group reformed with revised terms of reference; will also review bank rates to ensure these remain competitive • Project focusing on agency recruitment initially focused on doctors, now broadening across all staff groups • Two QI project in progress: one focusing on experience of new starters; second on further reducing the time to hire. In addition, there are 10 others, which are focusing on 'business as usual projects' to improve our services.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 6.3

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

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☐ Use resources efficiently ☐ Be a well led and effective partner ☒ Transform and improve ☐
BAF/Corporate Risk Register: (if applicable)	Risk register report
Purpose of paper:	Review and Discussion
Executive Summary:	

Current risks rated at 12 and above on the risk register	39
Potential new risks for Approval	4
12+ Risks that have changed score	1
Reduced, closed or suspended risk(s) no longer 12+ to note	3

Potential New Risks				
Risk no:	Title	Proposed Grading	Exec Lead	Care Group
1881	Financial control total 2023/24	16	CFO	Finance
1697	Increased waiting list for SACT treatment/ Capacity on Day units	15	CMO	Specialties
1811	Staff Vacancies and Skill mix deficit - Theatres	15	CPO	Surgical
1840	OPS Outlying patients	12	CMO	Medicine

	To note - Current 12+ Risks decreased or closed in month Risk no: | Title | Risk Owner | Risk Trend 1739 | Financial Control Total 2022/23 | Pete Papworth | Closed 1740 | ICS Financial Control Total 2022/23 | Pete Papworth | Closed 1744 | Inability to provide 24hr Maternity (Midwifery) Triage service | Tonge, Lorraine - Director of Midwifery | Reduced from 12 to 10 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 39 | 39 | 100% | ⟷
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* • *Review at the monitoring Committee*
Key Recommendations:	Work is currently being undertaken to address the overdue/ lack of actions for those risks that currently score 8-10 on the risk matrix.
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	16/05/2023	Discussion
Finance and Performance Committee	15/05/2023	Finance Risk ID 1739 being closed and 1881 being opened reported.

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

Risk Register Report

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

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	39
Potential new risks for Approval	4
12+ Risks that have changed score	2
Reduced, closed or suspended risk(s) no longer 12+ to note	2

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 184 approved risks on UHDs Risk register, of which 39 are rated as 12 and above**
2. **There are 0 risks rated as 12 and above that have not been reviewed in the last month.**
3. **There are 0 risks rated as 12 and above that do not have a current action plan.**
4. **Four (4) new risks rated as 12 and above were discussed at Quality Committee 16/5/23**

Risk Ref	**1697**
Risk Rating	15
Risk Title	Increased waiting list for SACT treatment/ Capacity on Day units
Risk Description	The waiting list to commence Systemic Anti-Cancer Therapies on HODU has increased to 4 weeks, if we do not reduce the waiting time for treatment patients will have sub optimal outcomes. Increase patient numbers impacting timely appointments for subsequent treatments. DCC at Poole also have high number of new referrals and are increasing length of time before appointment given
Risk Background	Risk originally opened 14/12/21 Recent increase in waiting list with an increase in referrals and restarting treatment. Daily review of capacity. Collaborative working between HODU/ DCC All subsequent appointments allocated at the appropriate time.
Leads	Marie Miller, Senior Matron Mandy Tanner, General Manager Exec Sponsor; CMO
Controls	Requirement to achieve a 2-week maximum wait time review of incidents reported review of patient feedback, complaints/concerns national guidance Monitor breach of 31-day target
Action plan(s)	Matrons to review daily capacity Collaborative working between HODU and DCC to use all spaces Due date 30/5/23

Risk Register Report

Risk Ref	**1811**
Risk Rating	15
Risk Title	Staff Vacancies and Skill mix deficit – Theatres
Risk Description	Multiple vacancies across all areas within the anaesthetic directorate for agenda for change staff for theatres. If vacancy gap is not addressed this will result in a negative impact on trust reputation, delayed service delivery, treatment and care to patients, negative impact on patient safety, reduced governance compliance, and increased cost pressure with the use of agency staff and paid overtime to staff. circa 70 WTE vacancies across UHD theatres as of March 2023
Risk Background	Risk opened 11/11/22
Leads	Clare Bone, Senior Matron Exec Sponsor; CPO
Controls	Working in line with AfPP, BADS, and RCOA guidance for safer staffing having a clear template and appointing accordingly, utilising our 642 process for list planning and booking Monitoring WTE of the vacancy rate Monitoring Sickness absence Monitor % of staff turnover Regular review of budget and vacancy rates in line with the workforce plan
Action plan(s)	Theatre action plan – 4 key workstreams • Increased vacancies • Diluted Skill Mix across specialities within UHD theatres • Staff Retention • Improve Staff health and wellbeing

Risk Ref	**1840**
Risk Rating	12
Risk Title	OPS Outlying patients
Risk Description	If OPS has a high number of patients outlying in non-specialty areas, then it could impact on patient safety, communication, patient flow and staff morale/stress.
Risk Background	Unclear number of patients are on non-speciality wards outlier list not standardised and doesn't state clinical concerns not enough time to visit all outliers, not enough staff to manage outlying list CST decide where to place patients no standardisation of process not enough time to communicate with families patients on outlying wards don't receive OPS MDT Challenges with Discharge

Risk Register Report

	Risk opened 21/12/22
Leads	Lisa Pigott, Deputy GM Sarah James, OPS Governance Lead Exec Sponsor; CMO
Controls	List of outliers- although different between the two sites morning handover to allocate staffing monitor numbers of outliers and staffing RCP safe staffing guidance monitor the LERNs/complaints Documenting comments in patient records 2 way communication with wards non speciality ward based staff care for patients and escalate as required
Action plan(s)	

Specialty	Title of Action	Description of action to be taken	Evidence of Effective Implementation	Start date	Due date	Action Status (type)
Older Peoples Services	create outlier list to identify outlying patients, where they are and what their clinical requirements are	create outlier list to identify outlying patients, where they are and what their clinical requirements are	upload list to Risk	03/04/2023	02/06/2023	Open
Older Peoples Services	Create a bleep for outlying patients specific per site and communication plan (2 per site)	Create a bleep for outlying patients specific per site and communication plan (2 per site)	a bleep number will be allocated	03/04/2023	02/06/2023	Open
Older Peoples Services	Formalise the process and standards for the management of patients who are outliers on non-OPS wards	Formalise the process and standards for the management of patients who are outliers on non-OPS wards	Attach SOP to Risk	03/04/2023	03/07/2023	Open
Older Peoples Services	Clinical audit against Outlier process and standards	Clinical audit against Outlier process and standards	Attach to Risk	03/04/2023	02/10/2023	Open

Risk Ref	**1881**
Risk Rating	16
Risk Title	Financial control total 2023/24
Risk Description	Trust at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit, a corresponding reduction in cash available to support the capital programme, and a potential deterioration in the trusts single oversight framework risk rating.
Risk Background	New risk for financial year 2023/2024. Agreed at FPC May 23
Leads	Papworth, Pete - Chief Finance Officer
Controls	Containment of expenditure within budgeted levels, through close budget monitoring, variance analysis and reporting to TMG, FPC and BoD Full achievement of the cost improvement programme target supported by weekly reporting and escalation/intervention as appropriate. Securing all budgeted income supported by close monitoring of elective activity and executive oversight of productivity opportunities.

Risk Register Report

Action plan(s)	Title of Action	Description of action to be taken	Evidence of Effective Implementation	Start date	Due date	Action Status (type)
	Cost improvement programme	Cost improvement programme to be identified in full supported by the establishment of a new programme management office together with enhanced governance and reporting.	Weekly CIP reporting shows CIP schemes that achieve the target in full.	02/05/2023	31/03/2024	Open
	Budgetary control	Detailed variance analysis to be prepared monthly with corrective actions identified as may be necessary to control expenditure within the agreed expenditure budgets.	Monthly reporting to the finance and performance committee	02/05/2023	31/03/2024	Open
	ICS Financial performance	ICS wide financial performance to be monitored and challenged through the Dorset ICS Operations and Finance Reference Group (OFRG) to identify risks to the overall financial delivery of the system and agree corrective/mitigating actions.	OFRG finance reports and financial forecast for the ICS.	02/05/2023	31/03/2024	Open

5. There is one (1) risk that has changed risk rating, but remains 12 or above, in month.

Site	Ref	Risk Rating	Details	Update	Risk Owner	Lead Executive	Last review date	Risk trend
UHD	1784	20	There is a risk that inter-programme dependencies (e.g. Beach, NHP, Decants) will impact negatively on the overall delivery of the Programme. Given the size, scope and complex funding streams of the overall programme, there are numerous projects, moves and decants that combine to form the Critical Path and the cumulative impact on this is high. Failure to manage progress and dependencies, identify & manage associated risks & issues and set realistic start / finish dates may delay completion and impact on other tasks. As a consequence, a delay to tasks and Projects along the Critical Path will delay the overall Programme end date	Risk score updated to 20. Issue remains the same and still awaiting full approval from the NHP team. The programme/timelines are now being monitored closely to manage delays and potential impacts.	Killen, Stephen - One Acute Network - Programme Director	Chief Strategy and Transformation Officer - Richard Renaut	19/04/2023	Increase from 16 to 20

Risk Register Report

6. There are 3 risks closed, reduced or suspended in month that were previously rated at 12 and above

Site	Ref	Risk rating	Details	Update	Risk Owner	Date risk accepted as a 12+ risk	Last review date	Date closed or reduced	Risk trend
UHD	1739	16	Trust at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit and a reduction in cash available to support the capital programme.	Financial outturn for the year reported a £188k favourable variance against the break-even control total.	Papworth, Pete - Chief Finance Officer	23/05/2022	19/04/2023	19/04/2023	Closed
UHD	1740	16	ICS at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit, a reduction in cash and regulatory intervention.	Final plan resubmission represents a financial break even budget.	Papworth, Pete - Chief Finance Officer	23/05/2023	02/05/2023	02/05/2023	Closed
UHD	1744	10	Inability to provide 24hr Maternity (Midwifery) Triage service	Risk grading amended to 10 following further discussion with DoM and the additional new Risk (1876). This amendment also reflects the midwife response rate within 15minutes, which is currently at 98% throughout the day	Tonge, Lorraine - Director of Midwifery			28/04/2023	Reduced from 12

7. Risk updates

Risk Number	Rating	Title	Last review date	Review for Board	Handler	Executive lead
1692	15	Safe Staffing - Medical	25/04/2023	Health rota work ongoing, currently prioritising junior doctors to facilitate creation of bespoke rota payments. Care groups need to update when newly funded posts are recruited. Additional monitoring can be provided from GSW reports	Williamson, Ruth	Chief Medical Officer - Peter Wilson
1647	12	Ineffective and inconsistent patient handover processes	04/05/2023	Risk score to remain the same. The Task and Finish group is now set up chaired by Deputy Chief Medical Officer Matt Thomas, he is recruiting constituents to deliver an options appraisal around which will inform a clear policy and process.	Hodson, Matthew	Chief Medical Officer - Peter Wilson
1214	16	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices.	27/04/2023	New example of independent purchase of ungoverned POCT (INR in Endoscopy), emails attached Discussed at CGG, new AMD for Governance and Risk and new	Massey, Paul	Deputy Chief Medical Officer UHD - Ruth Williamson

Risk Register Report

				Chair of CGG to review and arrange lead for task and finish group with Trust wide input.		
1483	16	Pharmacy vacancies are affecting patient care	19/04/2023	Critical 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. March 23 = 15.42 wte pharmacist vacancies 18% Almost all vacancies at the junior pharmacist level April 23 update: Undergoing a significant period of recruitment and going out with the recruitment and retention premium for junior pharmacists	Bleakley, Stephen	Deputy Chief Medical Officer UHD - Ruth Williamson
1843	16	Paediatric acute medical staffing	14/04/2023	Discussed with CD and general manager, rota co-ordinator interviews this week, successful appointment to Physician Associate post, interviews for senior clinical fellow in place, junior clinical fellow recruited.	Tighe, Mark	Deputy Chief Medical Officer UHD - Ruth Williamson
1355	15	Lack of integration between the Electronic Referral System (eRS) & Electronic Patient Record (ePR)	02/05/2023	Final elements of development are being clarified to gain some dates which will be available for the next update on this risk	Roberts, Michele	Deputy Chief Medical Officer UHD - Ruth Williamson
1202	15	Medical Staffing Women's Health	26/04/2023	Risk remains at 15. 2 substantive consultant posts have been advertised. Cannot currently staff 2 registrars overnight as cannot recruit locums. Evolving gaps on the registrar rota with sickness and resignations expected.	Taylor, Mr Alexander	Deputy Chief Medical Officer UHD - Ruth Williamson
1221	12	Medical Staffing Shortages - Medicine and Older Persons Medicine	26/04/2023	We have discussed this at our OPS Governance meeting 26/4/2023 and agree the risk remains 12. We are still working significantly under template at all levels from Tier 1 to Tier 3. We continue to have Lilliput open as a ward as well as escalated beds on Ward 22 and outliers on both sites. We have discussed monitoring our KPI monthly at our governance meetings and reviewing the risk. We continue to pursue avenues for funding for recruitment of further Consultants.	Brittan, Gemma	Deputy Chief Medical Officer UHD - Ruth Williamson
1395	12	Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting.	12/04/2023	Recent outsourcing of wax blocks to ease the burden has revealed multiple quality issues (one Poole case with clinical impact). A pause on outsourcing has been applied until investigation complete. The department is 7.0 wte deficient in order to meet current demand. A Recovery paper is in flight and needs another review by the Financial Planning Group and TMG approval. Department is still heavily reliant on bank and agency staff (using current underspend in Pathology).	Massey, Paul	Deputy Chief Medical Officer UHD - Ruth Williamson

Risk Register Report

				3 new, substantive office appointments have been made in Poole, the situation is fragile and the team are relatively new and require close mentoring is required in addition to agency assistance to cover vacancy factor. Pathway Navigator has started 1st April 2023. Training plan underway although this is an internal appointment and backfill still in flight. Digital pathology project runs at a linear pace. Software been signed off by the Trust. Validation underway. Offsite reporting solution (DPP and Source) and onsite locum consultant support continues at a premium cost. A key clinical retirement has meant a reduction support from DCH.		
1498	12	Patient Safety due to inadequate Medical Registrar Out of Hours Cover (RBH)	11/04/2023	Recruitment is ongoing following support for increased resources. There has been no significant change as yet so no change to the risk rating until vacancies have been filled.	Whitney, Sue	Deputy Chief Medical Officer UHD - Ruth Williamson
1758	12	Chemotherapy production in pharmacy now at capacity and limiting patients accessing treatment	28/04/2023	Limited number of parenteral items available on each site (23 at Poole, 25 at Bournemouth) in line with MHRA recommended capacity but knock on delay to some treatments. Staffing and recruitment remain a priority. Datix LERNS (clinician and pharmacy submitted) noted most weekdays where patient chemotherapy treatment has been delayed. Consideration to be given pause in all Free of Charge and Private Patient chemotherapy to focus on NHS patients (ICB/NHSE supported.	Bleakley, Stephen	Deputy Chief Medical Officer UHD - Ruth Williamson
1397	16	Provision of 24/7 Haematology/ Transfusion Laboratory Service	19/04/2023	Update at Directorate meeting: 3 new vacancies in month, 1 B7, 2 B6, on TRAC adverts out. New posts: B7 and 2 B6 recruited to start May, June and July Replacement posts, B6 x2 advertised, B5 x1 started 10/4, MLAs 3 advertised, 2 interviewed and selected. Interviews for Transfusion lead B8 this week.	Macklin, Sarah	Chief Nursing Officer Paula Shobbrook
1502	15	Mental Health Care in a Physical Health environment	01/05/2023	Establishment of MHSW workforce has been established, currently 15 cross sites	Aggas, Leanne	Chief Nursing Officer Paula Shobbrook
1283	12	Radiotherapy radiographer staffing	25/04/2023	Ongoing recruitment to fill vacant positions WCA post gone out to advert to support recruitment Will review recruitment and retention payments to see if it improves	Tanner, Mandy	Chief Nursing Officer Paula Shobbrook
1300	12	Provision of 24hr specialist care for children (under 18 years) who have mental health needs.	12/04/2023	Linked incident: Child aged 16 yrs 7 months, with ASD diagnosis and food refusal admitted to adult ward for ongoing management. Due to likely functional Avoidant restrictive food intake disorder ARFID). Complex history and difficulty in gaining therapeutic input due no service provision for children ARFID.	Lourence, Lynne	Chief Nursing Officer Paula Shobbrook

Risk Register Report

1303	12	Therapy Staffing	02/05/2023	Recruitment/ retention remains challenge. 3 x Band 6 physios in recruitment which is exciting, including two locums recruited permanently. Poole acute-Band 3 in recruitment Band 5 OT starting in June Band 6 Occupational Therapy vacancy (mat leave cover) to be utilised for Oncology Specialist Role out to advert May 1x B6 Physiotherapist – Decision made not to re-advertise whilst team identify role and skill mix need	Godden, Rebekah	Chief Nursing Officer Paula Shobbrook
1642	12	Midwifery Staffing	28/04/2023	Risk updated with DoM. Risk grading to remain the same as vacancy rate remains at 16%. International Recruitment Lead Midwife role appointed on 01/04/23. 17 wte posts offered for newly qualified band 5 midwives throughout the year. For further interview day in May for additional Band 5 posts	Taylor, Kerry	Chief Nursing Officer Paula Shobbrook
1771	12	Radiology Service Demands/ Radiologist staffing	13/04/2023	Outsourcing for February: PHT 4Ways: 10 OP PHT Hexarad: 390 OP RBH 4Ways: 791 (558 IP / A&E) RBH Hexarad: 576 OP Progress with Radiology Dashboard which allow department to view how many unreported examinations there are at any time	Knowles, James	Deputy Chief Medical Officer PH - Matt Thomas
1053	20	Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NRTR patients	26/04/2023	Discussed at Quality Committee and risk score of 20 approved. Noted that also supports the CQC 'Must' actions (Medical Care Group). Update Apr 23 - Some improvement in P1-3 discharges, successful ICB Community Hospital MADE event and commencement of D2A model/bed capacity saw some improvement in our NC2R delays. However, this remains variable and the outputs of change actions are yet to be evidenced sustainably, therefore, the risk score currently remains at 20. This will be closely reviewed as April/May sees a significant focus on the following: new Chief Medical Officer priority, UHD MADE event focusing on LLOS, Estimated Date of Readiness rollout supported by medical and clinical team engagement, continued development of D2A model, continued work to improve Health of the Ward data capture/reporting to support focus on opportunities for improvement. Note, shadow monitoring is in place following changes to HotW to identify any impact.	Horn, Val	Chief Operating Officer - Mark Mould
1074	20	Risks associated with breaches of 18-week Referral to Treatment and long waiter standards.	04/05/2023	Zero 104ww maintained in April. Industrial action and bank holidays in April resulted in a reduction in capacity for long waiters, hence 78 week waits at end of April increased due to higher numbers of patients breaching in month compared to removals from the waiting list. A revised forecast aims to	May, Judith	Chief Operating Officer - Mark Mould

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				eliminate 78 week waits by the end of June 2023. The total RTT waiting list is increasing - drivers include impacts of industrial action in Q4 22/23 and the validation team are currently training new staff which has reduced the capacity of the team's experienced validators to complete validation. Training will be complete by the end of May 2023. RTT performance is reducing due to growing waiting list, increasing the denominator, and reduction in overall activity in Q4 due to industrial action/bank holidays.		
1429	20	Ambulance handover delays - risk to patient harm, performance and organisational reputation	02/05/2023	Close daily monitoring continues. Improvements in Handover delays - particularly in relation to resus and direct to departments. Focused work on real time corrections with Delivery cell. Daily report improved and caveat re SWAST data. Continue to work with system weekly to improve.	Lister, Alex	Chief Operating Officer - Mark Mould
1460	20	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation.	02/05/2023	Controls reviewed and revised in light of 4-hour metrics and cessation of CRS. Work on system flow progressing with some 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.	Higgins, Michelle	Chief Operating Officer - Mark Mould
1872	20	Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding	02/05/2023	Capacity pressures remain, however improvement in occupancy levels over the past 2 weeks. Surge beds remain open alongside planned escalation beds, with plans to reduce escalation further. OPEL 3 position has been more consistently recorded in April. NCTR levels remain high with an average of 193 patients awaiting discharge in April. A MADE event with partners has looked at internal and external processes and will continue into May. Hospital Flow Improvement Group (HFIG) and a focussed trust wide plan to move towards achieving the 4-hour standard has shown improvements over recent weeks. The systemwide operational flow plan is in place and monitored via the QIG, monitoring the position against 92% occupancy. There remains concern that the system measures will not impact flow quickly and the phasing will need to be challenged to support timely ambulance handover, reduction of patients in the ED corridor and the 4-hour ED standard.	Wersby, Stuart	Chief Operating Officer - Mark Mould
1393	16	Endoscopy capacity & Demand	03/05/2023	No change to risk - await outcome of CDC case. Mobile unit and insourcing used as mitigation in Q1 (ERF funded).	Roberts, Hayley	Chief Operating Officer - Mark Mould
1863	16	Impact of Industrial Action on provision of services	02/05/2023	Risk rating reviewed and increased due likelihood of further action and clinical impact with the reduction in derogation/mitigations. A greater impact on patient care and the ability to provide elective activity is likely. Unions are in the process of balloting members for further industrial action.	Jordan, Sophie	Chief Operating Officer - Mark Mould

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1276	15	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients	25/04/2023	Improved performance (>50%) No change to risk. Action plan updated	West, John	Chief Operating Officer - Mark Mould
1386	12	Cancer waits-Corporate	01/05/2023	Further improvement in CWT performance. A/w system confirmation of priority actions on 5/4/23. Action plan detailing assurance will be added to this risk once confirmed.	Lake, Katie	Chief Operating Officer - Mark Mould
1292	12	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	25/04/2023	A significant number of validations have taken place by validation team and within specialties. The average closure rate of episodes which have been reviewed is 95% The total number of patients overdue a follow-up by > 3 years has reduced from 5362 to 2580 (a reduction of 52%) Pilot of Quick Question (DrDoctor) for Gynae Follow-up Validation exercise	Jose, Darren	Chief Operating Officer - Mark Mould
1378	15	Lack of Electronic results acknowledgement system	25/04/2023	Progress remains slow in addressing the issues around this. There is a need to embed the AOMRC guidance regarding referrer responsibilities and to provide a single policy and process for staff to track and act on the results of tests which they have requested. Task and finish group established to be chaired by Matt Thomas. 11 ongoing SI logged on STEIS related to diagnostic process currently.	Hill, Sarah	Chief Information & IT Officer - Peter Gill
1738	12	Radiotherapy Eclipse Treatment Planning System Failure	17/04/2023	Upgrade of Eclipse scheduled for w/c 19th June. Varian and Trust IT availability confirmed. In interim, IT actively working to apply updates to current Eclipse Citrix servers. Initial reports suggest system resilience has improved with no reports of staff being locked out of system. Performance issues persist.	Martin, Charlie	Chief Information & IT Officer - Peter Gill
1805	12	EPR Stability Issues	02/05/2023	Last outage was on the 6th April for 30 mins affecting one server. Hardware and database review has been completed by Graphnet and a follow up review of this will be held on the 12th May to clarify what else is required to ensure stability of this solution.	Hill, Sarah	Chief Information & IT Officer - Peter Gill
1492	12	Resourcing Pressures - Staffing	18/04/2023	Momentum being maintained in recruitment of Internationally Educated Nurses to meet our objective of 80 new starters in the next 8 months. International recruitment has also commenced or in planning stage for Midwifery, Radiotherapy and Theatres. Significant focus on addressing our HCSW WTE vacancy rate, which was reported as 227.5 WTE this week. With funding support from NHSI we continue to run Saturday Open Day events and review process for an improved applicant experience	Gill Parker, Tracy	Chief People Officer - Karen Allman

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				following each one. Activity and development of contracting, terms and conditions for new roles, trainees, various level apprentices and short- or long-term BU Partnership roles and placements continues.		
1493	12	Absence, Burnout and PTSD	05/05/2023	Risk rating to be reviewed at the next meeting of WODG (19/5/23) with a view to downgrading in light of the actions which have been completed and the substantive recruitment to the PSC and MSK posts within OH.	Mardon, Irene	Chief People Officer - Karen Allman
1416	16	GIRFT and Model Hospital	27/04/2023	Reviewed, no change	Rushforth, Helen	Chief Finance Officer - Pete Papworth
1595	16	Medium Term Financial Sustainability	17/04/2023	The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same	Papworth, Pete	Chief Finance Officer - Pete Papworth
1594	12	Capital Programme Affordability (CDEL)	17/04/2023	The Finance & Performance Committee reviewed the risk and agreed that the risk has not changed and should remain the same	Papworth, Pete	Chief Finance Officer - Pete Papworth
1604	20	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds	19/04/2023	19/04/2023: Issue remains the same and still awaiting full approval from the NHP team. The programme/timelines are now being monitored closely to manage delays and potential impacts	Killen, Stephen	Chief Strategy and Transformation Officer - Richard Renaut
1784	16	Critical Path Management	19/04/2023	19/04/2023: Risk score updated to 20. Issue remains the same and still awaiting full approval from the NHP team. The programme/timelines are now being monitored closely to manage delays and potential impacts.	Killen, Stephen	Chief Strategy and Transformation Officer - Richard Renaut
1260	12	Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling	28/04/2023	Risk score to remain the same. Extensive work ongoing to comply with regulatory bodies. CQC maternity call bells action plan has been completed. 2 x fire authority surveys completed with only minor suggestions. Fire escape plans in place. 30+ sets of fire do0rs replaced. 25% (1500 breaches) fire compartmentation work complete. £5.45m of capital funding allocated in 23/24 will support working through the backlog plan across UHD. Challenges around access to complete works, age of structures and recruitment and retention (20% down) remain.	Bhukal, Bernard	Chief Strategy and Transformation Officer - Richard Renaut

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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	10	6	6	
	Likely (4)	1	24	13	9	
	Possible (3)	4	39	30	5	
	Unlikely (2)		8	17	4	5
	Rare (1)			1	1	

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

Current Risk Score– UHD total	April 22	May 22	June 22	July 22	August 22	Sept 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23
Very Low (1-3)	3	2	2	1	1	2	2	2	3	2	4	**5**
Low (4-6)	96	88	81	73	71	67	67	68	69	71	70	**67**
Moderate (8-10)	87	86	97	89	92	91	85	78	80	82	75	**73**
Moderate (12)	17	17	16	17	17	17	17	17	19	19	19	**18**
High (15 -25)	18	21	21	21	22	22	22	23	23	25	24	**21**
Total number of risks under review	221	214	217	201	203	199	193	188	194	199	192	**184**

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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	39	39	100%	⟷
8 to11	73	63	86%	⟷
4 to 7	69	62	90%	↑ 12%
1 to 3	5	4	80%	↓ 20%
Total	**184**	**166**	**90%**	↑ **2%**

10. Recommendations

The Board is asked to:

- Receive and consider reports from the Executive Lead for any new risks graded 12+.

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Appendix B: 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 C: 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

NHS
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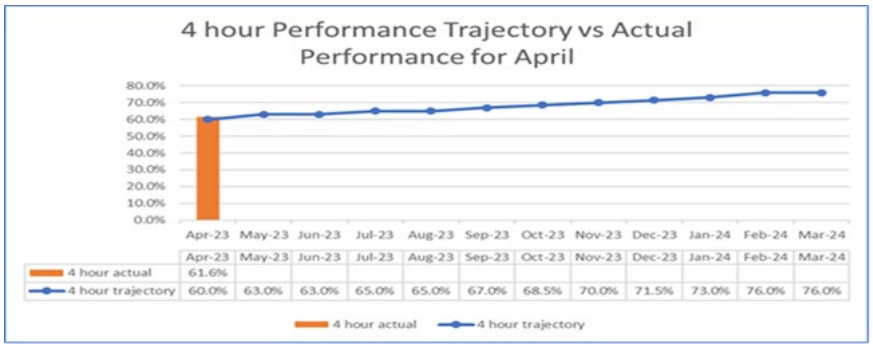
BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 6.4

Subject:	Integrated Performance Report
Prepared by:	Executive Directors, Alex Lister, Leanna Rathbone, Sophie Jordan, Judith May, David Mills, Fiona Hoskins, Matthew Hodson, Irene Mardon, Jo Sims, Andrew Goodwin
Presented by:	Executive Directors for portfolio areas

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☒ Use resources efficiently ☒ Be a well led and effective partner ☒ Transform and improve ☒
BAF	Trust Integrated Performance report March 2023 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	Continuing pressure across the Urgent & Emergency care pathway in April with attendances remaining static. However the Trust delivered a further reduction in Ambulance handover delays in April with 17% of ambulances waiting for more than 60 minutes. A reduction in the number of patients with 'No Reason to Reside' (NRTR) was also maintained contributing to reducing bed pressures, crowding in the emergency departments and overall bed occupancy, although all measures continue to remain high. Community and hospital associated cases of COVID-19 and Norovirus in Dorset remain variable and have impacted hospital flow. Workforce availability to meet escalating capacity levels are contributing to increased agency costs and impacting staff wellbeing. Impact on hospital reputation and increased challenges to elective care recovery as a result of having to move capacity to support emergency pathways.
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 an 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 linked to the Trust strategic objectives.

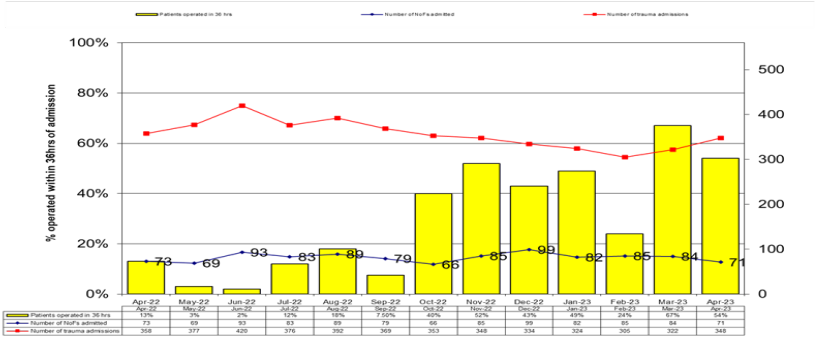
	• Providing SPC training to operational leads who compile the narrative against the data included within the report. • Linking the structure of the report to the delivery of our strategic objectives.
Urgent & Emergency Care (1 Alert, 1 Assure)	**Strategic objective: To continually improve the quality of care** ***Alert (1): The Trust will commence national reporting against the organisation 4 Hour safety standard (A&E waiting times) on 15 May 2023*** ***Assure (1): Time lost to ambulance handover delays and handovers>60 minutes – Improvement since March 2023*** *Further periods of planned industrial action and over 13,000 ED attendances in April 2023, mirrored March's growth in attendances as compared to January and February 2023.* • The average meantime for attendances continues to make a positive downward trajectory, reducing by one hour in April 2023. This is the third month of continuous improvement as well as the lowest meantime in over a year. • Ambulance conveyances remain static as compared to March 2023. Further improvement in ambulances waiting longer than 60 minutes with a decrease to 17% from 20%. • The Trust is also now shadowing reporting as of April 2023 against the 4-hour safety standard and met its internal trajectory for April of 61.3% against a target of 60%. The IPR provides detailed performance against the national Urgent & Emergency Care standards. (Type 1 only) Joint working with ED and Business Intelligence colleagues to include Type 3 performance in national submissions at the Trust.  The recovery plan to reintroduce the 4-hour standard by 15 May 2023 has commenced and replaces the previous weekly assurance meetings for Urgent and Emergency Care. This is now supported by the Trust Wide 4-hour safety standard campaign assisted by our communications team.
Occupancy, Flow & Discharge (1 Advise)	**Strategic objective: To continually improve the quality of care** ***Advise: Medically Ready to Leave (MRTL) - reduction delivered is not at a level to achieve reduction in funded bed occupancy*** • Both sites continued to maintain escalation beds open in April 2023. Occupancy remains at an average of 93.6% across the Trust. The Trust has de-escalated to declared OPEL 3 regularly in April 2023. While we continue to use planned escalation beds

	the Trust has successfully de-escalated from using SDEC capacity for beds. • There was an average of 193 patients MRFD occupying beds across both sites in April 2023, which is consistent with March and remains 50 fewer than February. • Discharge to Assess (D2A) continues to have an impact on discharge rates. • The Trust ran a Multi-Agency Discharge Event (MADE) towards the end of April 2023 to focus actions on supporting patients that were not progressing towards discharge in a timely manner. 23 discharges from the complex care wards were discharged during this time. Evaluation of the learning with system partners will direct plans for future discharge processes and targeted events.
Surge, Escalation and Ops Planning	**Strategic objective: To continually improve the quality of care** In May 2023 we are commencing an 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) (1 Alert , 1 Advise)	**Strategic objective: To ensure that all resources are used efficiently to establish financially and environmentally sustainable services** ***Alert (1): Four-day industrial action by junior doctors in April 2023 resulted in a high number of cancellations across inpatients, day cases and outpatient appointments, which impacted on cancer and RTT performance.*** ***Advise (1): Timely #NOF Pathway performance reduced in April 2023 and was below Best Practice Tariff and Quality***

Planning requirement	Mar 23	April 23	
Referral to treatment 18-week performance	53.8%	52.65% ▼	National Target 92%
Eliminate > 104 week waits	0	0	Plan Trajectory 0 by February 23
Eliminate >78 week waits	96	112 ▲	Plan Trajectory 0 by 31 March 2023
Eliminate >65 week waits		1,249 ▼	Plan trajectory 1,268 April 2023
Hold or reduce >52+ weeks	4,100	4,380 ▲	
Stabilise Waiting List size	72,770	74,557 ▲	

Targets.

- The Trust maintained delivery of zero elective waits over 2 years into March 2023, but waits over 78 weeks, increased to 112.
- Planned industrial action during April 2023 and Easter bank holidays reduced capacity for elective care and in May 2023 means that the Trust is challenged to recover this activity until

	June. Consequently, the Trust's trajectory to eliminate 78-week waits has been extended further to 30 June 2023. • Reducing 78 week waits remains a priority for the Trust, and from April this is now alongside reduction plans to eliminate 65 week waits by 31 March 2024. • All efficiency markers for theatre utilisation showed improvement in April 2023 and theatre utilisation rate also increased to 71% against a plan for 80%. • High cancellation rates were reported due to theatre staffing shortages/sickness and industrial action. Ongoing improvement work is maintaining a focus on theatre staffing, scheduling, digital solutions and pre-op assessment capacity. • April 2023 performance for time to theatre for fractured neck of femur (# NoF) patients decreased against both the NHFD Best Practice Tariff Target and Quality Target. 54% achieving surgery within 36 hours from admission and 72% achieving surgery within 36 hours of being clinically fit for surgery. This is against an increase in trauma admissions. 
Cancer Standards (1 Assure)	**Strategic objective: To ensure that all resources are used efficiently to establish financially and environmentally sustainable services.** ***Assure (1) Validated cancer waiting times performance in March 2023 confirms achievement of the Faster Diagnosis Standard (FDS) and an increase in performance against the 62-day standard.*** • The Faster Diagnosis standard in March 2023 was achieved with the Trust reporting 75.4% ahead of the planned timescales for recovery. The last time the Trust achieved this standard was in August 2021. • The Trust continues to benchmark above the current national average performance for the 62-day standard (60.8%) and reported a 6.1% increase in March 2023 compared to February. • The number of patients over 62 days on a cancer diagnosis pathway also decreased.

KPI	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Jan 23 FINAL	Feb 23 FINAL	March 23 FINAL	Apr 23 Prov
ED Presentation	73	121	76	80	28	26	31	23
28 Day Standard *Target 75%*	70.2%	63.7%	63.5%	70.4%	65.0%	71.0%	75.4%	71.5%
62 Day Standard *Target 85%*	71.4%	68.5%	65.7%	63.8%	63.6%	61.9%	65.4%	63.3%
31 Day Standard *Target 96%*	97.4%	97.4%	97.4%	96.0%	94.9%	96.0%	97.1%	95.3%
62 Day Screening Standard *Target 90%*	82.4%	94.0%	83.7%	75.3%	67.5%	60.9%	75.3%	60.4%

- The priority areas for recovery in the next quarter are colorectal, gynaecology and urology with specific Task & Finish Groups being established.
- Work is ongoing with ICS partners and Primary Care to ensure at least 80% of colorectal 2ww referrals are accompanied with a FIT test. The March 2023 position for colorectal 2ww referrals accompanied with a FIT result decreased to 73.4% compared to 76.1% in February 2023.

Looking forward

In line with RTT performance April's validated performance is expected to show a reduction due to industrial action and Easter bank holidays impacting capacity.

- April's provisional FDS performance is currently 71.5%. Although this is a decrease it remains above the operational plan trajectory.
- 62 day standard performance is at 63.3%.

DM01 (Diagnostics report)

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

UHD continued to deliver a good level of diagnostic performance (DM01) to achieve 8.4% in April 2023.

The DM01 standard has achieved 91.6% of all patients being seen within 6 weeks of referral, 8.4% of diagnostic patients seen >6weeks.

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

March	Total Waiting List	< 6weeks	> 6 weeks	Performance
UHD	11,729	10,747	982	**8.4%**

UHD remains the top performing Trust for diagnostics in the south-west region.

Elective Recovery Actions

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

- **A Theatre improvement programme -** to optimise theatre efficiency and utilisation and improve staff and patient experience of theatres.

	• **Outpatient Enabling Excellence and Transformation programmes -** including three elements: 'back to basics' outpatient improvements focused on achieving immediate and sustainable efficiency improvements in Outpatients; Digital Outpatients transformation, and speciality led outpatient reviews of capacity and utilisation. • **Diagnostics recovery:** Endoscopy, Echocardiology and imaging • **Data and validation optimisation:** Ensuring access to the best quality data for elective care delivery and planning. • **Cancer recovery and sustainability:** Developing a sustainability plan to improve Cancer Waiting Times across 6 priority tumour sites which aligns with the Dorset Cancer Partnership objectives.
Health Inequalities	**Strategic objective: To transform and improve our services in line with the Dorset ICS Long Term Plan** 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 of the average (median) weeks waiting by ethnicity grouping and Index of Multiple Deprivation (IMD) identifies 1 weeks average variation between patients within community minority groups and White British populations, with the former waiting longer, and between the 20% most deprived and the rest of the population treated in Q1 to date. This is a reduction in the level of variation reported last month. Variation between age and length of wait on the waiting list is noted within the report with the greatest variation between 1-19yrs and 20+ age bands. However, this variation has reduced in Q1 to date compared to 22/23. Paediatric waiting times in oral surgery, ENT and community paediatrics contribute to this variation. A health inequalities improvement programme is supporting action on health inequalities in the Trust.
Infection Prevention and Control:	**Quality, Safety, & Patient Experience Key Points** Hospital Associated cases trend (22/23)  Norovirus continued to cause outbreaks at Poole site in April with some ward and bay closures with COVID-19 continuing. • New national guidance was received from NHSE on 31st March, introduced via comms on 14th April, around wearing of masks and COVID screening. • The development of an IPC Nurse Consultant post continued to be processed. • New National IPC Manual now mandatory. • 1 new MRSA bacteraemia being investigated and scoped. • New PIR process for discussing HCAI cases agreed with CNO.

Metric	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Hospital Associated Infections - MRSA					1	1			1			1
Hospital Associated Infections - MSSA	4	2	3	3	3	7	2	3	3	1	1	4
Hospital Associated Infections - C Diff	10	9	9	11	9	2	4	5	6	4	5	5
Hospital Associated Infections - E Coli	1	7	4	7	9	6	7	5	10	7	14	5

Clinical Practice – fundamentals of Care	**Moving & Handling** There remains a vacant B4 Associate Practitioner Falls and Moving and Handling practitioner which despite active recruitment, did not fill, therefore this has been reviewed and advertised as a development post. Our Moving and Handling lead has also a new role and will be leaving in May. The clinical practice and Head of Education are reviewing current needs with an interim solution. **Essential Core Skills** • The ability to meet the face-to-face level two training. requirements for clinical staff continues to be a challenge. The risk register entry remains at 10 (moderate) and under continuous review. • An SBARN has been circulated and approval regarding the proposal to deliver a hybrid model of refresher level 2 training, this is currently being developed and is progressing at pace. **Falls prevention & management** • The Lead practitioner for Falls and Moving & Handling is currently vacant however, after a successful recruitment campaign we are interviewing in early May 2023. • There were five falls' incidents in month, one moderate harm, three patients sustained #nofs (severe), two of the incidents were unwitnessed falls. One patient was found unresponsive on the floor and later passed away. 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 has been distilled into a risk register entry 1821 and rated as 9 (moderate), an action plan has been completed and updated. The number of complex patients being referred to the service remains high. • The number of referrals to the service are now consistently above 200 per month. • The number of complex patients who are remaining on the caseload during admission are also on the increase. • A band 5 advert has gone to temporary staffing for additional support but was unsuccessful, this banding is being reviewed. A total of six newly acquired category three ulcers were reported in April: • Two deteriorated from category 2 damage that was present on admission. • Two deteriorated from newly acquired tissue damage. • One patient had two separate areas of newly acquired damage identified. Four of the patients with newly acquired tissue damage were end of life.
Patient Experience:	**PALS and Complaints** FFT response rates have returned to normal levels In April 2023 there were 412 PALS concerns raised, 57 new formal complaints and 14 Early Resolution complaints (ERC) processed.

Nurse Staffing:	The number of complaints that were responded to and closed in April were 77. Regular meetings with the care groups continue to focus on closing of complaints. Key themes from PALS and complaints: ○ Respect, caring and patient rights. ○ Quality – clinical standards. ○ Safety – errors, incidents and staff competence. **Complaint response times** The number of complaints that were responded to and closed still remains low with a high number of complaints exceeding 55-day response time, which remains a concern, however the additional resource has been sourced and were undergoing training during April, these staff will support and address these long response times and reduce additional pressures on operational teams. **Mixed Sex Accommodation Breaches** There were no MSA incidents in April 2023
	Care Hours per Patient Day (CHPPD) Advise April 2023's CHPPD for registered nurses and midwives was slightly elevated by 0.1 to 4.9 CHPPD. A new loyalty incentive scheme for staff was piloted in April, the data impact of which is currently under analysis. Red flag reporting on Safe Care was not published at the time of producing the May 2023 IPR and will be noted in the June IPR.
Workforce Performance:	**As at the time of writing, the figures for April 2023 were not received.** **UHD turnover** has reduced to 13.8% as at end of March 2023, for the rolling 12 months. **Vacancy rate** is being reported at 5.96% as at end of March 2023. Previous months data continues to adjust as the data cleanse in ESR continues. **Sickness absence** for March 2023 is not available until working day 8. Latest in-month for February was 4.7%, in line with January and much less than 6.4% we saw in December. **Statutory and Mandatory training:** Overall Trust compliance is standing at 87.8 % as at end of March 2023, a slight improvement on previous month. Our aim is to reach 90% across all sites. Face to face courses are still proving difficult.
CPO Headlines:	
People Operations:	The BMA/HCSA trade unions took official strike action from 06:59 on Tuesday 11 April 2023 until 05:59 on Saturday 15 April 2023, as a result of the National dispute around pay. There were no derogations in place for this action. Well established tactical and strategic responses were in place during the action, which saw over 80% of doctors taking strike action.

	We have been working towards a system solution (Health Rota) to allow for individually paid rotas for all trainees and locally employed Trust doctors. This is anticipated to be in place by the Summer. The National 2018 contract refresh outlined its commitment to individualised pay. Meanwhile, in partnership with LNC representatives, we have agreed a local alternative process to facilitate the payment for those doctors who have worked more hours than the average paid in their rota. The 2021 Specialty Doctor (SAS) contract reform introduced the SAS advocate role, a new strategic role to support SAS doctors. The Trust is progressing recruitment to introduce this new role to promote and improve access to health and wellbeing services for SAS Doctors across the organisation.
Blended Education & Training	Overall compliance for mandatory and statutory training currently sits at **87.8%** across the Trust, a slight increase on last month. • Simulation training programmes for medical trainees including F2 and F2 and Internal Medical Trainees is aligned with curriculum requirements and being delivered cross-site. • Bournemouth University and the Student Team have worked with maternity to create an improvement action plan that has been sent to the NMC, safeguarding pre-registration student learning following the recent CQC report. • The GMC Survey was live until 4 May. Results are expected late July. • 10 Trainee Nurse Associates have begun their apprenticeship across the Trust. The next recruitment cycle starts in June for a September start, and we are aiming for another 10-15. Thereafter we are working as a Dorset system for recruitment into the programme. • Poole library is now open again after full refurbishment providing more study space and small teaching areas. • Manual Handling Level 2 – Current compliance is 62.63% and has declined for the fifth month running, current demand for training outstrips the capacity of training staff and will continue to be challenging. The risk register entry remains at 10 (moderate) and under continuous review. No new classes beyond June have been released for staff to book as a result of diminished capacity. Work to create an e-learning refresher update has been approved and is in development led by the Risk and E-Learning Teams. • Information Governance is below the 95% national compliance required – currently it is 88.7% A new Power BI report has been launched with an on-demand, instant report that updates daily for managers and service leaders alike to report on compliance. The new report can be found here: WORK.PBI105 Essential Core Skills - Power BI Report Server (uhd.nhs.uk)
Resourcing	**Medical Recruitment**: There were 15 Medical starters in March 2023, and we posted 26 jobs in month. Having received significantly lower numbers of applications in February this has reversed in March with the highest number of applications since reporting started in May 2022. **General Recruitment:** Despite the number of starters remaining at the same levels as last month, the number of applicants were the

	highest received over the past year, along with more jobs being advertised. This should hopefully result in higher starters next month. **HCSW recruitment (Health Care Support Worker)** remains a focus area, with over 100 candidates either completing checks or ready to start. We are progressing with the recruitment process to fill the Recruitment Manager vacancy within the Resourcing team. We are working with the **Dorset ICS** on system recruitment on TNA, (Trainee Nurse Associate) RNDA (Registered Nurse Degree Apprenticeship) and Vocational Scholarship appointments
Workforce Systems	**Changes:** The number of changes processed by the team in March 2023 was 2693 which was an increase of 899 from the previous month, 1300 of those changes were position changes. **ESR**: All TNA's, RNDA's and NA data has been cleansed and are now coded correctly, as many were originally aligned to HCSW codes. **Rostering:** Roster finalising saw a big improvement this month with only 4 units finalising late compared to previous months when between 80-100 units had not been finalised. **Transformation:** All of the Stroke moves have been completed in ESR and Health Roster along with the Cardiology moves. **Projects:** The new starter questionnaire project is well under way with the month 1 questionnaire focussing on the recruitment and onboarding process being designed. This will promote active feedback being secured on all recruitment activity leading up to when an individual joins the Trust. Work alongside our IT colleagues continues on the reporting and distribution of these E forms before they are launched. **Medical Rostering Project**: Testing of the ESR (Electronic Staff Record) attendance interface is almost complete. Updated details for new rotations for the Post Graduate Doctors in Training (PGDiT) are on the platform and the team are working with ITU, Cancer Services and Paediatrics to prepare for its launch. Work is ongoing with General Surgery, Medicine and OPS to consolidate and ensure all PGDiT's are on the platform by the end of Quarter 1.
Temporary Workforce	**End of "Golden Shift" Incentive Payments:** This legacy incentive scheme ended on 2 April. Drop-in sessions were held in March at Bournemouth and Poole for individuals with a bank contract to discuss any concerns or raise questions, and feedback from these were passed to senior management for awareness and consideration. The new Easter loyalty scheme is running 3-16 April 2023 (inclusive), and usage, financial implications and effectiveness will be analysed at the end of April. The nursing leadership team are discussing how and when future incentive schemes may run. **Bank Recruitment:** Recruitment activity remains high, with rolling monthly adverts for key roles (HCSW/Student Nurses/Staff Nurses) in addition to department-specific roles. The team are currently developing a new reporting dashboard to capture and display bank recruitment activity. To ensure full compliance with the NHS

	employment check standards and local policy/best practice, a new audit process has been introduced for all candidates which will be completed prior to the issue of any unconditional offer. **BU Engagement Work:** The team attended the BU jobs fair on 14 March 2023 and received 90 expressions of interest (and doubled the number of applications received for the bank administration advert which was live at the time). We are in discussions with our BU colleagues to set up additional bank-specific recruitment drives to support individuals with flexible working options (outside of formal careers events). BU have been extremely welcoming with support for both clinical and non-clinical roles, including MHSWs (Mental Heath Support Workers). **TSS (Temporary Staffing Service) Rebranding:** The #ProudToBeBank campaign launched in March has been well received, with over 1,000 engagements on our new Twitter account from the first poster. The new TSS intranet site is live and will be externally accessible for bank workers. **Medical Bank (Locum's Nest):** 1,933 shifts were requested in March, with 71% filled via Locum's Nest and 29% unfilled. The top three users for March were: Medicine (659 shifts, 71% filled), Emergency Medicine (518 shifts, 65% filled) and General Surgery (237 shifts, 44% filled). 3% of all shifts filled were by doctors from the Digital Collaborative Bank. The RBH fill rate was 65%, Poole was 77% and Christchurch was 95%. 66 new locum affiliation requests were received by the Trust in March. **General Nursing and Midwifery:** Overall, requested hours increased by 16.2% in March – requests for RNs and HCSWs increased significantly (14.4% and 19.7% respectively) with a smaller increase in requests for RMs (7.4%). Although overall agency usage increased by 3.0% in March, the number of hours filled by off-framework agencies decreased by 1.7%
Organisational Development	**Leadership & Talent** 360 feedbacks are being conducted on the First Leadership in Action cohort since it has been re-launched and cohort 3 of Leadership Fundamentals has now been delivered. Small pilots for involvement on the National Talent Tool (Scope for Growth) have commenced. Recruiting to second cohort of ILM7 Senior Leadership programme with Bournemouth University. **Team Development** A new prioritisation process has been agreed with Strategy and Transformation colleagues which will lead to 6 priority teams being identified by Care Groups for Q1 & Q2. Successful referrals of team leaders requesting support to the training module on leading teams through integration and change have been received with excellent feedback. **Culture & Engagement** The 2022 National Staff Survey results were published in March, team leaders have been sent their team heat maps and have been signposted to a new online module and action plan template. Drop-in sessions are being held for line managers to ask questions. UHD new Staff Awards launched in March with 12 award categories. New Pulse survey pilot for April was completed with results being made available shortly.

	EDI A re-launch of the PRIDE (LGBTQ+) staff network is taking place.
Trust Finance Position	At the end of April 2023 the Trust has reported a deficit of £2.3 million against a planned deficit of £1.4 million representing an adverse variance of £878,000. This is being driven by energy cost inflation above the national planning assumptions £600,000, the net cost of the Junior Doctors Strike £300,000, together with premium cost pay overspends in the Care Groups which at 30 April 2023 is £1.3 million above budgeted establishment. This has been off-set in part by additional bank interest due to a higher cash holding £425,000, reduced depreciation charges due to the timing of capital expenditure £300,000, and favourable variances associated with reduced patient activity during the Junior Doctors strike action. Cost Improvement Programme savings of £1.3 million have been achieved during April against a target £1.3 million. This includes non-recurrent savings of £592,000. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £14.8 million representing a shortfall of £18.5 million and a recurrent shortfall of £22.2 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 April the Trust has committed capital expenditure of £5.3 million against a plan of £16.6 million representing an underspend of £11.3 million. This underspend relates mainly to the New Hospitals Programme and STP Wave 1. These programmes are expected to remain consistent with the full year budget. As at 30 April 2023 the Trust is holding a consolidated cash balance of £92.7 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of MOU capital funding for multiple schemes alongside a re-phasing of the capital programme spend. The balance attracts Government Banking Services interest of 4.14% at current rates, together with a PDC benefit of 3.5%. The Trust is currently paying 96.7% of invoices within the agreed payment terms, against the national Better Payment Practice Code standard of 95%.
Key Recommendations:	**Members are asked to:** • Note the content of the report • Note and consider the areas of Board focus
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	May 2023	
Quality Committee (Quality)	May 2023	
Finance & Performance Committee (Operational / Finance Performance)	May 2023	

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

Integrated Performance Report

Reporting month: April 2023
Meeting Month: May 2023

Contents:

Performance at a Glance Indicators (1)

			standard	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
SAFE																	
Quality	Presure Ulcers (Cat 3 & 4)			5	7	2	2	3	9	8	5	8	8	8	9	5
	Inpatient Falls (Moderate +)			2	5	1	5	7	5	3	2	5	9	3	3	5
	Medication Incidents (Moderate +)			1	0	0	2	2	1	0	1	0	0	1	2	4
	Patient Safety Incidents			1011	1024	1004	1133	1112	1021	1166	1133	1106	1060	910	973	788
	Hospital Acquired Infections	MRSA		0	0	0	0	0	1	1	0	0	1	0	0	1
		MSSA		4	4	2	3	3	3	7	2	3	3	1	1	4
		C Diff		9	10	9	9	11	9	2	4	5	6	4	5	5
		E. coli		6	1	7	4	7	9	6	7	5	10	7	14	5
EFFECTIVE																	
Mortality	SMR	Latest Jan 21	(source Dr Foster)	100.79	91.83	102.71	102.40	109.20	109.40	110.90	109.90	107.60				
	Patient Deaths		YTD	227	211	236	234	226	225	256	256	294	273	217	259	238
	Deaths within 36hrs of Admission			41	31	37	30	29	29	41	37	50	38	37	32	36
	Deaths within readmission spell			13	18	35	21	22	21	21	17	24	23	23	16	22
CARING																	
	Complaints Received			55	63	80	78	83	90	98	100	75	92	84	86	73
	Complaint Response Rate (55 Days)			66.70%	56.90%	66.70%	67.70%	63.90%	56.60%	66.70%	58.70%	62.90%	51.80%	51.40%	47.40%	45.50%
	Friends & Family Test			88%	90%	88%	86%	90%	90%	90%	90%	88%	91%	93%	90%	91%
WELL LEAD																	
Safety	Risks 12 and above on Register			36	37	34	34	35	38	37	35	37	38	41	38	38
	Risks 15 and above on Register			17	17	18	17	19	20	19	19	19	20	20	19	19
	Red Flags Raised*			159	41	45	86	128	142	107	74	84	41	43	38	
People	Turnover			14.50%	12.80%	14.80%	14.50%	14.50%	14.70%	14.60%	14.70%	14.80%	14.94%	14.72%	13.90%	13.83%
	Vacancy Rate			7.53%	7.6%	5.68%	6.03%	8.88%	6.19%	7.96%	8.82%	7.3%	7.0%	6.4%	6.0%	5.8%
	Sickness Rate			6.5%	4.8%	5.1%	5.8%	4.7%	4.9%	5.7%	5.2%	6.4%	4.8%	4.7%	4.7%	
	Statutory and Mandatory Training			84.79%	83.42%	84.40%	85.54%	87.11%	86.75%	85.32%	85.80%	85.92%	86.31%	86.81%	86.98%	87.84%

Performance at a Glance Indicators (2)

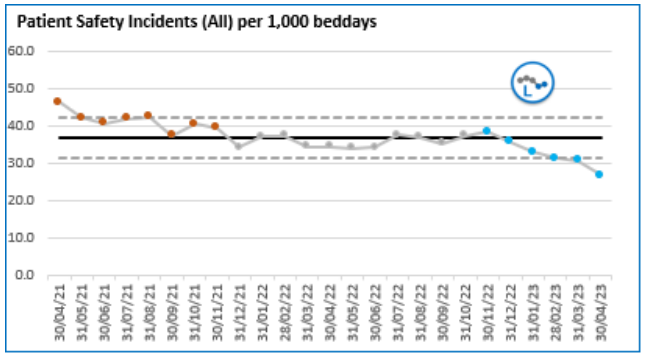
		standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	
RESPONSIVE																
RTT	18 week performance %	92%	56.1%	59.2%	58.2%	58.3%	57.1%	54.9%	55.5%	56.1%	55.1%	55.4%	54.3%	53.8%	52.6%	
	Waiting list size	44,508	61,278	72,568	73,932	75,502	75,065	72,860	70,918	71,161	70,259	71,230	72,522	72,770	74,557	RAG cf trajectory 22/23
	Waiting List size variance compared to Sep 2021 (cf Mar 19 up to Mar 21, cf Jan 20 up to oct 21)	0%	19.0%	40.9%	43.6%	46.6%	45.8%	41.5%	37.7%	38.2%	36.4%	38.3%	40.8%	41.3%	44.8%	
	No. patients waiting 26+ weeks		17,433	19,913	20,428	20,244	21,326	21,172	20,227	20,765	21,024	21,726	22,109	22,248	24,223	
	No. patients waiting 52+ weeks		2,798	3,325	4,493	4,170	4,010	3,559	3,468	3,634	3,472	3,565	3,861	4,100	4,380	RAG cf trajectory 22/23
	No. patients waiting 65+ weeks		1,322	1,116	1,714	1,405	1,464	1,420	1,449	1,342	1,195	1,127	1,147	1,070	1,249	
	No. patients waiting 78+ weeks	0	759	550	520	492	502	504	513	487	473	395	274	96	112	RAG cf trajectory 22/23
	No. patients waiting 104+ weeks	0	238	194	118	100	95	76	63	37	25	10	0	0	0	RAG cf trajectory 22/23
Theatre	Theatre utilisation (capped) - main	98%	71%	76%	78%	74%	75%	75%	69%	75%	73%	71%	71%	65%	72%	
	Theatre utilisation (capped) - DC	91%	62%	69%	73%	69%	69%	70%	74%	74%	69%	69%	67%	57%	69%	
	NOFs (Within 36hrs of admission - NHFD)	85%	24%	3%	2%	12%	18%	8%	40%	52%	43%	49%	24%	67%	54%	
Outpatients	**Outpatient metrics**															
	Overdue Follow up Appts		46,566	36,798	25,671	32,621	33,268	33,840	32,999	32,757	33,369	34,863	34,756	34,302	31,778	
	% DNA Rate	5%	6.7%	6.9%	8.3%	8.3%	8.0%	7.4%	6.8%	6.5%	7.5%	7.5%	6.5%	7.1%	7.6%	
	Patient cancellation rate		12.7%	10.5%	10.7%	11.2%	10.5%	11.4%	11.0%	10.5%	12.3%	10.6%	10.8%	9.2%	8.9%	
	% non face to face (telemedicine) attendances	25%	24.0%	22.6%	22.9%	22.5%	21.8%	21.1%	20.4%	20.0%	20.2%	20.8%	21.3%	18.5%	18.6%	
DM 01	**Diagnostic Performance (DM01)**															
	% of >6 week performance	1%	19.9%	18.6%	19.5%	20.2%	22.6%	20.0%	16.4%	11.0%	13.6%	10.7%	7.4%	7.0%	8.4%	
Cancer	28 day faster diagnosis standard	75%	71.9%	71.8%	66.9%	63.6%	62.9%	64.7%	63.1%	59.6%	68.4%	65.0%	71.0%	75.4%	71.5%	*Apr 23 provisional*
	62 day standard	85%	71.5%	69.6%	73.4%	66.2%	65.9%	71.2%	69.4%	64.3%	63.4%	63.6%	61.9%	65.4%	63.3%	*Apr 23 provisional*
	PTL Over 62 Day (Avg)		195	204	242	264	273	332	306	293	261	301	261			
Emergency Dep	Arrival time to initial assessment	15	7.0	9.0	18.0	21.6	30.0	15.0	16.0	15.0	20.5	11.0	15.0	13.0	16.0	
	Clinician seen <60 mins %		26.9%	24.4%	20.0%	20.9%	26.6%	26.0%	25.5%	24.3%	21.8%	31.6%	25.7%	26.1%	31.6%	
	PHT Mean time in ED	200	307	296	317	297	295	303	325	307	357	499	377	338	280	
	RBCH Mean Time in ED	200	314	302	300	329	355	406	355	347	433	357	368	376	310	
	Patients >12hrs from DTA to admission	0	188	88	105	97	103	129	295	157	343	234	294	211	220	
	Patients >12hrs in dept		758	626	769	879	779	886	1292	1074	2000	1108	1443	1238	849	
SW AST	Ambulance handovers		3394	3796	3696	3758	3743	3657	3716	3855	3545	3602	3360	3988	4007	
	Ambulance handover >60mins breaches		557	606	629	642	445	547	666	583	1568	733	859	900	698	
Patient Flow	Bed Occupancy (capcity incl escalation)	85%	94.7%	94.3%	93.4%	93.6%	93.4%	92.8%	94.2%	92.7%	93.3%	93.1%	94.1%	94.5%	93.6%	
	Stranded patients:															
	Length of stay 7 days		549	539	539	543	577	567	605	550	522	564	582	543	523	
	Length of stay 14 days		361	355	360	357	400	397	421	375	332	366	387	355	337	
	Length of stay 21 days	108	247	254	256	255	295	303	315	281	228	250	269	255	235	
	Non-elective admissions		5485	6401	5802	5778	5367	5472	5535	5817	5956	5693	5165	6203	5690	
	> 1 day non-elective admissions		3488	4081	3633	3652	3396	3475	3578	3676	3905	3673	3202	3881	3612	
	Same Day Emergency Care (SDEC)		1994	2317	2168	2126	1971	1996	1956	2141	2050	1979	1963	2316	2078	
	Conversion rate (admitted from ED)	30%	29.20%	28.40%	26.90%	26.50%	26.30%	27.60%	25.80%	29.10%	28.30%	30.90%	27.79%	28.30%	29.70%	

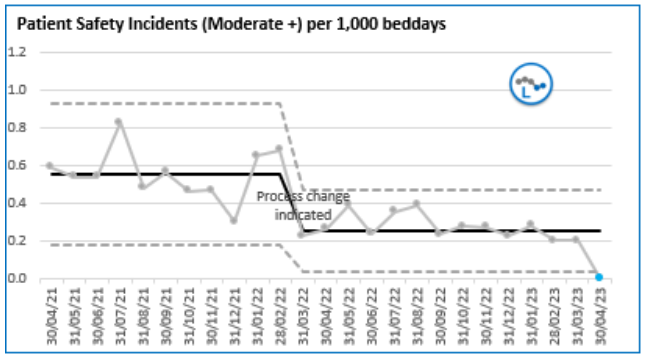
Statistical Process Control (SPC) – Explanation of Rankings

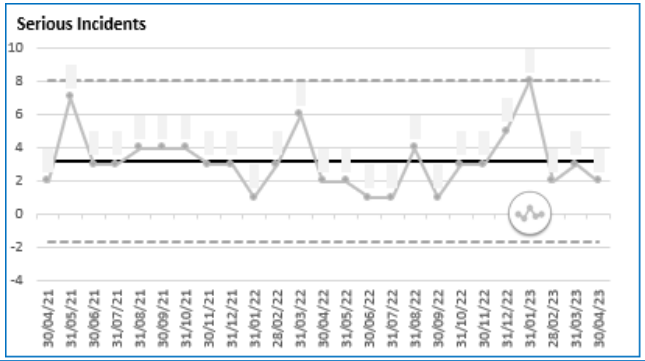
Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: None
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **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 (1) – Safe

Executive Owner: Professor Paula Shobbrook (Chief Nursing Officer/ Deputy CEO) Dr Peter Wilson (Chief Medical Officer)
Management/Clinical Owner: Jo Sims





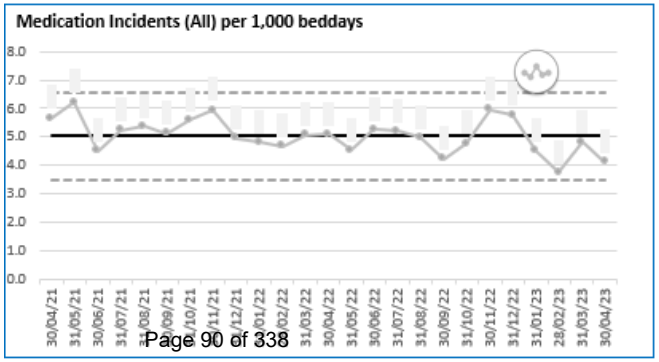


Background/target description
To improve patient safety.

Performance:

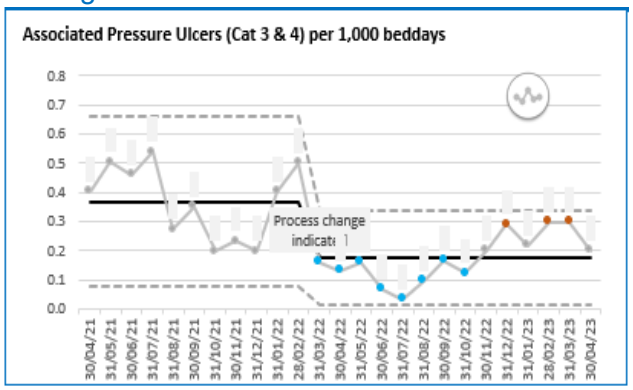
- Two (2) externally reported incidents reported in month (April 23).
- Reduction in reported patient safety incidents – linked to changes in national definitions for reportable patient safety incidents. Trend will continue as the Trust begins to transition to LFPSE. Reduction being seen nationally by all early adopters. Agreed at ICS Patient Safety Specialists Steering Board that Trusts should place this as a concern on their individual risk registers – in progress.

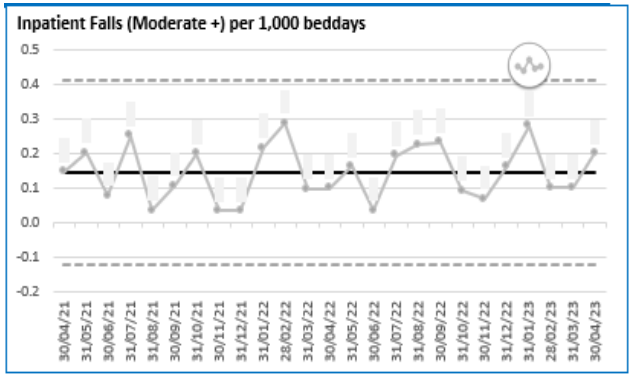
Actions:
Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

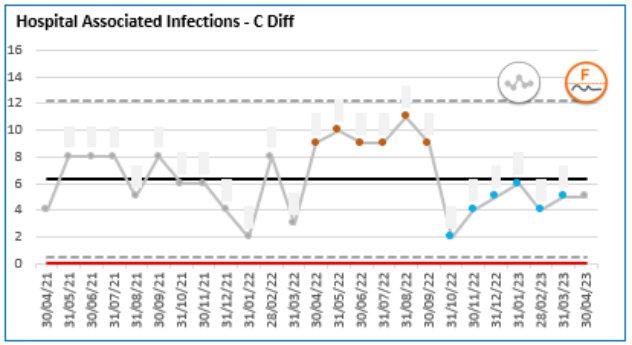


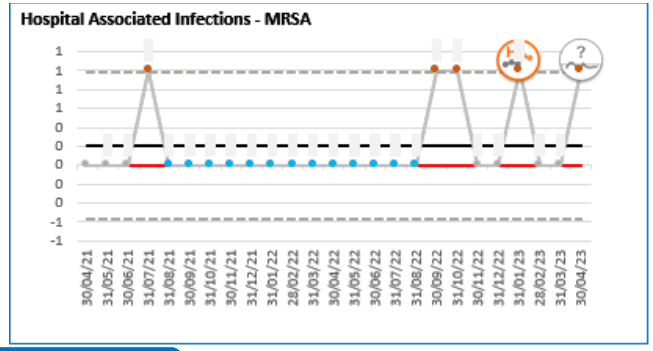
Quality (2) – Safe

Executive Owner: Professor Paula Shobbrook (Chief Nursing Officer/ Deputy CEO) Dr Peter Wilson (Chief Medical Officer)
Management/Clinical Owner: Matthew Hodson









Background/target description
To improve patient safety and care; supporting reduced length of stay.

Overview:

- Six new category three pressures ulcers reported. With 22 category three and 3 category four pressure ulcers noted on admission.
- There were five fall incidents in month, one unwitnessed as a moderate fall, and three patients sustained #nofs (severe), and one person found unresponsive following an unwitnessed fall, who later passed away. These falls will be following the appropriate scoping and investigation process.

IPC

- Norovirus continued to cause outbreaks at Poole site in April with some ward and bay closures with COVID-19 continuing.
- New national guidance was received from NHSE on 31st March, introduced via comms on 14th April, around wearing of masks and COVID screening
- The development of an IPC Nurse Consultant post continued to be processed
- New National IPC Manual now mandatory and being introduced into UHD
- 1 new MRSA bacteraemia being investigated and scoped.
- New PIR process for discussing HCAI cases agreed with CNO.

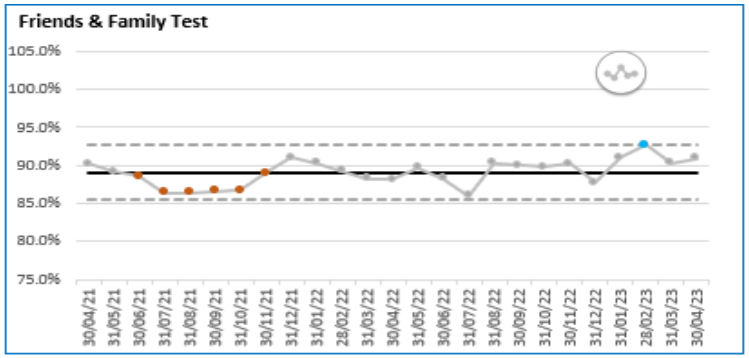
Actions:
Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

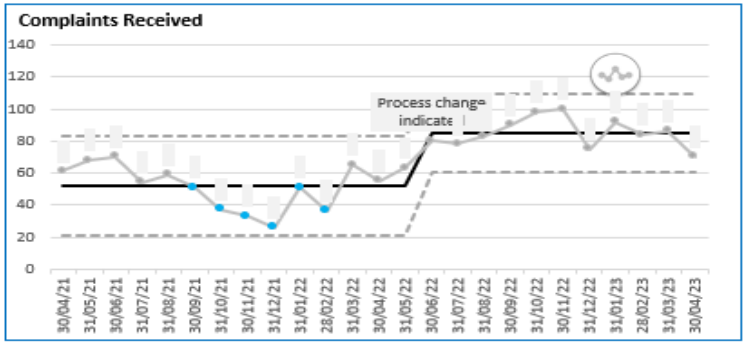
Hospital Associated Infections Summary for IPR

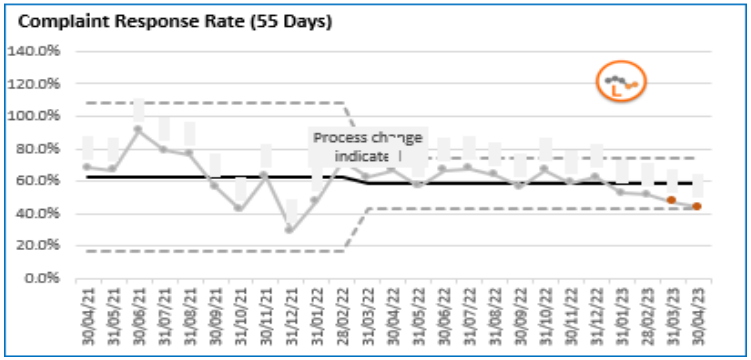
Month	C Diff	E Coli	MRSA	MSSA
May-22	10	1		4
Jun-22	9	7		2
Jul-22	9	4		3
Aug-22	11	7		3
Sep-22	9	9	1	3
Oct-22	2	6	1	7
Nov-22	4	7		2
Dec-22	5	5		3
Jan-23	6	10	1	3
Feb-23	4	7		1
Mar-23	5	14		1
Apr-23	5	5	1	4

Quality (3) – Caring

Executive Owner: Professor Paula Shobbrook (Chief Nursing Officer/ Deputy CEO)
Management/Clinical Owner: Matthew Hodson







PALS and Complaints Data for April:

- 412 PALS concerns raised
- 57 new formal complaints
- 14 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in April were 77.

- Key themes from PALS and complaints:
  - Respect, caring and patient rights
  - Quality – clinical standards
  - Safety – errors, incidents and staff competence

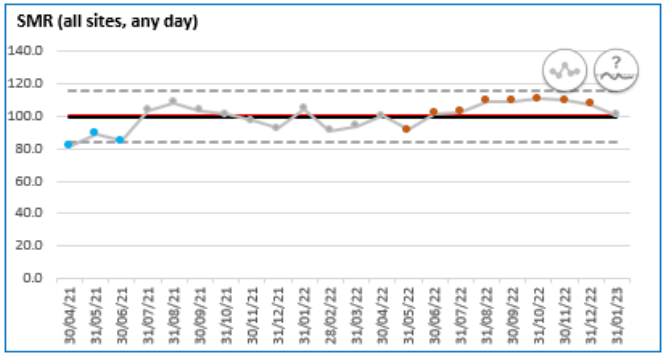
To note: Additional resource to support responding to and closing complaints within the 55-day response has been recruited and are in training.

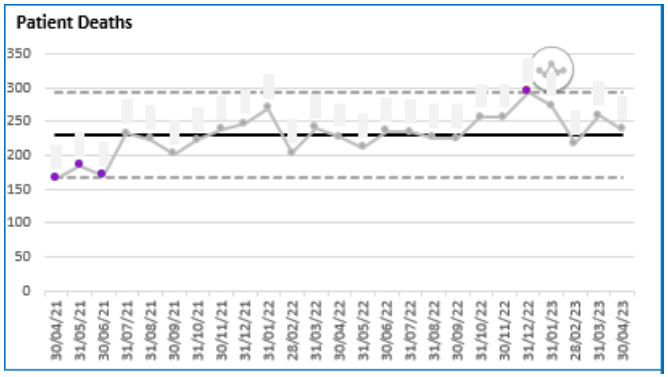
Friends and Family Test (FFT)
A return to normal response levels for FFT is noted

Mixed Sex Accommodation Breaches
There were no MSA incidents in April 2023

Quality (3) – Effective & Mortality

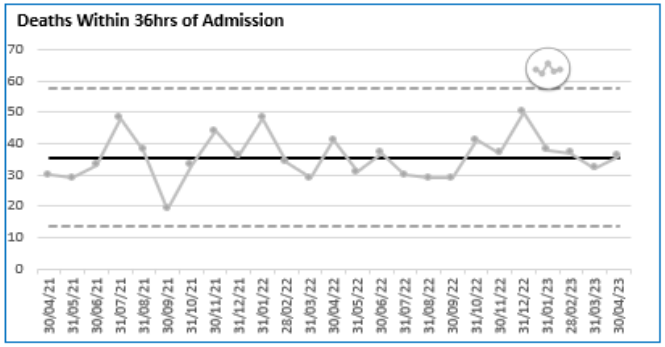
Executive Owner: Peter Wilson (Chief Medical Officer)
Management/Clinical Owner: Jo Sims

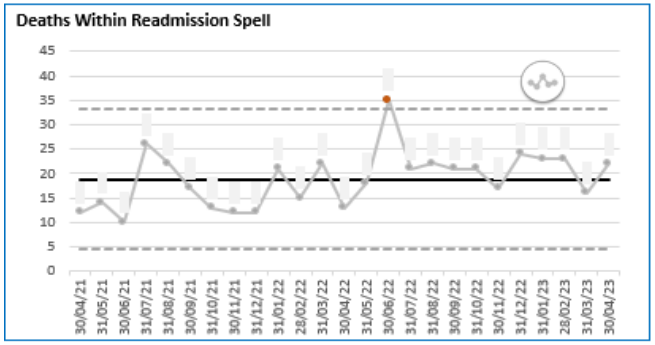




Performance:
Latest SMR (standardised Mortality Ratio) monthly position is January 2023 which shows UHD at 100.8. This is in the expected range and dropping. Recently our HSMR has been higher than our SMR and we are yet to have this for January. Our latest SHMI for UHD is below expected at 0.89 from January's data release.

Actions:
Sean Weaver has been appointed clinical lead for mortality. This is an opportunity to review the governance around mortality and how the mortality steering group functions. Mortality is a visible but late indicator of patient safety. The data also lags real time. Therefore, ensuring an integrated approach with all patient safety work and the roll out of PSIRF is crucial.

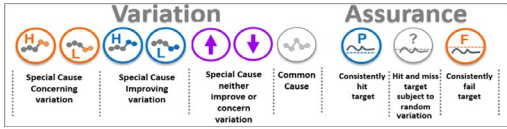




Performance at a glance
Quality - Key Performance Indicator Matrix

UHD Quality

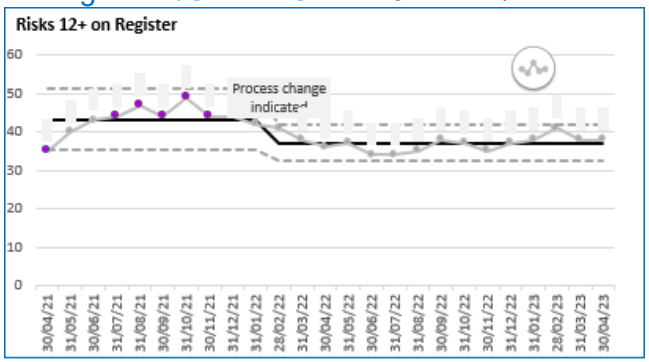
KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	Apr 23	0.2	-			0.2	0.0	0.3
Inpatient Falls (Moderate +) per 1,000 beddays	Apr 23	0.2	-			0.1	-0.1	0.4
Medication Incidents (Moderate +) per 1,000 beddays	Apr 23	0.1	-			0.0	-0.1	0.1
Medication Incidents (All) per 1,000 beddays	Apr 23	4.2	-			5.0	3.5	6.6
Patient Safety Incidents (All) per 1,000 beddays	Apr 23	26.7	-			36.8	31.4	42.1
Patient Safety Incidents (Moderate +) per 1,000 beddays	Apr 23	0.0	-			0.3	0.0	0.5
Serious Incidents	Apr 23	2				3	-2	8
Never Events	Apr 23	0	-			0	-1	2
Hospital Associated Infections - MRSA	Apr 23	1	0			0	-1	1
Hospital Associated Infections - MSSA	Apr 23	4	0			4	-1	8
Hospital Associated Infections - C Diff	Apr 23	5				6	0	12
Hospital Associated Infections - E Coli	Apr 23	5	0			7	-2	15
Risks 15+ on Register	Apr 23	19	-			19	18	21
			-					
Mixed Sex Accommodation Breaches	Apr 23	0	0			4	-16	24
Complaints Received	Apr 23	73	-			85	62	109
Complaint Response Rate (55 Days)	Apr 23	45.5%				59.0%	43.7%	74.2%
Friends & Family Test	Apr 23	90.9%	-			89.1%	85.5%	92.6%
SMR (all sites, any day)	Jan 23	100.8	100.0			99.8	84.0	115.5
Patient Deaths	Apr 23	238	-			230	166	294
Deaths Within 36hrs of Admission	Apr 23	36	-			36	13	58
Deaths Within Readmission Spell	Apr 23	22				19	4	33
Risks 12+ on Register	Apr 23	38				37	32	42
Red Flags Raised	Mar 23	38				101	22	180
CHPPD (Registered Nurses & Midwives)	Apr 23	4.9				4.6	4.3	5.0

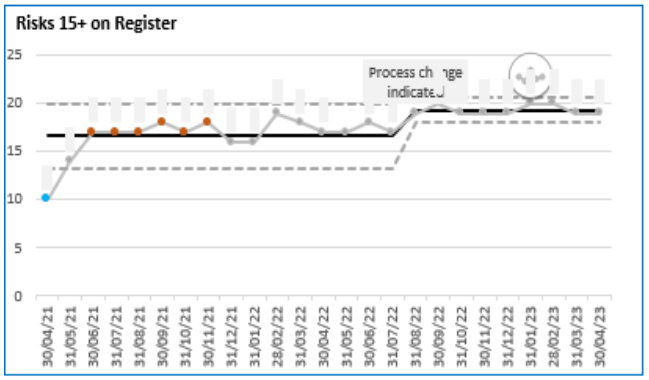


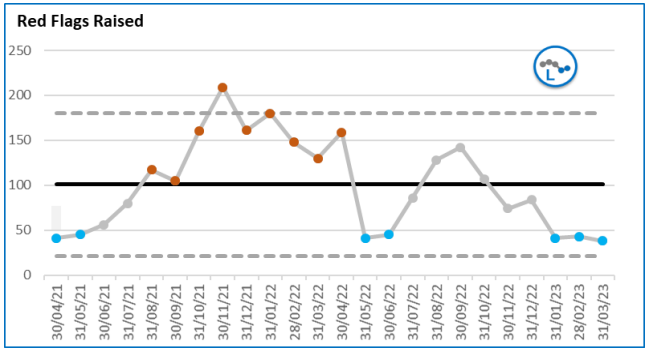
Quality (4) – Well Led

Executive Owner: Professor Paula Shobbrook (Chief Nursing Officer/ Deputy CEO) Dr Peter Wilson (Chief Medical Officer)

Management/Clinical Owner: Jo Sims / Fiona Hoskins







Performance:

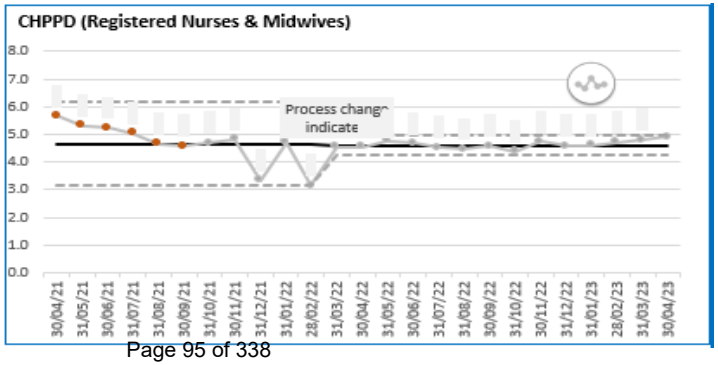
- CHPPD (Care Hours Per Patient Day) for registered nurses and midwives in April 2023 aggregated was 4.9. This is slightly elevated compared to March which was 4.8 CHPPD.
- April Red Flag data is not available and will updated either verbally or in the next IPR.

Actions:

- Risk register update provided in Quality Committee, TMB, and Board report.
- Heat map risk reports provided to Finance and Performance Committee, Workforce Committee and Operations and Performance Group .
- The differential of 0.5 CHPPD between the Poole and Bournemouth and Christchurch data is being reviewed as part of the annual establishment review process.

Safe Staffing (Rota Fill Rate and CHPPD) - Toatal (Day & Night Combined) April 2023

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	15529	79453.9	79079.9	99.53%	5.1
Bournemouth & Christchurch	16222	74965.4	75399.7	100.58%	4.6
UHD Total	**31751**	**154419.3**	**154479.7**	**100.04%**	**4.9**



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 Ockenden 1 requirements**
- **There are a number of items which require narrative rather than graphic benchmarking and these are described below**

Findings of review of all perinatal deaths using the national monitoring tool	Matters for Board information and awareness	Progress in achievement of NHSR/MIS Yr 4
MBRRACE reportable cases: **There have been 5 reportable cases for MBRRACE in April.** **3 x Stillbirths** 1 x antenatal stillbirth at 35+5 gestation, for PMRT review in May 23 - L105470 1 x antenatal stillbirth at 25+3 gestation, for PMRT review in May 23 - L105515 1 x antenatal stillbirth at 24+1 gestation, for PMRT review in May 23 - L105538 **1 x late fetal loss** 1 x Late fetal loss at 22+5 gestation, for PMRT review in June 23 – L106180 **1 x MTOP** Medical termination of pregnancy (MTOP) for abnormalities at 26+2. Reportable to MBRRACE, but does not meet criteria for PMRT review – L106395 Learning will be reported through safety champions report.	**.PQST dashboard** **Incidences to note:** 3 and 4th degree tears fluctuation this month-overall not a concern as overall trend stable. Apgar's 2.3% greater than national average of 1.2%, this is being monitored with an improvement plan in place. Overall trend per quarter will be reported Stillbirth rate raised this month –all cases will be reviewed through PMRT, no initial themes or trends identified. Possible fluctuation as previous months low Training compliance standards not being met – recording of training on beat in progress which will enable staff to track their non -compliance and provide accurate records for reporting	**Awaiting year 5 MIS standards** Year 4 accepted as noncompliant by NHSI and reduced funding given to support improvements. Work continues on all safety standards with monthly assurance meetings to monitor compliance Good progress is being made on recording of training on BEAT.

Maternity (2)

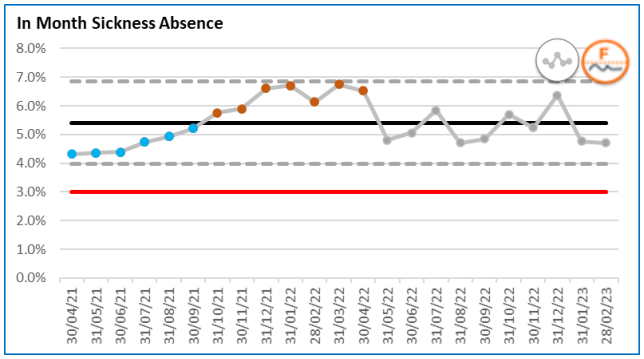
Executive Owner: Paula Shobbrook (Chief Nursing Officer)
Management/Clinical Owner: : Sarah Macklin (GDO) / Lorraine Tonge
Director of Midwifery / Mr Alex Taylor Clinical Director

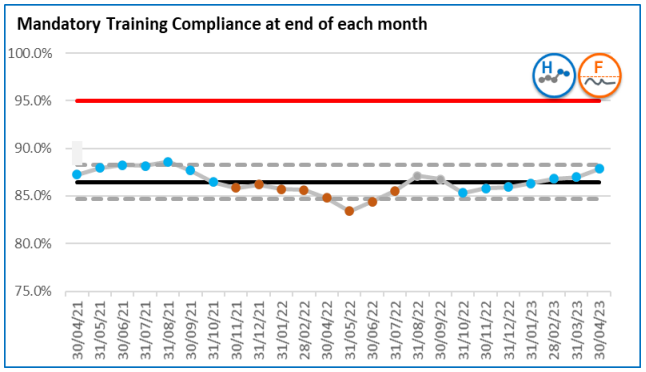
Maternity Perinatal Quality Surveillance Scorecard

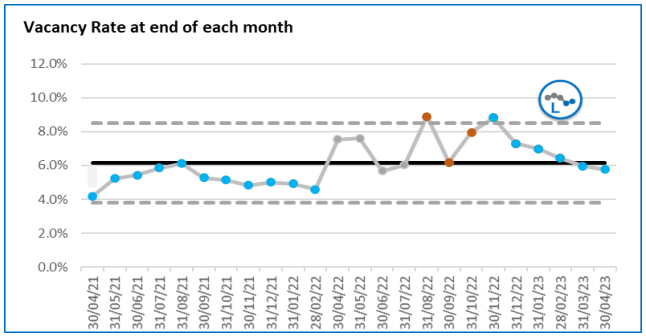
	Alert (national standard/average where available)	Running total/average	22-Nov	22-Dec	23-Jan	23-Feb	23-Mar	Apr-23
Red flags: 1:1 care in labour not provided	0		0	0	0	0	0	0
3rd/4th degree tear overall rate	> 0.0%	1.99%	2.50%	4.10%	1.60%	1.40%	0.60%	3.1%
Obstetric haemorrhage >1.5L	> 0.0%	#REF!	2.10%	3.70%	4.20%	2.10%	4.30%	2.10%
Term admissions to NNU	National <6%, Regional <5%	0	6.10%	6.60%	5.80%	3.40%	6.20%	5.9%
Apgar < 7 at 5 minutes	> 0.0%	2.3%	1.50%	2.50%	2.30%	2.40%	1.10%	2.3%
Stillbirth number	Actual	4	1	0	0	1	0	4
Stillbirth number/rate (per 1,000)	> /1000	13.29	3	3	0	3	0	13.29
Rostered consultant cover on Delivery Suite - hours pw	<	72.0	72	72	72	72	72	72
Dedicated anaesthetic cover on Delivery suite - per week	<	58.0	58	58	58	58	58	58
Midwife/band 3 to birth ratio (establishment)	00:00	1:21	01:21	01:21	01:21	01:21	01:21	01:21
Midwife/band 3 to birth ratio (in post)	00:00	1:25	01:23	01:23	01:23	01:23	01:25	01:25
Number of compliments (Smiles via Badgernet)		42	66	not available	62	18	43	42
Number of concerns (PALS)		0	1	0	0	2	0	0
Complaints		2	2	1	2	0	4	2
FFT Repsonse -returns as % of deliveries not mandated now)			100% +	previous =	% positive	12%	40%	not available
UHD Mandatory training - women's health	90%	82.0%	79%	79%	79%	87%	86%	82%
PROMPT/Emergency skills all staff groups	90%	82.0%	76%	93%	96%	94%	94%%	82%
K2/CTG training all staff groups	90%	91.8%	88%	80%	89%	85%	85%	91.76%
CTG competency assessment all staff groups	90%	91.8%	88%	80%	89%	not know	not know	91.76%
Core competency framework compliance	90%	84.0%	80%	92%	92%	not know	84%	84%
Coroner Reg 28 made directly to the Trust		Y/N	N	N	N	N	N	N
HSIB/CQC etc. with a concern or request for action		Y/N	Y (CQC)	Y (CQC)	Y (CQC)	Y (CQC)	Y (CQC)	Y (CQC)

Well Led - Workforce (1)

Executive Owner: Karen Allman (Chief People Officer)
Management/Clinical Owner: Carla Jones / Irene Mardon







Performance:

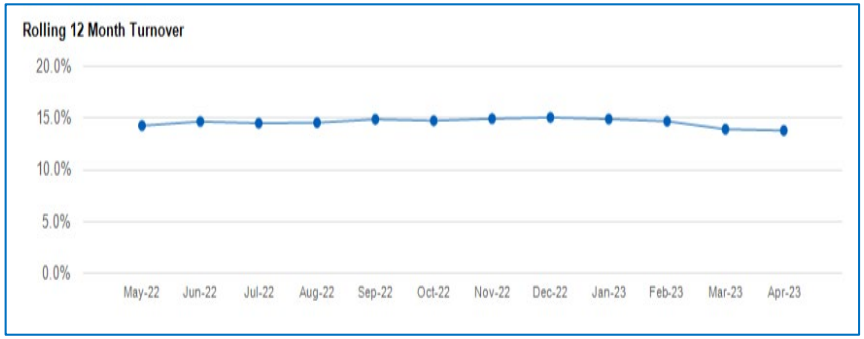
- Rolling 12 month Turnover rate (excluding fixed term temp) is at 13.8%, which is a reduction compared to the usual trend.
- April absence data is not available until working day 8. In month sickness absence for March 2023 was at 4.7%, the same as previous month. Latest rolling 12 month rate (as at end of February 2023) is 5.3% which is a reduction on previous month.
- Mandatory Training has improved slightly to 87.8% as at end of April 2023. Our aim is to reach 90% across all sites.
- Latest vacancy position is 5.8% (April 2023). Previous months data continues to adjust as the ESR data cleanse continues.

Underlying issues:

- Face to face courses are still proving difficult in supporting mandatory training compliance.
- The ESR establishment work and data cleanse process is ongoing.

Actions:

The BEAT team are reviewing an alternative blended online version for Manual Handling with the Risk team. Information Governance is currently below the 95% national compliance required – currently it is 88%.



Appraisal Compliance
Latest (31/03/23)

Values Based
1.3%

Medical & Dental
60.4%

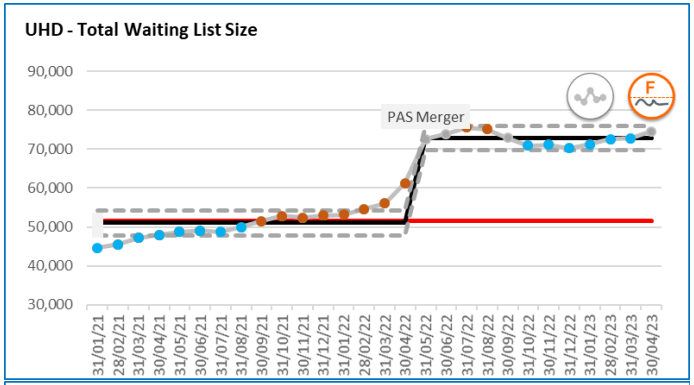
Performance at a glance
Well Led - Key Performance Indicator

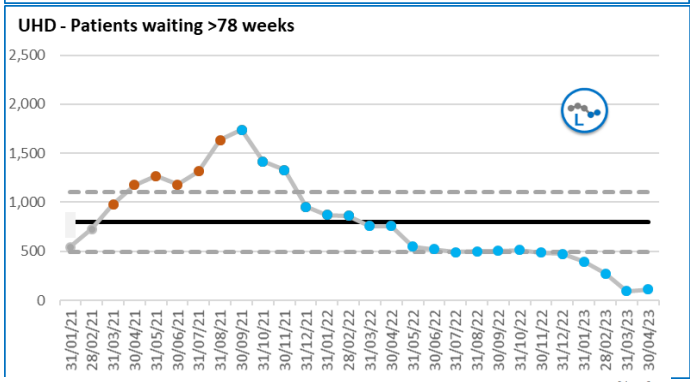
UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Apr 23	5.8%	-			6.2%	3.8%	8.5%
In Month Sickness Absence	Mar 23	4.7%	3.0%			5.3%	3.9%	6.7%
Mandatory Training Compliance at end of each month	Apr 23	87.8%	95.0%			86.4%	84.7%	88.2%
Temporary Hours Filled by Bank	Apr 23	58.9%	-			53.7%	46.7%	60.8%
Temporary Hours Filled by Agency	Apr 23	20.2%	-			14.4%	12.2%	16.5%

Responsive – (Elective) Referral to Treatment)

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)





	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	52.65%	
Waiting list size	51,491	74,557	17%
Waiting List size variance compared to Sep 2021 %	0%	44.8%	
No. patients waiting 26+ weeks		24,223	20%
No. patients waiting 40+ weeks		10,902	23%
No. patients waiting 52+ weeks (and % of waiting list)	5.9%	4,380	29%
No. patients waiting 65+ weeks (and % of waiting list)	1.7%	1,249	40%
No. patients waiting 78+ weeks (and % of waiting list)	0.2%	112	94%
No. patients waiting 104+ weeks (and % of waiting list)	0.0%	0	-
% of Admitted pathways with a P code		98.54%	

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.
New: Number of patients on an elective RTT waiting list whose wait exceeds 78 weeks. National target 0 by March 2024.

Performance

The Trust maintained delivery of zero elective waits over 2 years into April 2023, but waits over 78 weeks, increased to 112 .
The total waiting list was 74,557. This is 129 below the operational planning trajectory for April 2023 (74,686).

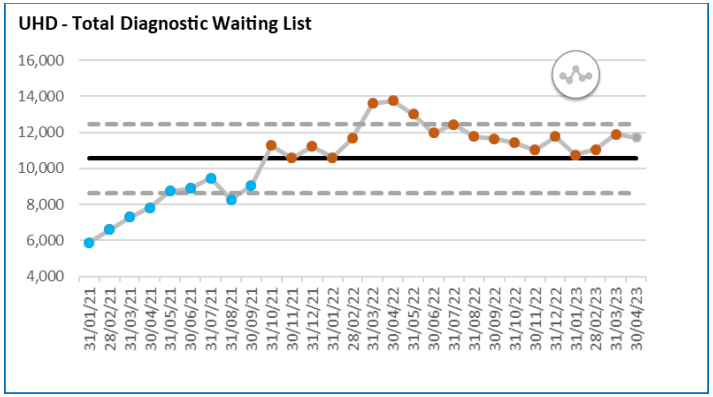
- Non-elective pressures, higher than optimal bed occupancy and high numbers of no criteria to reside patients continue to impact the elective bed base in April.
- A 4-day period of planned industrial action during April alongside Easter bank holidays also reduced capacity for elective care and the impact of further industrial action in early May means that the Trust is unlikely to recover this activity until June. Consequently, the Trust's trajectory to eliminate 78-week waits has been extended to 30 June 2023.
- Reducing 78 week waits remains a priority for the Trust, and from April 2023 this is alongside the elimination of 65 week waits by 31 March 2024. 1,249 patients breached 65 weeks in April; 19 below the planned trajectory.

Key Areas of Focus

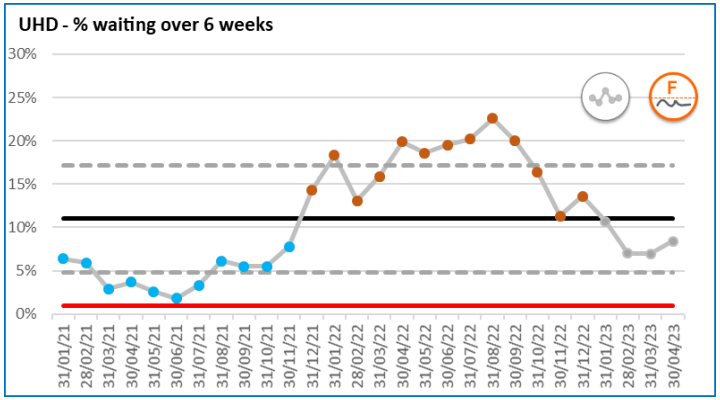
- Re-book all patients displaced due to industrial action in April (1,958) into future capacity.
- Deploy NHSE Southwest Validation pilot personnel following completion of training, within specialities identified as experiencing a rise in their waiting list.
- Prioritise all patients with a wait over 52 weeks for completion of their first outpatient appointment by September 2023, through an increase in insourcing and outpatient productivity measures in June.
- Independent sector theatre capacity has been mobilised in May to support recovery.

Responsive – (Elective) Diagnostic Waits

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)



Diagnostic Performance (DM01)				
% of >6 week performance	(6+ Weeks / Total)	1%	982/11729	8.4%



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

Overall diagnostics (DM01) performance has fallen in April to 8.4%

Endoscopy increased to 28.1% at the end of April (27.7% at the end of March).

- Endoscopy continue to have their 'Task & Finish' group meetings to support recovery actions.
- Significant impact in March and April following junior doctor strikes on capacity.
- Outsourcing utilising elective recovery funding is on-going to mitigate.

Echocardiography has improved from 12.3% in March to 10.1% in April.

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

Neurophysiology has increased since February (1.7%) to 3.1% in March.

- Consultant vacancy leading to reduced capacity and longer waits within department – ongoing use of locum cover and shifting of other clinical work in dept to manage performance. Consultant vacancy out to advert and working with recruitment team to extend reach via social medical platforms.

Radiology has increased since March (1.6%) to 3.9% in April.

- Imaging position deteriorated predominately due to ongoing reduction in cardiologist CT / MRI sessions. Ongoing work within Cardiology to establish sustainable workforce plan to resource cardiac CT and MR; candidate successfully recruited to in March to undertake CT and MRI cover.
- Increased numbers of ultrasound breaching patients due to BH and unfilled WLIs. Additional AECC provision in June to recover backlog.

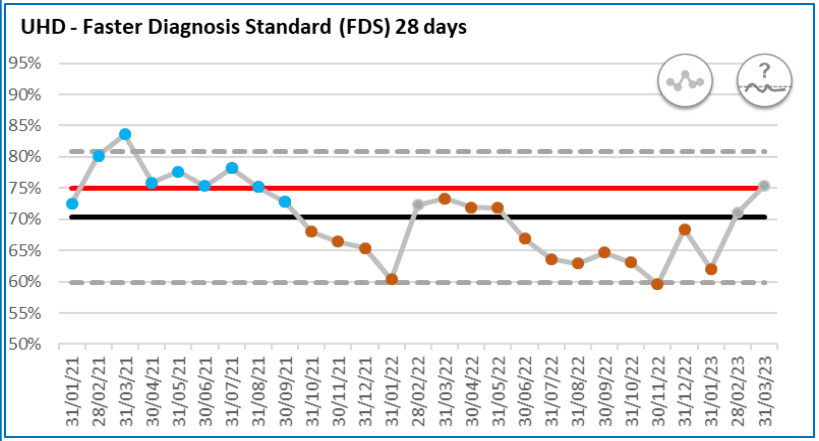
Key Areas of Focus

- Mitigation of the impact of industrial action in April 2023.
- Continued delivery of 3 Endoscopy rooms per day running at weekends during Q1 2023/24 supported by ERF funding.
- Delivery of reduction in DNA using dedicated A&C support and recruitment campaigns continue in Echocardiology.
- Continued assistance from AECC planned in May.

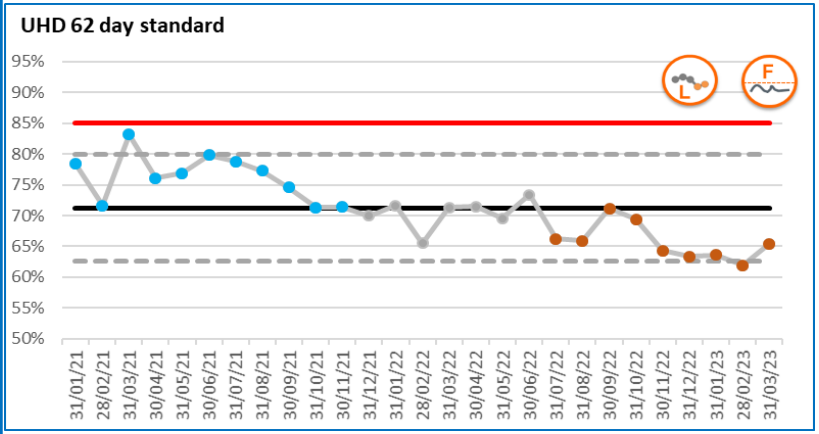
Responsive (Elective)
Cancer FDS 62 Day Standard

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)

28 Day Faster Diagnosis Standard (Target 75%)
March Performance by Tumour Site (75.4%)



62-Day Standard (Target 85%)
March Performance by Tumour Site (65.4%)



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 March Performance

- 28 Day Faster Diagnosis Standard - Performance for March was achieved reporting 75.4% (4.4% increase compared with February). The last time UHD achieved this standard was in August 2021. 9 out of 14 tumour sites achieved the standard. Recovery plans in place for the remaining tumour sites.
- 62 Day performance in March reported 65.4% (an increase of 6.1% compared to February) and is above the current national average (60.8%).
- The number of patients over 62 days decreased in March by 21 to 240 compared to the previous month and was 31 above the revised trajectory. The trajectory was not achieved due to the impact of recent industrial action

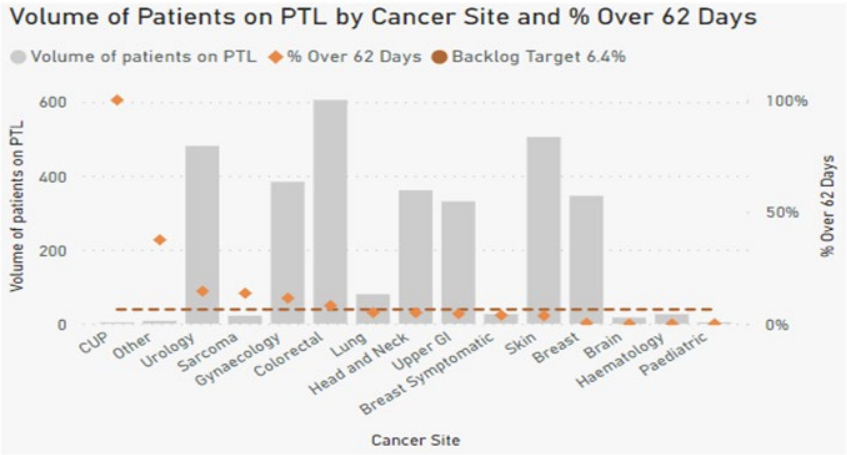
Predicted April Performance (un-finalised)

- 28 Day - The provisional performance for April is currently 71.5% and although this is a decrease compared to the previous month, it is above the 71% Trust operational plan trajectory. This standard has been impacted by industrial action in April.
- 62 Day - The provisional performance for April is currently 63.3%, however, this is expected to increase as treatments are reported by month's end.

Responsive (Elective)
Cancer over 62 Day Breaches

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Judith May (DOPO)

62 Day Breaches (Target March 209)
March Performance 240 62-Day



High Level Performance Indicators

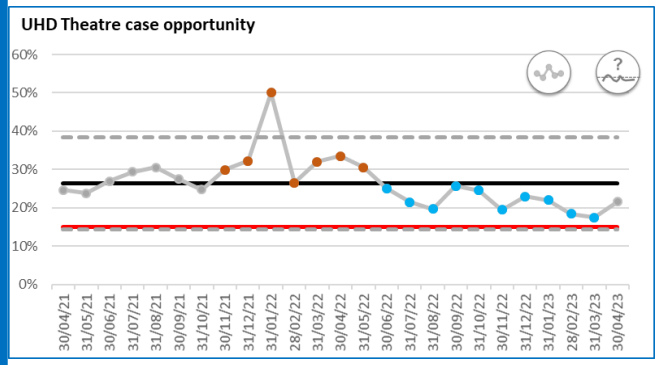
Cancer Standards	Standard	Final	Predicted
		Mar-23	Apr-23
31 day standard	96%	97.1%	95.3%
28 day faster diagnosis standard	75%	75.4%	71.5%
62 day standard	85%	65.4%	63.3%

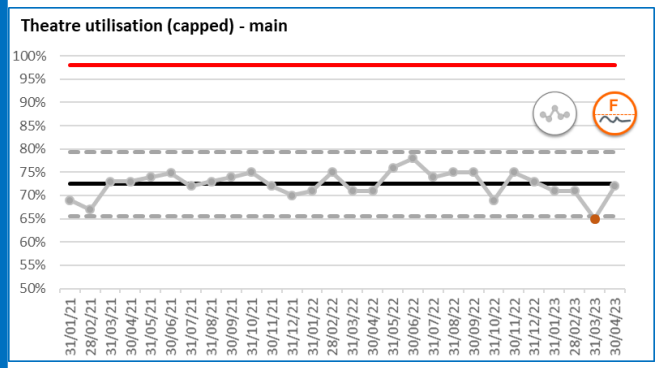
Key Areas of Focus

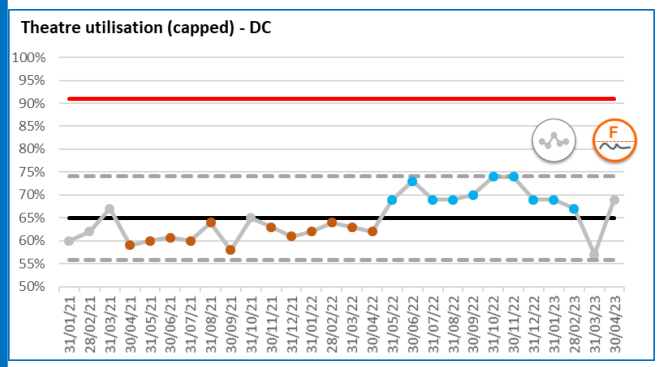
- The priority areas for recovery in the next quarter are colorectal, gynaecology and urology with specific Task & Finish Groups being established.
- Targeted deployment of pathway navigators working with clinical teams and designated clinicians to reduce waits within the patient pathway with a focus on the over 62-day PTL and 28D pathways.
- Mobilise additional clinics during May for urology to reduce waits for first outpatient appointments.
- Work with the ICS partners to ensure at least 80% of colorectal 2ww referrals are accompanied with a FIT test. The March position for colorectal 2ww referrals accompanied with a FIT result decreased to 73.4% compared to 76.1% in February.
- Re-book all patients displaced due to industrial action in April and May.
- Ensuring clinical review of the longest waiters to reprioritise into clinic slots where appropriate.
- Implementation of Tele-Dermatology in Q1 of 2023/24.

Responsive (Elective)
Theatre Utilisation

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Abigail Daughters (GDO) , Mr Robert Howell (GMD Surgical)







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.

Performance

- April 2023 month end snapshot of intended utilisation is 80% but actual utilisation of 71.0%

- Booked utilisation showing improvement currently stands at 72%
- Average late starts have decreased from 42mins to 29mins (down by 31%)
- Average late finishes showing decrease from 17mins to 9mins (down 47%)
- Average early finishes have decreased from an average of 81min to 50min (down 38%)
- Current vacancy factor within theatres stands at 60wte across UHD. This is a combined total of trained and untrained staff.
- Rise in 1–2-day cancellations due to theatre staffing shortages and sickness
- The second round of junior doctor strikes in April (4 days) combined with the impact of the bank holidays has led to high numbers of cancellations leaving only Emergency and Trauma cover across UHD due to the need to ensure wards are safely staffed.

Underlying issues:

- Continued industrial action has had negative impact on achieving theatre metrics.
- Some improvement seen however bed occupancy across the Trust remains high leading to a potential risk of cancelling elective procedures.
- Ongoing staffing shortages across theatres remains a significant barrier to providing a full template for all surgical specialities.

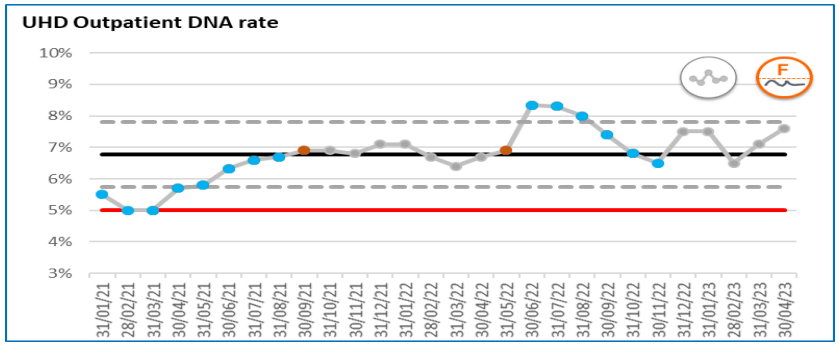
Key Areas of Focus

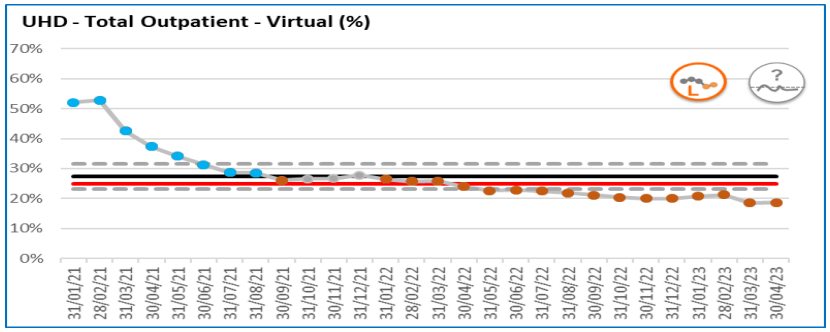
Ongoing improvement work focussing on theatre staffing as a top priority supported at Executive level, scheduling, digital solutions and pre-op assessment. 2023 improvement plan in progress including leadership and development programme for theatre leads.

Responsive (Elective) Outpatients

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Sarah Macklin (GDO) Dr Jonathan Marks

Referral Rates (acute only)		Standard	Last Year	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	10743	8321	-22.5%
Total Referrals Rate year on year		-0.5%	17116	12723	-25.7%
Outpatient metrics (acute only)					
Overdue Follow Up Appointments					31778
New Appointments					16546
Follow-Up Appointments					24835
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%		3415 / 41381	7.6%
Hospital cancellation rate	*(Hospital Canx / Total Booked Appts)*			7965 / 57907	13.8%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*			5146 / 57907	8.9%
Reduction in face to face attendances (acute only)					
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%		7693 / 41381	18.6%





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 April increased to 7.6%, remaining consistently above target levels.
18.6% of attendances were delivered via telemedicine/video.
The number patients waiting an overdue follow up appointment reduced in April.

- 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.
- Planned industrial action at UHD has had an impact on outpatient booking teams' capacity.

Key Areas of Focus

- Continued DrDoctor expansion to build on soft launch undertaken of 'Quick Question' and Broadcast messaging'. Pilot of 'quick question' functionality to support validation of the follow up waiting list in Gynaecology is also planned in May.
- Outpatient forum driving data review at specialty level following launch of outpatient performance dashboard (including all Outpatient KPIs).
- Delivery of non-admitted waiting list and outpatient productivity improvements.

Responsive - (Elective) Screening Programmes

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Leanna Rathbone/Sarah Macklin (GDO)

Breast Screening

High Level Board Performance Indicators
APRIL position :

Breast Screening	Standard	ACHIEVED
Round Length within 36 months	90.00%	100%
Screening to first offered assessment appointment within 3 weeks	98.00%	97%
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 April.

Underlying issues:
- The screen to assessment target has been missed due to lack of appointment slots due to Radiology staffing.
- The issue at Think Big with regards to static electricity has been resolved. Extra anti-static mats have been provided in the screening room.

Actions:
- Regular failsafe batches are being generated throughout each month to effectively manage any potential delays for women moving into area and reaching screening age.
- To manage future demand increases which will reflect the high volume of screening carried out to facilitate the recovery of the service, the round plan is being managed in line with the NHSE 'Round Plan Smoothing Guidelines' for the next 3 years, whereby women can be called early for their recall, up to 24 months since their last screening.

Bowel Screening

Bowel Screening Standard	Target	Trust April Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	73%

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 not achieved in March 2023

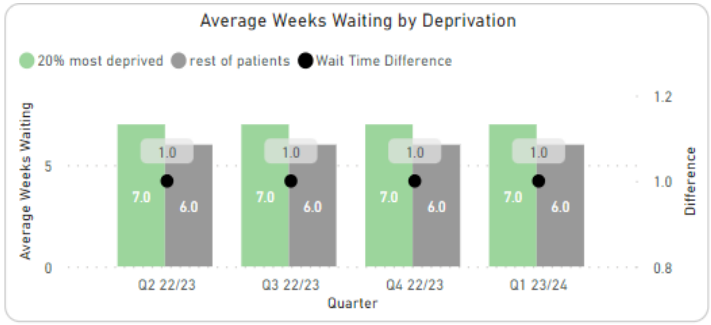
Underlying issues:
This was due to losing 7 colonoscopy lists through junior doctor strikes. In addition, Q4 22/23 saw another increase in numbers of FIT positive screening subjects coming through SSP clinics; averaging 36 per week throughout March compared to 17 and 29 per week in December and January. Three weekends of insourcing activity has led to improved performance in April to 73%. There are no breaches in May at this time and sufficient capacity for patients currently booked into clinic.

Actions:
- Deliver additional weekend list at Dorset County in May
- Plan for insourcing activity throughout 23/24 once finance plan agreed
- Develop a succession plan for accredited screeners

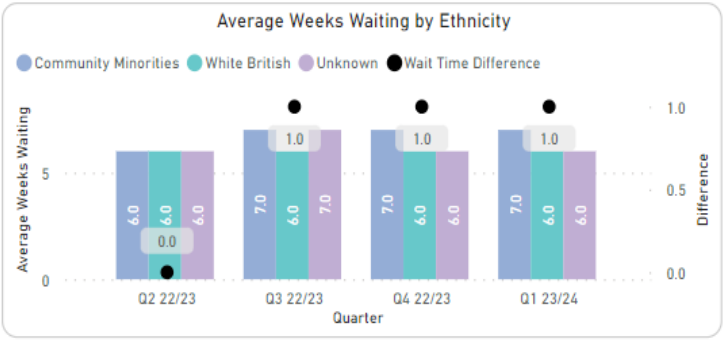
Health Inequalities

Executive Owner: Peter Wilson (Chief Medical Officer)
Management/Clinical Owner: Judith May (DOPO)

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	8.0
10-19	7.0	8.0	10.0	8.0
20-29	7.0	7.0	7.0	5.0
30-39	7.0	7.0	6.0	6.0
40-49	6.0	7.0	6.0	5.0
50-59	6.0	6.0	6.0	7.0
60-69	6.0	6.0	6.0	6.0
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) 8.1% of the Trust's waiting list are patients living within the 20% most deprived areas of Dorset by Index of Multiple Deprivation (IMD) (reduction 0.1% compared to March). Analysing RTT activity in Quarter 1 to date, the median weeks waiting at the point of treatment shows 1 week's average (median) variation between the 20% most deprived and the rest of the population treated. Greatest variation is seen in Paediatrics and OMF services.

Waiting list by ethnicity: Where ethnicity is recorded, 10.8% of patients on a UHD waiting lists are within community minority ethnic populations. This is a decrease of 0.2% since March. An analysis of the median weeks waiting by ethnicity grouping identifies 1 week's average (median) variation between patients within community minority groups and White British populations in Q1 to date; this is an improvement on the position reported last month.

Waiting list by age band: There is variation between age and length of wait on the waiting list with the greatest variation between 1-19yrs 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

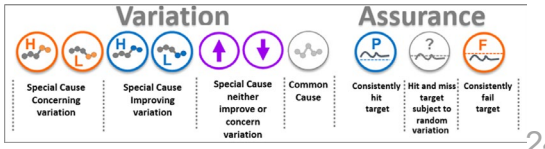
Building on the first population health and system committee held in April 2023 the Trust Health Inequalities group are working to:

- Develop a work programme with clear output and outcome measures
- Align its health inequalities programme with the ICS key strategic priorities
- Take action on reducing DNAs and variation according to IMD and ethnicity, with a focus on Paediatric attendances.
- 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.

Performance at a glance
Responsive (Elective) Key Performance Indicators

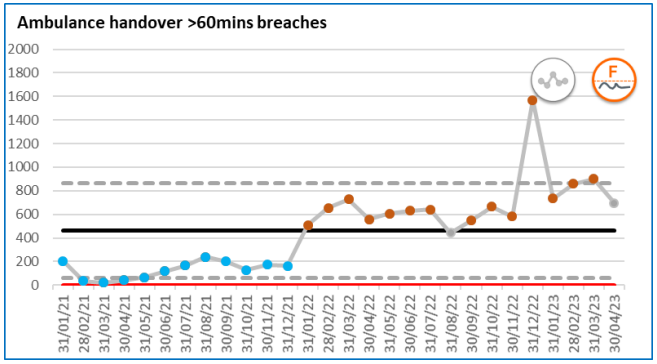
UHD Elective Care

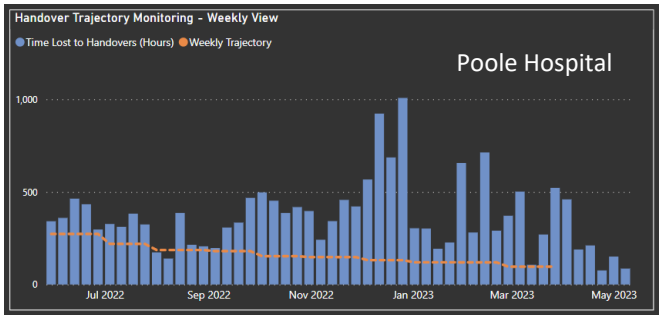
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Apr 23	74557	51491		F	72779	69644	75913
UHD - Patients waiting >104 weeks	Apr 23	0	0	L	F	115	35	195
UHD - Patients waiting >78 weeks	Apr 23	112	-	L		801	498	1104
UHD - Patients waiting >65 weeks	Apr 23	1249	-	L		1730	1285	2175
UHD - Patients waiting >52 weeks	Apr 23	4380	-			3745	2906	4584
UHD - Patients waiting >26 weeks	Apr 23	24223	-	↑		16289	14364	18214
UHD - RTT Performance against 18 week standard	Apr 23	52.6%	92.0%	L	F	55.9%	53.5%	58.3%
UHD - Total Diagnostic Waiting List	Apr 23	11729	-			10541	8611	12470
UHD - % waiting over 6 weeks	Apr 23	8.4%	1.0%		F	11.0%	4.8%	17.2%
UHD - Faster Diagnosis Standard (FDS) 28 days	Mar 23	75.4%	75.0%		?	70.3%	59.8%	80.8%
UHD 62 day standard	Mar 23	65.4%	85.0%	L	F	71.2%	62.6%	79.9%
Trauma Admissions	Apr 23	348	-			359	292	426
% of NOF patients operated on within 36 hrs of admissi	Apr 23	54.0%	85.0%		F	29.2%	-15.8%	74.3%
UHD - Total Outpatient - Virtual (%)	Apr 23	18.6%	25.0%	L	?	27.4%	23.3%	31.5%
UHD Outpatient DNA rate	Apr 23	7.6%	5.0%		F	6.8%	5.8%	7.8%
Theatre utilisation (capped) - main	Apr 23	72.0%	98.0%		F	72.5%	65.5%	79.4%
Theatre utilisation (capped) - DC	Apr 23	69.0%	91.0%		F	65.0%	55.9%	74.1%
UHD Theatre case opportunity	Apr 23	21.6%	15.0%		?	26.4%	14.5%	38.4%

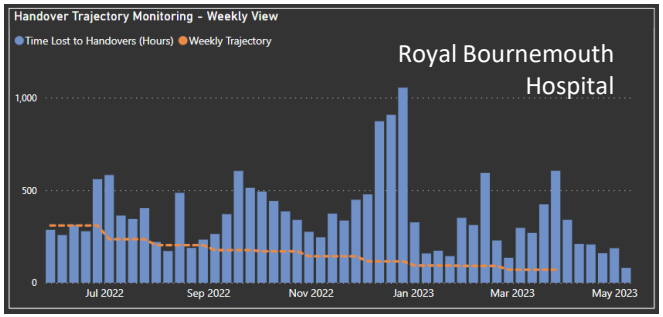


Responsive – (Emergency) Ambulance Handovers

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Leanna Rathbone (GDO) Tristan Richardson(GMD)







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

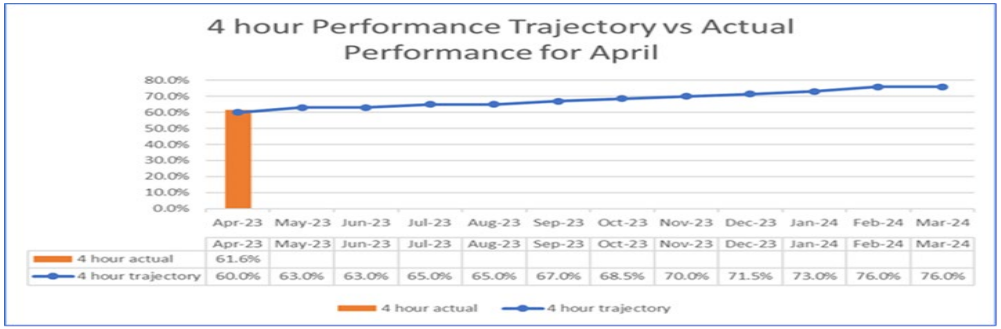
- Total number of ambulance conveyances in April remain relatively static as compared to March. RBH 1977 PH 2030.
- Further improvement seen in Ambulances waiting longer than 60 minutes in April There has been a further decrease to 17% from 20%.
- In total there were 1183 hours at PH and 1101 hours at RBH totalling 2284 hours lost in April vs 2742 hours reported as lost at UHD sites in March.
- SWAST saw a significant decrease regionally in handover delays to 20,087 for the South West Region overall vs 34,833 hours in March.
- SWAST are providing support to cohorting, but the handover time continues to run for each patient cohorted by SWAST until transferred to ED care.

Key Areas of Focus

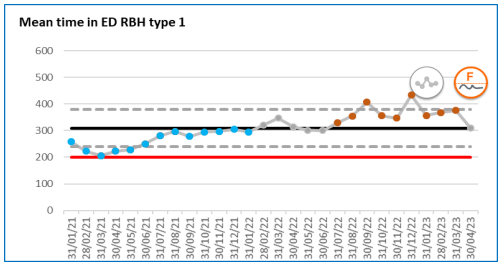
- Dorset ICB have re-established the joint meetings with UHD and SWAST to address the handover challenge, including a data cell that met initially in mid March.
- The Trust's ED 4 hour recovery meeting, chaired by the COO continues to oversee ED performance and departmental decompression, which will support a reduction in ambulance handovers.

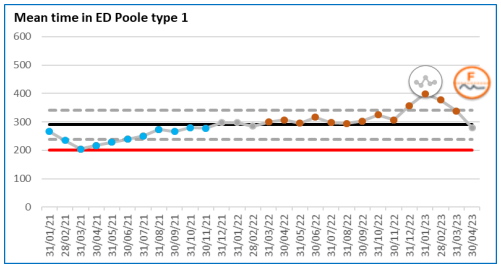
Responsive (Emergency) Care Standards

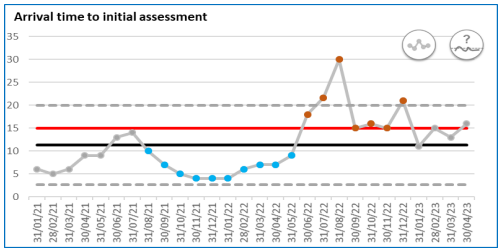
Executive Owner: Mark Mould (Chief Operating Officer)
Owner: Leanna Rathbone (GDO) Harry Adlington (CD Emergency Care)

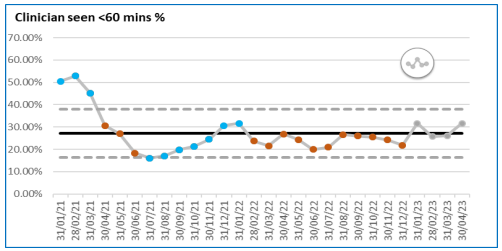


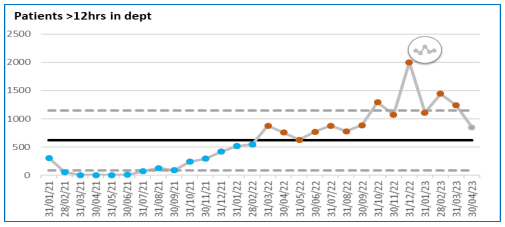
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
4 hour actual	61.6%											
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	70.0%	71.5%	73.0%	76.0%	76.0%

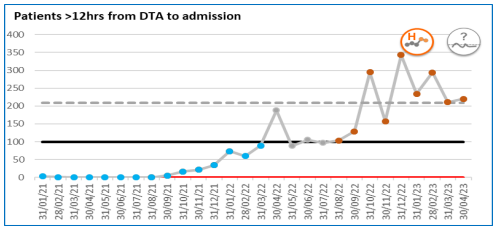












Data Description and Target

UHD will continue to report against the pilot UEC standards, however we have now had formal notice this will cease. As previously reported a recovery plan to support the transition back to the 4-hour ED standard is in place, and UHD will be reporting against the 4 hours standard from mid May 2023

Performance

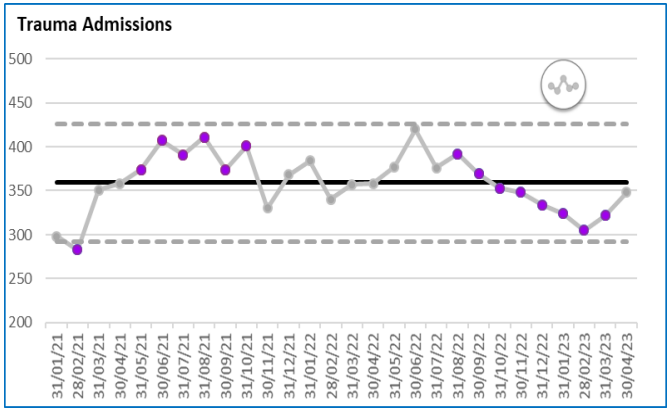
Attendances remain relatively static when compared to March (a difference of approximately 20 patients per day) however remain consistent with an overall growth from January and February.
The average meantime for attendances continues to make a positive downward trajectory, reducing by one hour in April. This is down to 295 minutes against a target of 200 minutes. This is the third month of continuous improvement as well as the lowest meantime in over a year.
A decrease in the number of patients spending more than 12 hours in our EDs (389 less in month) was achieved in April. Though the number of patients waiting for more than 12 hours after a decision to admit remains relatively static at 220 vs 211 in March.
The Trust is also now shadowing reporting as of April 23 against the 4 hour standard and met its internal trajectory for April of 61.3% against a target of 60%.

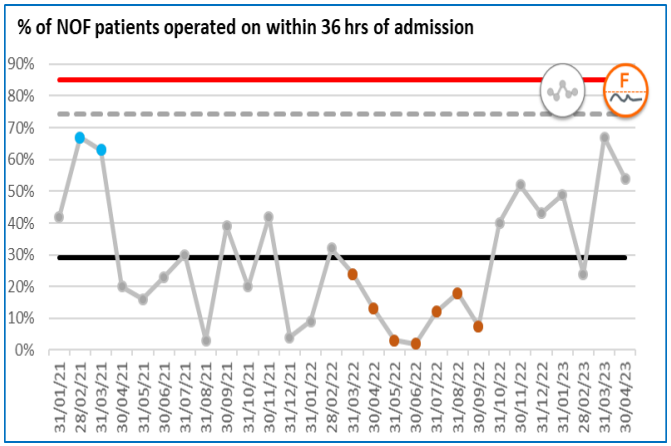
Key Areas of Focus

Focus on reduction and turnaround for non-admitted patients as part of reintroducing the ED 4-hour safety standard at UHD.

Responsive (Emergency)
Trauma Orthopaedics

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Abigail Daughters (GDO) & Mr Paul Pavlou (CD 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

April performance for time to theatre for fractured neck of femur (# NoF) patients: 72% achieving surgery within 36 hours of being fit for surgery and 54% with surgery within 36 hours from admission.

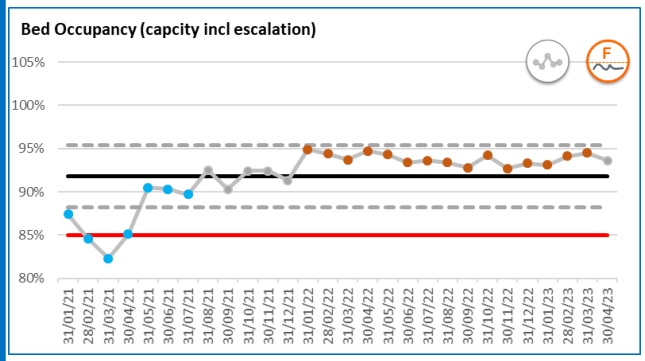
- 12 patients fit on admission but were delayed for surgery, 9 were delayed due to complexity of injury necessitating specific surgeon and equipment.
- 9 Shaft of femur (SoF) fractures admitted in April all of whom had surgery. 3 required revision THR (Total Hip Replacement) for their fracture. 8 patients with a # NOF required a THR increasing required theatre time.
- 11 patients required 2 or more trips to theatre, resulting in an additional 32 trips to theatre, some of which were complex revisions and septic patients.
- 99.8% of patients receiving prompt OG review (<72 from admission). This is the best performance across all NHFD
- Challenge to access to laminar flow theatres with radiological cover continues.

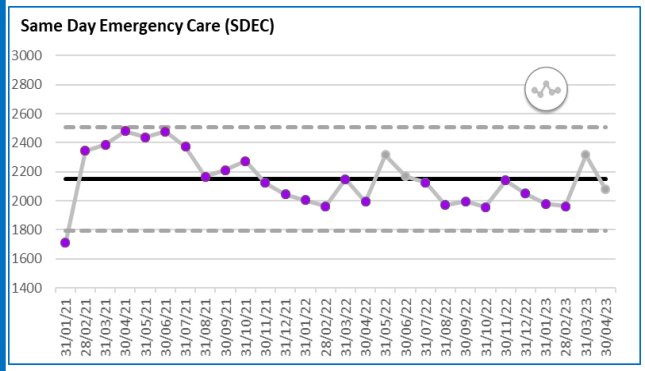
Key Areas of Focus

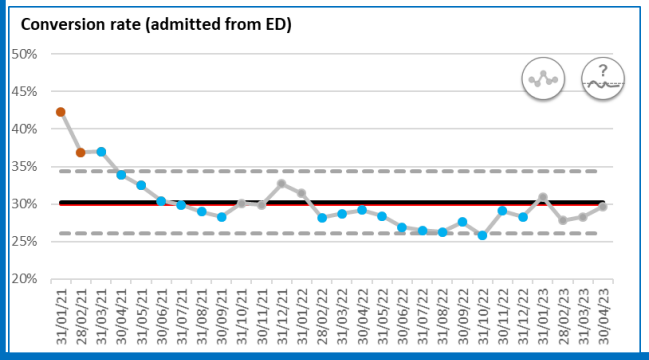
- e-Trauma Business case approved with procurement in place, implementation requires IT engagement. Implementation group to commence with dedicated T&O Lead in post.
- Trauma Ambulatory Care Unit (TOACU) - Service relocated to OPD to protect capacity. Service now has consistent ringfencing resulting in up to 40 patients/week with admission avoidance >85%.
- Liaison and working with Trust operational flow project (TAD) to support reduction in high level of MRFD patients across trauma (40%).
- #NOF summit areas of focus agreed to include pre-hospital "Pre alert" and #NOF admission pathway (mirror approach of stroke/cardiology).

Responsive – (Emergency) Patient Flow

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Alex Lister (DCOO) Care Group Directors (GDOS /GDON / GMDS)







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 **remains above 85% at 93.6%** (down 1% in month), this includes planned winter escalation but does not account for additional surge beds opened in extremis.

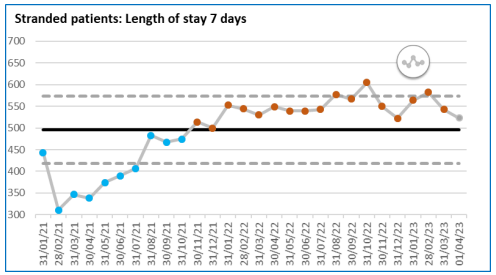
- Additional capacity has been required to support the pressures of Covid/Flu occupancy, maintaining elective activity and emergency care demand.
- High occupancy is in the main attributed to a significant number of MRFD patients within the Trust.
- April saw **more patients discharged** than admitted (net difference of 36 patients). However, there remained a consistent need to open surge capacity to manage high occupancy and MRFD levels.
- The mean bed wait for a patient has reduced by approximately 1 hour to an average of 3 hours. Challenges remain due to a lack of flow across assessment areas and downstream pathways which continue to hamper ED recovery.

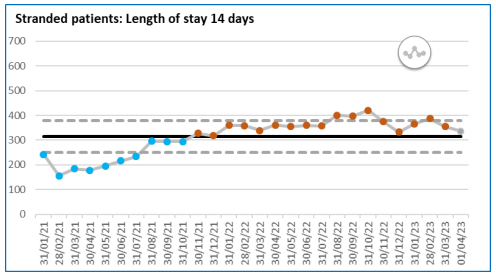
Key Areas of Focus

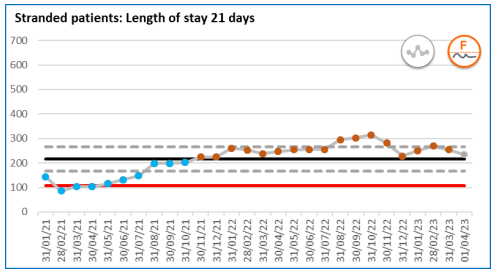
- Continued targeted focus on Timely Admission and Discharge (TAD) process and significant improvement in utilisation rates of Departure Lounges.
- Introduction of the Discharge to Assess model will reduce length of stay and provide improved flow.
- Rapid review of daily bed management process, including implementation of the centralised bed model trial in May 2023, with expected improvements in oversight, coordination and transfer time.

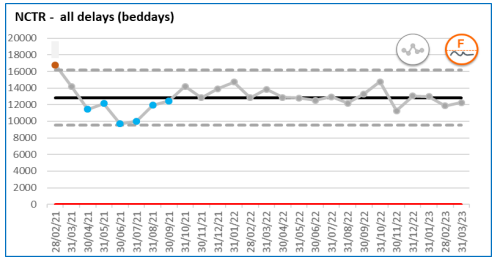
Responsive – (Emergency /Elective)
Length of Stay & Discharges

Executive Owner: Mark Mould (Chief Operating Officer)
Management/Clinical Owner: Alex Lister (DCOO) Care Group Directors (GDOS /GDON / GMDS)









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 by 50%.

Performance

The average daily number of patients who are ready to leave/have no criteria to reside was 193 in April, **stabilising for the 2nd month in row**.

- The overall delayed discharge position continues to challenge hospital flow. The overall proportion of MRFD patients **increased to** 28%. (+1%)
- The number of internal delays reported **increased to** 22% (+2%), work continues to improve internal processes.
- The number of patients with a length of stay (LoS) over 21 days **reduced to 235** (-20 patients)**.**
- Delays in accessing community health and social care driven by bed, workforce and processing capacity are the significant factors impacting LoS and patients waiting discharge.
- Internal delays are reviewed and challenged daily, key themes include completion of therapy assessments and discharge referrals.

Key Areas of Focus

- Internal incident support pre/post-strike days to reduce internal and all delays
- Daily partner meetings focusing on MRFD
- System led accelerated Discharge to Assess (D2A) model commenced in February 2023 and was formally introduced from1st April
- System visits to UHD and Community Hospitals identified key system themes and opportunities for improvement
- Focus for organisation via Hospital Flow Programme Workstream 4, with an aim of improving early discharge planning, D2A pathways and data completeness in Health of the Ward (HotW). Internal MADE event commented at the end of April resulting in 23 discharges from the complex care wards were discharged during this time. Evalution of the learning with system partners will direct plans for future discharge processes and targeted events

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

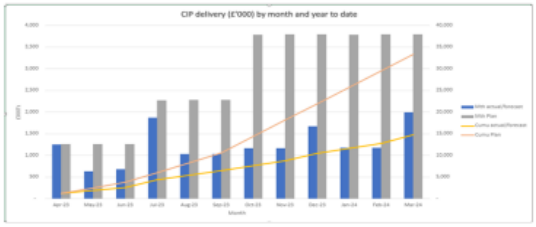
UHD Emergency Care and Patient Flow

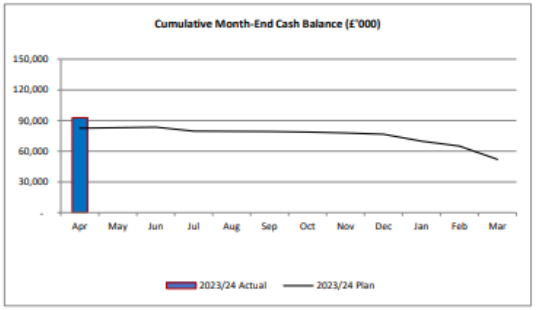
KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mean time in ED RBH type 1	Apr 23	310	200		F	309	239	379
Mean time in ED Poole type 1	Apr 23	280	200		F	290	238	341
Arrival time to initial assessment	Apr 23	16	15		?	11	3	20
Clinician seen <60 mins %	Apr 23	32%	-			27%	16%	38%
Patients >12hrs from DTA to admission	Apr 23	220	0	H	?	99	-12	210
Patients >12hrs in dept	Apr 23	849	-			617	90	1144
Ambulance handovers	Apr 23	4007	-			3937	3421	4453
Ambulance handover >60mins breaches	Apr 23	698	0		F	460	58	862
Bed Occupancy (capcity incl escalation)	Apr 23	94%	85%		F	92%	88%	95%
Stranded patients: Length of stay 7 days	Apr 23	523	-			496	418	574
Stranded patients: Length of stay 14 days	Apr 23	337	-			314	250	378
Stranded patients: Length of stay 21 days	Apr 23	235	108		F	217	168	266
UHD NCTR % - all delays	Apr 23	40.3%	-	L		49.7%	41.7%	57.7%
Non-elective admissions	Apr 23	5690	-			5867	4924	6809
> 1 day non-elective admissions	Apr 23	3612	-			3715	3048	4381
Same Day Emergency Care (SDEC)	Apr 23	2078	-			2150	1793	2507
Conversion rate (admitted from ED)	Apr 23	29.7%	30.0%		?	30.2%	26.1%	34.4%
NCTR - all delays (beddays)	Mar 23	12250			F	12838	9531	16145
Ready to leave (beddays)	Mar 23	9356			F	7941	6366	9517

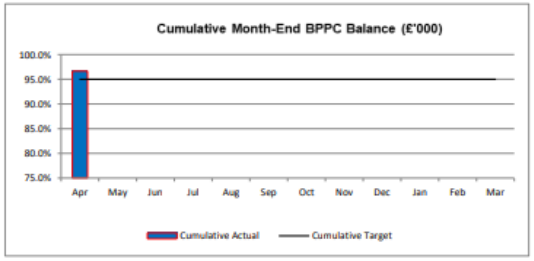
Well Led - Finance

Executive Owner: Peter Papworth (CFO)
Management/Clinical Owner: Care Group Directors (GDOS /GDON / GMDS)/ Exec Budget Holders

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(1,435)	(2,312)	(877)
Capital Programme	16,600	5,310	11,290
Closing Cash Balance	82,523	92,700	10,177
Public Sector Payment Policy	95.0%	96.7%	1.7%







At the end of April the Trust has reported a deficit of £2.3 million against a planned deficit of £1.4 million representing an adverse variance of £878,000. This is being driven by energy cost inflation above the national planning assumptions £600,000, the net cost of the Junior Doctors Strike £300,000, together with premium cost pay overspends in the Care Groups which at 30 April 2023 is £1.3 million above budgeted establishment. This has been off-set in part by additional bank interest due to a higher cash holding £425,000, reduced depreciation charges due to the timing of capital expenditure £300,000, and favourable variances associated with reduced patient activity during the Junior Doctors strike action. Cost Improvement Programme savings of £1.3 million have been achieved during April against a target £1.3 million. This includes non-recurrent savings of £592,000. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £14.8 million representing a shortfall of £18.5 million and a recurrent shortfall of £22.2 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 April the Trust has committed capital expenditure of £5.3 million against a plan of £16.6 million representing an underspend of £11.3 million. This underspend relates mainly to the New Hospitals Programme and STP Wave 1. These programmes are expected to remain consistent with the full year budget.

CAPITAL	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Estates	960	841	119
IT	846	488	358
Medical Equipment	351	75	276
Donated Assets	54	145	(91)
Strategic Capital	14,389	3,762	10,627
Total	**16,600**	**5,310**	**11,290**

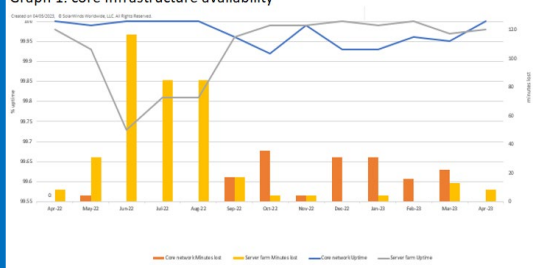
As at 30 April 2023 the Trust is holding a consolidated cash balance of £92.7 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of MOU capital funding for multiple schemes alongside a re-phasing of the capital programme spend. The balance attracts Government Banking Services interest of 4.14% at current rates, together with a PDC benefit of 3.5%. The Trust is currently paying 96.7% of invoices within the agreed payment terms, against the national Better Payment Practice Code standard of 95%. The Trust is currently delivering strong performance of 96.7% against the national Better Payment Practice Code standard of 95%.

Well Led - Informatics

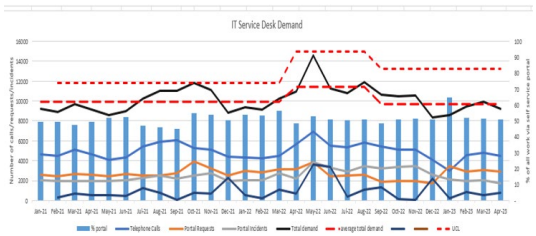
Executive Owner: Peter Gill (CIO)

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

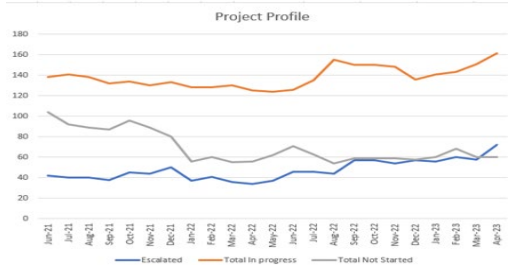


Table 4: Information Asset Compliance

All Active Assets

Status	Total	%
Draft Only (Pending Updates)	17	6.05%
Awaiting IAO Review/Approval	144	51.25%
Awaiting IG Review/Approval	35	12.46%
DSPT Compliant (2022/23)	85	30.25%
Total	281	

Table 5: Training Statistics

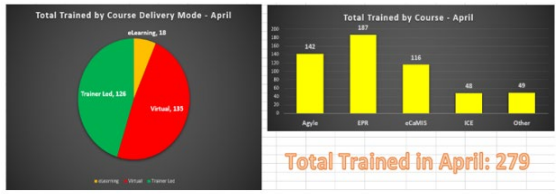


Table 6: Cyber Security - Obsolete systems

	Supported	Obsolete	Mitigated	Unsupported
Windows Desktops	95.8%	4.2%	0.0%	4.2%
Windows Servers	87.8%	12.2%	0.0%	12.2%

Table 7: FOI compliance

	Total rec'd	Compliance
December '22	45	67%
January '23	59	80%
February '23	63	73%
March '23	60	68%

Commentary

Graph 1 : Core Infrastructure uptime remains optimal at greater than 99.9% during Apr 2023.

Graph 2 : The reduction in Service Desk demand to the levels seen before the single PAS(May 2022), appears sustained.

Table 3 : 8 Projects completed in month including two electronic forms (Physio and Rheumatology) and updates to the Electronic Staff Record.

Table 4 : The progress being made towards the end June 2023 target to ensure all our active assets are compliant to the Data Security and Protection Toolkit is insufficient to provide assurance that UHD will be compliant and more attention is now required.

Table 5 : Some snapshot data shows the total numder of staff trained by the IT training team in April.

Table 6 : The percentage of Windows servers now unsupported is gradually reducing again.

Table 7: Freedom of Information compliance restored to a respectable level, although less than the required standard of 90%.

University Hospitals Dorset
NHS Foundation Trust

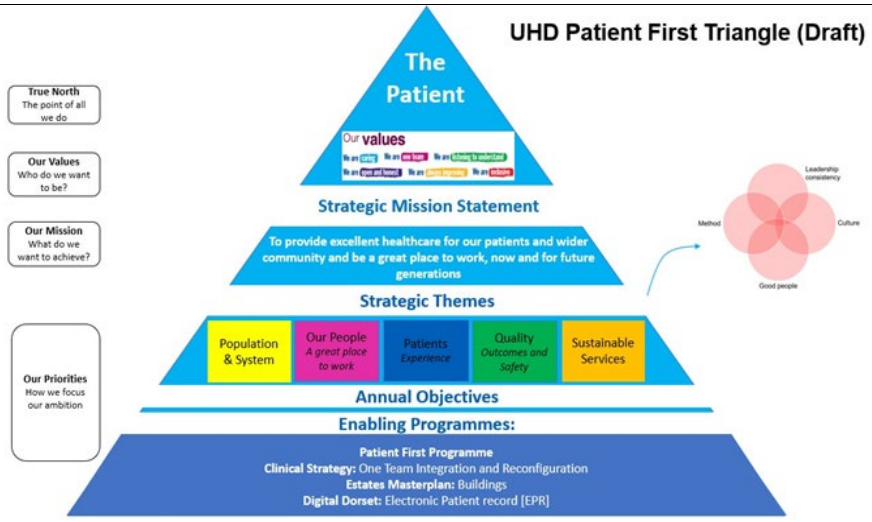
BOARD OF DIRECTORS – PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 7.1

Subject:	Operational Plan 2023/2024
Prepared by:	Alan Betts, Director of Integration and Improvement
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer

Strategic Objectives that this item supports / impacts:	Continually improve quality ☒ Be a great place to work ☒ Use resources efficiently ☒ Be well governed and managed ☒ Transform and improve ☒
BAF / Corporate Risk Register:	To be updated with 2023/2024 BAF
Purpose of paper:	Decision / Approval
Background:	In line with the operational planning guidance and the NHS Dorset Integrated Care Board planning process, annual plans have been developed at specialty Care Group and Trust level that support delivery of quality, financial, workforce and operational objectives alongside the Trust's reconfiguration plans. As this is a transition year to embedding a Patient First approach, some aspects are in development, including adapting a smaller more focused set of strategic themes. The Trust will also align with the ICS Forward Plan and focus on prevention, thriving communities and joined up services.
Executive Summary:	This report provides a summary of key messages from the Annual Plan. Our True North, Strategic Themes and Annual Objectives are being developed as part of our Patient First approach. These are summarised below and will underpin our work in 2023/2024.



The Annual Plan provides more detail as to the strategic themes and enabling programmes that will underpin our work during 2023/2024.

Core to an improved approach, based on the "well-led" evidence base, is having a shorter, more specific set of objectives. These are proposed as:

Themes	Goal	2023/24 Objectives (SMART wording being developed)
Systems and Partnerships	To meet the patient national constitutional standards for Planned and Emergency care. supporting inequalities in outcome and access and improving productivity and value.	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 zero non admitted patients above 52 weeks by March 2024]. To achieve 76% of patients treated within 4 hours through the emergency care pathway by March 2024.
Our People	To significantly improve staff experience, engagement and retention over the next 3 years [with NHS Staff Survey results in top 20% of comparator trusts].	All wards / departments taking action to improve their 2022 National Staff Survey results, by March 2024. Overall 2023 NHS Staff Survey results: Staff Engagement Score > 7/10 Staff Morale Score > 6/10 Q23c: I would recommend my

		organisation as a great place to work > 62% People Promise 'We are safe and healthy' > 6/10 To achieve a 13% staff turnover rate by March 2024.
Patient Experience	To achieve top 20% in the inpatient survey about the quality of care provided at UHD over the next 3 years. 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.	Family and Friend Test (what our patients say) Feedback rates increases from baseline in all service over the next year. Is in top 20% rated 'good' over a 3-year period • Every ward / clinical service has access to monthly Have Your Say survey information and data by March 2024.

Quality (Outcomes and Safety)	To achieve top 20% of trusts in the country for HSMR over the next 3 years. To reduce moderate/severe harm patient safety events by 30% over a 3-year period through the development of an outstanding learning culture	To reduce HSMR over the next 18 months [Sept 2024].
Sustainable Services	To return to recurrent financial surplus from 2026/27.	To reduce the recurrent underlying deficit over a 3-year period [Closing balance of £20m by March 2024].
Patient First Programme	To successfully and sustainably adopt the Patient First	To deliver Year 1 of transitioning to the Patient First approach including all

	approach across UHD.	staff attending a 'Let's have a Conversation' session and encouraged to identify improvements in their ward / department.
One Team *Patient Ready for Reconfiguration*	To integrate teams and services, then to reconfigure, and so create the planned and emergency hospitals	For every service to have an agreed plan to integrate and start delivery so they are "move in" and "patient ready" for the future

UHD Annual Operating Plan process

The Trust's Annual Operating Plan narrative is included as Appendix 1. This narrative has been drafted by nominated leads throughout the Trust has undergone Executive, Trust Management Group (TMG) and Council of Governors' review at the time of submission to the Board.

The plan has been accepted at Dorset ICS, and SW region level as being compliant and not requiring further revision.

Tracking delivery of the plan will be more focused than previous years, with Board committees using the Board Assurance Framework as a main item for their attention and tracking if plans are on track or require escalation.

Operational responsibility for delivery will be via TMG and the groups reporting into this. This will require a re-formatting of the TMG and Board committee agendas and time allocated, with a focus on corporate objectives being delivered. Other measures will be 'watched' and managed as business as usual.

Key Recommendations

Trust Board are recommended to:

- **Note** the challenges in delivery of the objectives within the Annual Plan for 2023/2024 and the ongoing work required to meet financial, activity, workforce and quality objectives alongside delivery of performance objectives. The risks to achievement will be tracked through the Board Assurance Framework.
- **Approve** the Trust's Annual Plan (noting that minor drafting changes may occur requiring CEO approval).
- **Note** the change in how we work in 2023/2024 with greater focus and tracking of progress on a smaller number of higher impact actions, with a 'watch' business as usual approach for the other measures and actions.

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**
Board of Directors Part 2	25/04/23	Draft for approval
Trust Management Group	22/03/23	Recommendation
Council of Governors	20/03/23	Information / update
Trust Management Group	21/02/23	Information / update
Trust Management Group	07/01/23	Information / update

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

University Hospitals Dorset
NHS Foundation Trust

2023/24 Operational Plan: University Hospitals Dorset NHS Foundation Trust

MASTER VERSION

Contents

1. Foreword – A Year of Transition Ahead

University Hospitals Dorset (UHD) has had a turbulent few years with Trusts merging, the Covid pandemic and an extensive reconfiguration programme. Looking to the future, UHD will play its role in the NHS Dorset forward view for our community - a healthy and happy population with ill-health prevention, thriving communities to live in, and services joined up, delivering care when it is needed.

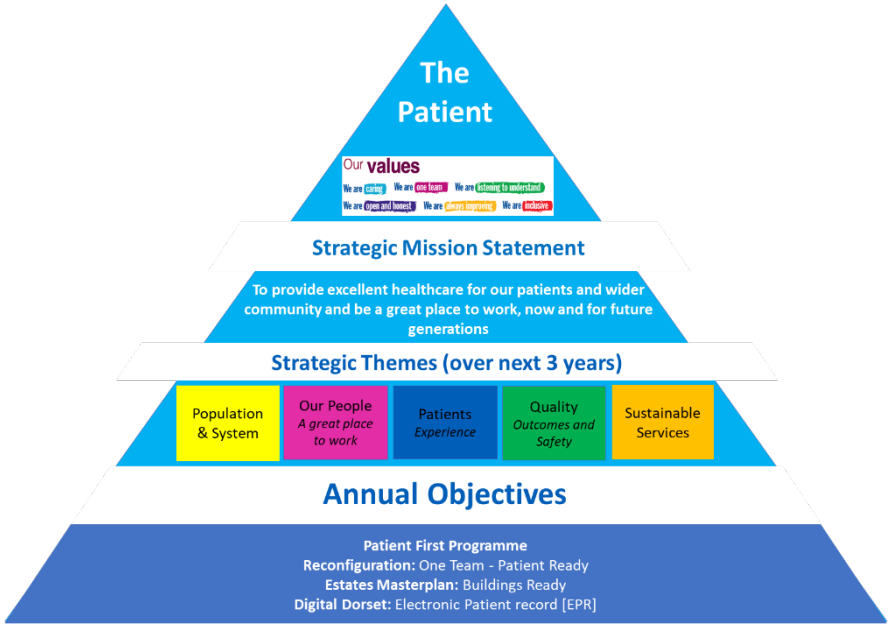
UHD will strive to provide high quality services with effective outcomes, are safe and provide a good patient experience. None of that is possible without our brilliant staff. Faced with ever rising challenges, vacancies, and the cost of living, caring for our teams and each other is paramount. This plan sets out how UHD will deliver those ambitions using the Patient First approach and extra support for our staff.

Both population health and putting patients first requires a sustainable set of services – sustainable financially, environmentally and sustaining the trust of the public. This requires us to change and improve. We have four enabling programmes to help us achieve this:

- Patient First approach to how we do things
- One team: Integrate and reconfigure services
- Our New Hospitals building programme
- Preparing for our Electronic Patient Record

All this is only possible by staying true to the values that were designed by our staff and ensuring that these become universal in 'how we do things around here.'

The diagram below describes how our values are the heart of what we do, helping us to deliver our mission through our priorities and enabling programmes.



This is a year of transition between our current way of working and our future, Patient First, way. We have a long way to go to become the outstanding organisation that we aspire to be to be.

This is a five-year journey, with several stages:

- Develop Patient First over 2023
- Integrate services over 2023 and 2024
- Reconfigure in 2025 to create the planned and emergency hospitals
- Upgrade our digital systems by 2025
- Embed these changes alongside the greater prevention, thriving communities and joined up services.

Such a set of ambitions represents the largest changes in Dorset's healthcare in the past 25 years. This journey requires us to change, for teams to work with patients to solve problems and continually improve services. It also requires us to be focussed, so we do not try and do everything, everywhere, all at once. Instead, over five years to stay focussed on the changes that will make the biggest impact against our strategic priorities of population & system, patients, quality, our people, and sustainable services.

The 2023/24 year is likely to be especially challenging. The effects of industrial action, staff vacancies and the burn out of many staff working in healthcare globally are very real for our staff. Our investment in staffing levels and safety mean we have a record deficit, and we know we have patients in our beds who would be better cared for in their homes, instead of on a hospital ward. We need to return to the pre-pandemic levels of productivity and go beyond this to match the top performers in the NHS. We do this so we can offer shorter waiting times for our patients.

The plan for 2023/24 sets out how we can do things better. Details are provided in relevant chapters, such as quality, workforce, performance and transformation. Despite our challenges, we know what better care could look like and will work together to deliver it. Across a large organisation like UHD, there are many shining exemplars of excellence. Our task is to set the course, stay focussed on a smaller number of high impact improvements, and free teams up to excel in their own areas.

The next few years will be challenging, exciting and well worth the effort as we will become an organisation where we are proud to work, where we want our families and friends to be treated, that lives our values and where Patient First is always the way we do things.

I hope you will join us on this journey, starting with making this annual plan come to life, in the care we provide to patients, partners and staff every day.

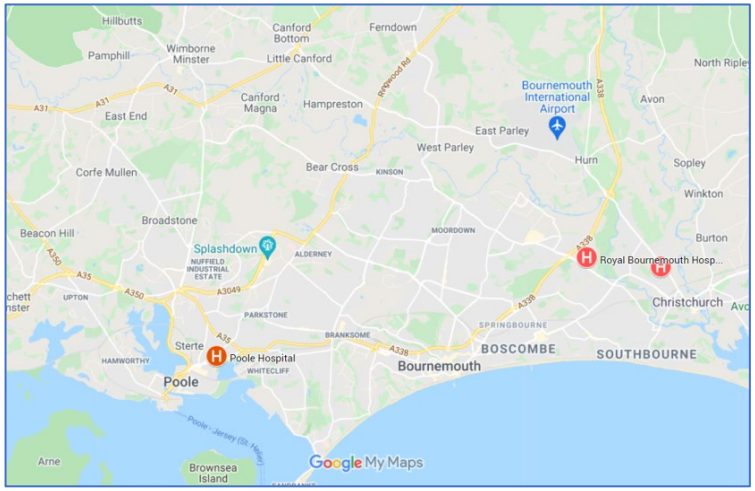
With very best wishes

Siobhan Harrington

1.1 Introduction

University Hospitals Dorset NHS Foundation Trust (UHD) was formed in October 2020 with the merger of Poole Hospital NHS FT and Royal Bournemouth and Christchurch Hospitals NHS FT bringing together teams to service Dorset and beyond.

The Trust spends approximately c£680m and employs c9,500 staff across 3 hospitals – Poole Hospital (PH), Royal Bournemouth Hospital (RBH) and Christchurch Hospital (XCH) plus staff in community settings



The Trust's services include the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services, delivering the following annual activity:

- 169,000 Type 1 ED attendances
- 70,000 Non-elective admissions
- 14,000 Elective admissions
- 88,000 Day case treatment
- 589,000 Outpatient attendances
- Over 4000 births
- Diagnostics & other services.

These services are provided primarily to a catchment population of approximately 700,000 in the Bournemouth, Poole, Christchurch and east Dorset and New Forest areas.

Specialist services such as vascular, oncology, neurology, cardiology are provided for a wider population of 1 million and most of our services are delivered with our partners including Community & GP's, social care, ambulance and other NHS services and many others.

1.2 Trust Values, Mission and Priorities

Underpinning our Mission are ***our UHD values*** ***(***https://www.youtube.com/watch?v=g18KK8e-x_U&t=6s***).*** These guide how patients and visitors are treated, and also how staff treat each other. The values are embedded into every part of UHD, such as recruitment, appraisal and development.

The Values were drawn up by our staff, facilitated by our Change Champion volunteers, following widespread listening and testing.

Our values underpin how we deliver our services and meet our

objectives and help us to develop our UHD culture over many years. Our priority objectives are re-visited each year to ensure they remain aligned with the national and local strategies and represent the goals and ambitions of UHD.

This is a transition year as we take the Patient First approach to setting our objectives. Developing our strategic thinking and actions to deploy this includes agreeing our “True North”

guiding objective, that allows us to organise around what's most important.

The A3 method is a process to get to the root cause of what's stopping us excelling in this area, and then prioritising the most effective ways to improve (out of the many possible actions we could take). In effect this means doing a smaller number of more effective things, really well.

Objectives are SMART (Specific, Measurable, Action planned, Resources identified, and Timebound) and are tracked as part of our Board Assurance Framework. This allows greater continuity and certainty about what we're working on and allows objectives to better cascade down to teams and individuals within teams.

We will remain flexible in how we go about achieving these objectives, as we learn and listen, try different approaches and develop our improvement skills. What is key though, is the True North and Strategic Objectives remain consistent, so as a team we are all pulling in the same direction.

Themes	Goal	2023/24 Objectives (SMART wording being developed)
Systems and Partnerships	To meet the patient national constitutional standards for Planned and Emergency care. supporting inequalities in outcome and access and improving productivity and value.	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 zero non admitted patients above 52 weeks by March 2024]. To achieve 76% of patients treated within 4 hours through the emergency care pathway by March 2024.
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Patient Experience	To achieve top 20% in the inpatient survey about the quality of care provided at UHD over the next 3 years. 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,	Family and Friend Test (what our patients say) Feedback rates increases from baseline in all service over the next year. Is in top 20% rated 'good' over a 3-year period • Every ward / clinical service has access to monthly Have Your Say survey information and data by March 2024.

	their families and/or carers.	
Quality (Outcomes and Safety)	To achieve top 20% of trusts in the country for HSMR over the next 3 years. To reduce moderate/severe harm patient safety events by 30% over a 3-year period through the development of an outstanding learning culture	To reduce HSMR over the next 18 months [Sept 2024].
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One Team *Patient Ready for Reconfiguration*	To integrate teams and services, then to reconfigure, and so create the planned and emergency hospitals	For every service to have an agreed plan to integrate and start delivery so they are "move in" and "patient ready" for the future

In addition to delivering our objectives, there are **four enabling areas of major change** in the coming years:

1. **Our Patient First approach** using evidence based actions to improve on the quality of care, safety and reliability and to improve the working lives of staff.

2. **The One Team** value means this year, we will continue **to integrate teams**, rotas, policies and day-to-day work, so care delivered is the same regardless of location. This will include essential preparations for service reconfiguration, with some services moving in 23/24, and most in 25/26. Progress here makes teams and services stronger, and care for patients improves.

3. UHD is undergoing a major **reconfiguration** programme. This will create the planned hospital and emergency hospital from 2025. During 2023/24 we will see the continuation of significant building works as we build our improved, modern estate. These changes will deliver significantly better, safer and more sustainable care for the population. Of note, the Poole Theatres, One Dorset Pathology, RBH Catering, Wessex Fields link road and many other schemes will complete in 2023/24.

4. **Digital systems** underpin much of modern life, and healthcare especially so. An Electronic Patient Record (EPR) allows better information to guide clinicians, decisions and can improve care. During 2023/24, UHD will specify and tender for

a new EPR, and develop a plan to migrate current systems. This is a major undertaking but done well can release time to care and improve patient outcomes.

In summary 2023/24 is a year of opportunity to develop our Patient First approach of True North and Strategic themes, to get to root causes of problems and then update our plan and actions to develop the services we would want to be consistently in place for our family and friends.

This is a journey that will take many years and includes delivery of our key enabling programmes that will set us up for success. Taken together this is an ambitious plan, that will require our upmost ability and resilience to see through but is the right thing for us to ensure we achieve putting our patients first.

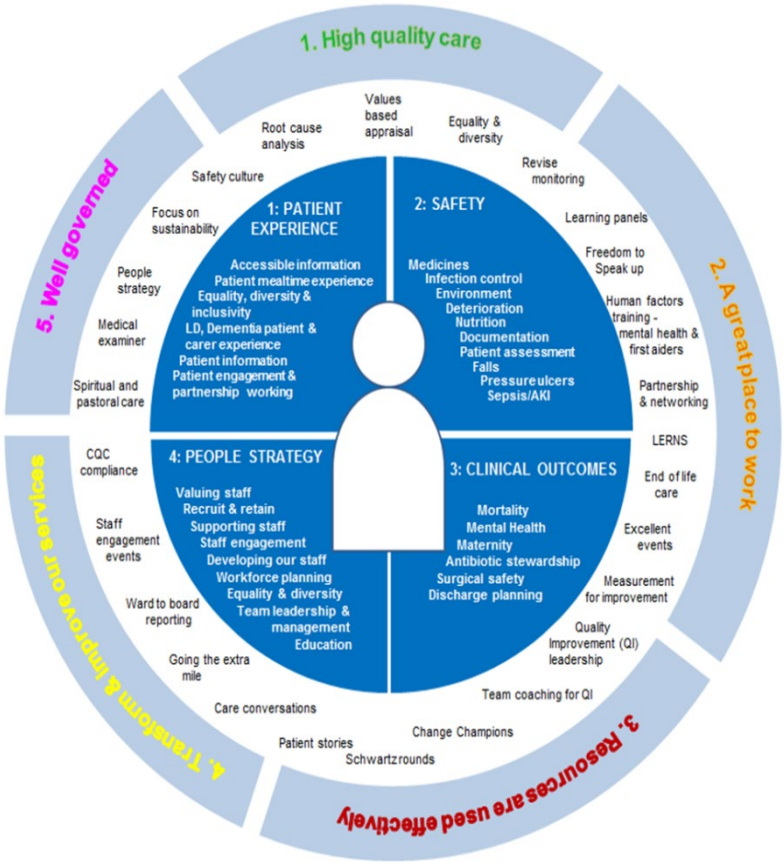
2. Improving the Quality of Care and Safety

2.1 Quality and Safety

The Trust's quality priorities are arranged within the domains of quality; safety, patient experience and clinical effectiveness (clinical outcomes). High quality care can only be achieved when all three of these domains are discussed, prioritised and embedded equally and simultaneously.

We recognise the fundamental role that our staff play in delivering high quality care and our people strategy therefore forms the fourth domain of our quality strategy. Individual priorities within each domain are derived from the national guidance and triangulation of internal data from a variety of sources including patient feedback, external stakeholders, regulators, governors, internal and external reviews and patient safety reporting.

Each of the three pillars of quality; Patient Safety, Patient Experience, Clinical Outcomes/Clinical Effectiveness are monitored through the respective reporting groups in the trust quality and clinical governance framework.



Quality reporting across the Trust supports the review, analysis and delivery of quality priorities related to patient experience, patient and staff safety and the clinical effectiveness of services.

The identification, measurement, analysis and review of quality and safety information is embedded principle and priority across all the Trust and ensures a culture of learning and continuous improvement.

Board and Board subcommittee discussions and reviews support wider quality assurance processes such as peer review, clinical audit, and internal and external audit. Information in the Board and Quality Committee reports routinely includes progress on quality, patient safety and patient experience metrics including:

- Risk register additions, updates, controls, action plans and assurances
- Serious incidents, incident reports, near misses and learning outcomes from investigations and reviews Trends – current and future risk, assurance and quality issues
- Internal comparisons and external benchmarks
- Directorate, specialty, ward and consultant level data where appropriate
- Quantitative and qualitative data
- Patient stories and patient feedback
- Statistical interpretation and analysis.

Quality objectives for 2023/24:

The main patient safety quality priorities for 2022/23 support the implementation of the National Patient Safety Strategy:

- Implementation of the new Patient Safety incident Reporting Framework
- Appointment of Patient Safety Champions
- Embedding the principles of Just Culture
- Implementation of the National Patient Safety Syllabus
- Implementation of the new Learn from patient safety events (LFPSE) service.

Learning from deaths and medical examiner service reviews
Maintaining effective processes for the planning, coordination and implementation of National Patient Safety Alerts.

2.2 Care Quality Commission (CQC)

The CQC undertook an unannounced focused inspection on the 28th and 29th September 2022. The CQC did not look at all key lines of enquiry and limited their review to a small number of areas where concerns had been raised in the Older Peoples Services and Surgery services.

CQC rated Poole Hospital's Surgical Services as Requires Improvement. The Inspectors' assessment of the hospital's Medical Care services did not lead to a rating being issued. The service remains rated 'Good'. The CQC rated Poole Hospital as "Requires Improvement" overall. It was previously rated 'Good'.

Rating : Poole site
CQC Inspection September 2022 : report published 8 March 2023

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016
Medical care (including older people's care)	Requires improvement →← Mar 2023	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020
Surgery	Requires improvement →← Mar 2023	Requires improvement ↓ Mar 2023	Good →← Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Mar 2023
Critical care	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Maternity	Inadequate ↓ Mar 2023	Good Jan 2020	Outstanding Jan 2020	Outstanding Jan 2020	Inadequate ↓↓ Mar 2023	Inadequate ↓↓ Mar 2023
Services for children and young people	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
End of life care	Good →← Jan 2020	Good →← Jan 2020	Outstanding ↑ Jan 2018	Good →← Jan 2020	Good ↑ Jan 2020	Good →← Jan 2020
Outpatients	Good May 2016	N/A	Good May 2016	Good May 2016	Good May 2016	Good May 2016
Overall	Requires improvement →← Mar 2023	Good →← Mar 2023	Outstanding ↑ Jan 2020	Good →← Jan 2020	Requires improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023

No rating was issued for the Royal Bournemouth Hospital. The hospital remains rated 'Good' overall. Similarly, the inspectors' assessment of the hospital's medical care and its surgery did not lead to new ratings being issued. Both remain rated 'Good'.

***Rating :* Bournemouth site**
CQC Inspection September 2022 : report published 8 March 2023

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018
Medical care (including older people's care)	Requires improvement ↓ Mar 2023	Good ↔ Mar 2018	Good ↑ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018
Surgery	Requires improvement ↓ Mar 2023	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018
Critical care	Good Mar 2016	Good Mar 2016	Good Feb 2016	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016
Maternity	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018
Services for children and young people	Good Feb 2016	Good Feb 2016	Outstanding Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
End of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Outpatients	Good Feb 2016	N/A	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Overall	Requires improvement ↓ Mar 2023	Good ↑ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018

The inspection did not lead to Trust-wide ratings being issued.

In medical care at the Royal Bournemouth Hospital and Poole Hospital, inspectors found:

- There were not always enough staff to keep people safe.
- Staff did not always complete and update risk assessments, and records were not always stored securely.
- Medicine storage was not always safe.
- People did not always receive enough food and drink.
- Some people who were medically fit for discharge stayed in the service longer than they needed to, due to a lack of community and social care packages in the region.
- Staff morale was low but still focussed on the needs of patients receiving care.

However:

- Staff knew how to protect people from abuse, and managed safety well.
- Infection risk was controlled well.
- Staff mostly identified and quickly acted for people at risk of deterioration.
- Staff assessed and monitored people regularly to see if they were in pain, and they mostly administered pain relief in a timely way.

- Staff supported people unable to communicate using suitable assessment tools, and they gave additional pain relief when needed.
- Staff collaborated well, to benefit people.
- Staff treated people with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues it faced.
- The service had an open culture where people, their families and staff could raise concerns without fear.

In surgery at the Royal Bournemouth Hospital and Poole Hospital, inspectors found:

- There were not always have enough staff to care for people and keep them safe.
- Care was not always planned to meet local people's needs.
- At Poole Hospital, people on a fractured neck of femur pathway did not always receive treatment within recommended timescales.
- People remained in Poole Hospital's surgery service when they were fit for discharge, due to a lack of community and social care packages in the region.

However:

- Staff assessed risks to people, acted on them and mostly kept good care records.
- Staff treated people with compassion and kindness, respecting their privacy and dignity.
- Staff were focused on the needs of people receiving care.

The CQC recognised that the Trust was aware of a number of these issues and noted that in a number of areas organisational and system wide actions were in place to mitigate risk. The Trust has developed a detailed action plan to address the issues highlighted in the report. The Quality Committee will ensure oversight of effectiveness of the actions identified.

CQC reviews will remain an important part of the quality approach at UHD, and we will continue to use these to understand where further improvements to our services can be made.

2.3 Maternity Services

The CQC inspected Maternity services at Poole Hospital in November 2022 as part of a national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country to held understand what is working well to support learning and improvement at local and national level. The CQC aim to publish a national report on the overall findings of the programme in 2023/24.

The inspection at Poole Hospital was a short notice announced focussed inspection looking at Safe and Well led key questions.

The inspection report was published on the 10 March 2023.

The CQC rated Poole Hospitals Maternity service as 'Inadequate'. The service was previously rated 'Good' (January 2020).

In Poole Hospital maternity services, the report noted that inspectors found:

- There were not always enough staff to keep women safe.
- Systems and processes for managing risk were not always effective, especially in maternity triage.
- Maintenance of the environment especially regarding the emergency call bell systems, were not adequate to maintain people's safety. The CQC acknowledged that at the time of the inspection the Trust was implementing a new call bell system and confirmed it had addressed this issue.
- Managers did not always investigate incidents thoroughly or in a timely manner.
- The maternity leadership team was new and did not always have enough capacity or experience.

However:

- Staff understood how to protect women and children from abuse.
- The environment was visibly clean.
- Staff managed medicines safely.
- Staff felt respected, supported and valued. They were focussed on the needs of women receiving care.
- The service had an open culture where women, their families and staff could raise concerns without fear.

The Trust has identified a detailed action plan to address the issues raised in the CQC report. The Quality Committee will ensure oversight of effectiveness of the actions identified.

2.4 Quality Improvement and Innovation

Progress has continued to be made on delivering the Quality Improvement (QI) and Innovation strategies through 2022/23.

The 2023/24 year is one of transition between the existing QI strategy and the new Patient First programme. Patient First seeks to develop a culture of continuous improvement and learning across UHD in which everyone is empowered to make changes to improve the quality of clinical and non-clinical services to improve patient care.

Patient First has a proven track record of delivering change and will assist in aligning UHD priorities with improvement programmes and focus on delivery of specific breakthrough objectives while rolling out cultural and organisational change to clinical and non-clinical teams.

During 2022/23 staff across Dorset and UHD have been trained in QI methodology using the QI lite and QSIR methodology and this will continue throughout 2023/24 whilst Patient First training is developed and deployed.

The QI priorities for 2022/23 will continue to be delivered into 2023/24 while the Patient First objectives are determined. The QI priorities include IV Fluids, Deteriorating Patient Programme, Difficult IV Access, Safety Checklists, Cancer Care Recovery Programme, Acute Kidney Injury, Blood Glucose Management and 'Think Steroids.'

The work of the Dorset Innovation Hub (DIH) is in its second year with Health Foundation funding supporting the Hub until April 2024. The Hub has undertaken a series of training and development events with staff and stakeholders and has developed a partnership approach to increasing the impact of the spread and adoption of innovation. The Hub priority of malnutrition in ageing people has progressed and the DIH will be seeking nominations for its 2023/24 work programme from members in early 2023.

An Innovation Summit has been planned for 2024 to showcase the spread and adoption of innovation across Dorset. This event will seek to further develop the ways by which we can use innovation to improve outcomes for the people of Dorset and will consist of national and local presenters alongside focussed workshops.

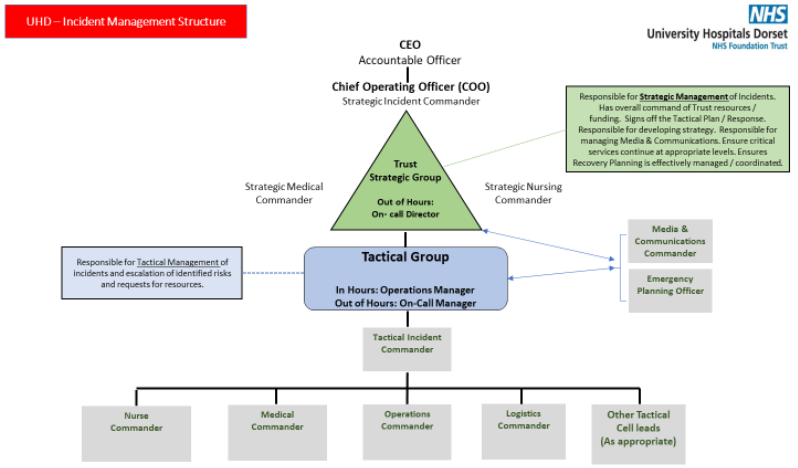
The future sustainability of the DIH is being taken forward with DIH partners and in particular with the Dorset Integrated Care Board.

2.5 Incident Management

UHD has a well-established incident management response model which covers operational, tactical, and strategic levels of command. At the heart of this response model is a cadre of Trained On-call Managers and Directors who have responsibility for the management of any significant incidents that may affect the Trust.

The Trust's response to any given incident may be scaled up or down as appropriate for the circumstances encountered at the time. The effective coordination and management of incidents may be further enhanced by the establishment of Incident Coordination Centres in dedicated rooms on either of the Trust's acute sites.

The Trust has a number of prepared plans designed to guide and inform the response to incidents e.g. Major, Business Continuity, and Critical Incident Plans.



At the current time, Poole Hospital site is the Trust's Headquarters and is designated as the primary Incident Coordination site, with back up locations at Royal Bournemouth Hospital. Once the current building works at the Royal Bournemouth Hospital site have been completed in 2025, this position will reverse with the Royal Bournemouth Hospital site becoming the designated primary ICC site for UHD.

3. Becoming a great place to work: Organisational Development and Workforce

3.1 People Strategy

Our People Strategy which launched in 2021 sets out how we will unite our workforce behind our vision and make UHD a great place to work. Our people have remained under increasing pressure since the response to Covid-19 and in 2022 our staff have also been impacted by the cost-of-living crisis, workforce capacity issues and a need to focus on the large-scale integration activities.

Our People Strategy has proved to be acutely important as it continues to drive the actions needed to keep our people safe, healthy and well, both physically and psychologically, and provide the necessary support and development needed to deliver patient care, and related services. Adapting the Patient First approach will help this further. This is needed as we work in an environment of high demand, and at a time of significant change in the way patient services are organised and delivered across Dorset.

Successful delivery of our strategy will support us to improve our people's experience and ensure the Trust is a great place to work. We recognise the importance of engaging and involving our people, and despite the challenging time ahead for us and for the wider NHS, it is essential that we hold this at the heart of what we do as we move into our new buildings and reconfigure our services and adapt new digital systems.

We know there is a shortfall of trained people to meet the rising demands for healthcare and that we will need to be more flexible, creative and innovative in how we attract, retain and develop our people, to enable us to fulfil our core purpose and achieve our vision with a key focus on workforce planning. Our People Strategy has five key action themes, which, through service integration, will enable appropriate support and care for our people while strengthening our organisational capabilities. Our work continues to be underpinned by the principles of the NHS Long Term Plan, the CQC Well Led domain and the NHS People Plan.

We recognise that there is a lot to do, and that we have some real strengths to build on, specifically the extraordinary commitment of our people to deliver excellent patient care.

Key Actions for 2023/24:

Supporting the Health and Wellbeing of Staff and taking action on recruitment and retention

Our focus continues to be on how we enable staff to be healthy in 'body and mind', to allow them to work effectively to face the challenges and changes of the future.

We recognise that recovery will be different for everyone and there is no one-size fits all. This highly personalised experience will include the need to support rest and recuperation, mental, emotional, physical and financial wellbeing and provide meaningful roles with the right resources and support so that our staff feel equipped for the future.

Compassionate and Inclusive Leadership

We will continue to place health and wellbeing at the heart of our line manager's duties, encouraging them to have meaningful conversations, giving feedback and communicate clearly and consistently about expectations and objectives. Ensuring the strong voice of staff is essential to ensure their involvement and innovation. We recognise colleagues that most need help are the most unlikely to speak up. We will also continue to face the inequalities agenda head-on, with a particular focus in 2023 on improving key WRES indicators.

Key actions:

- Continue focussed work on the Trust's cultural development programme to embed organisational values and ensure the voice of our staff continues to be heard.

- Launch our new online *Thank You* tool, and a new annual staff award event to show staff how proud we are of everything they do for UHD.

- Continue focus on supporting our managers to have valued based appraisal conversations with a focus on individual development and aligning objectives to the Trust's True North.

- Further develop our leadership and lifelong learning offers for staff including embedding the Level 7 Leadership Apprenticeship in partnership with Bournemouth University and further developing a modular programme to support basic people management skills and competencies.

- Introduce a pilot for our talent management tool in line with the national *Scope for Growth* initiative and participate in a national pilot study.

- Review the 2022 staff survey results at team, directorate and care group level and design improvement interventions, including:
    - increase in % BAME composition target to improve leadership diversity by 2025
    - improvements in our Black, Asian and minority ethnic disparity ratio
    - continue to implement priorities within our *Leading for Equality, Diversity and Inclusion* plan and health inequalities within our staff groups.

- Continue to enhance staff network engagement and intersectionality to strengthen contribution to organisational decision-making process.

Systemic Wellbeing Offer

Our enhanced wellbeing service will continue to meet the need for staff access to immediate, acute psychology support. It will be integrated and coordinated for sustainability with a focus on prevention and organisational resilience. We will also focus on local interventions, supporting line managers to have 'psych savvy' conversations with staff.

The Trust has launched a new Managing Attendance Policy which recognises the need for staff to recover after periods of ill health by offering an extended phased return programme.

Key actions:

- Further develop our Mental Health First Aid (MHFA) and Wellbeing Ambassador programmes.
- Embed a range of targeted education and support sessions for line-managers.
- Continue to support the work of our Freedom to Speak Up Guardian and ambassadors to identify staff areas of concern and help remove any barriers staff may face in speaking up.
- Increase proactive health and wellbeing initiatives enabling staff to remain well at work.
- Review "hotspots" of MSK injury-reviewing processes and working patterns and continue to work closely with the ICS MSK team.
- Continue work with the respiratory Physiotherapy team in running the long Covid rehabilitation programme for UHD staff.
- Further develop the trauma pathway to include running a regular "stabilisation group" in collaboration with the ICS and Steps2Wellbeing along with refining referral pathways and co-developing support options for UHD staff.

3.2 Organisational Development & Integration of Teams

Since the merger in October 2020 much progress has been made in teams coming together to improve services for the benefit of patients. Single leadership teams are in place across the Trust in senior clinical and managerial positions and early patient benefits are being delivered in clinical services such as stroke, cardiology and older peoples services.

The Trust cultural champions have completed work on how staff would like to be valued and recognised with a series of recommendations that are being taken forward within the Trust. Work on embedding the Trusts Mission and Values has continued with events and work programmes throughout the year.

In the past year there have been many successes. These included changes being made to the national merger guidance that reflected UHD input and will hopefully make the merger process more grounded and easier to navigate for others. Completion of post-merger actions has continued, a care group integration assessment has been undertaken that has highlighted areas on which to focus and is supported by an action plan based on staff feedback that is in place to get the basics right.

There is however much still to do. The pandemic has bought about delays in the bringing together of teams in some services at Tiers 4 and below and planned cultural changes are still very much underway. Support for leadership development and team integration is in place with teams developing their own plans for coming together to be 'match fit' for the reconfiguration in 2024-2026.

Teams are Everything

Post pandemic, staff will continue to need supportive relationships with those they work closest to, and we will prioritise support to encourage strong social bonds within our home teams.

Key actions:

- Ensure our team leaders can build and lead effective teams at directorate and specialty level as part of COVID-19 recovery, service transformation and our organisational change programme.

- Continue to provide team interventions e.g., action learning sets, coaching, debriefing sessions and peer review facilitation to support resilience and reflective practice.

3.3 Developing our Workforce

Workforce Planning, Recruitment and Retention

During 2023/24 we will continue to focus on Workforce Planning by generating information, analysing it to inform future requirements of staff and skills and translating that into a set of actions that will develop and build on the existing workforce to meet UHD's future resource requirements.

Workforce plans are iterative and do change throughout the year but having robust multi-year plans are essential to have the right skills and people for the future.

Looking forward, the effectiveness of the workforce plan will be reviewed regularly by the HR Team in conjunction with the Operational Leadership Group, and a quarterly report will be presented to the People and Culture Committee. Trust Board will be assured of progress via the board committee which is chaired by a Non-Executive Director.

Recruitment

Current market forces mean significant challenges in sourcing candidates for an increasing number of hard to fill roles, so improving our reach and attraction of candidates via an increased use of social media and focused marketing is important to us.

Key actions:

- Consolidate workforce planning activity across UHD and working through the Dorset ICS and wider system communicate the core requirements of the individual stakeholder in the overall short, medium and long-term Workforce Plan.
- Engage in national and regional recruitment programmes and initiatives for key roles, including international nursing and health care support workers [HCSWs].
- Work alongside the ICS to further develop the HCSW vocational scholarship.
- Increase our uptake on the UHD preceptorship programme and apprenticeship scheme for both clinical and non-clinical roles.
- Full implementation of refreshed ESR Exit module and BI analytics to develop an evidence-based attraction and retention strategy that supports both local and system wide staffing gaps.
- Reduction in agency spend and off framework agency usage.
- Expansion of the international nurse offer to define the pathway of development for newly appointed international nurses towards their first Band 6 role.

- Implement the UHD Temporary Staffing model with resources focused on the attraction and retention of a flexible temporary workforce as a priority.

Retention

Retaining our current workforce remains a priority for us and we will endeavour to offer more flexible, varied roles.

We recognise that flexible working is about more than just retention. It can unlock new opportunities and contribute to people's mental health, wellbeing and engagement with their role, and we know that in the NHS more engaged staff leads to better patient care. We have worked in partnership with staff side colleagues to develop and agree UHD's our Flexible Working and Agile Working Policies, in line with the NHS People Plan principles.

We also recognise that the fair treatment of staff supports a culture of compassion, fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.

Key actions:

- Embed Just and Learning principles into our core people management training.
- Continue to develop and support the offering of flexible working practices.
- Develop attraction and retention incentives at local and system wide level.
- Continue to develop and embed the UHD employee value proposition to support reputation as a 'good place to work.'
- Ensure elective care pathway restoration includes a) talent management and succession planning and b) bespoke health and wellbeing offer for staff and patients.

4. Improving our Operational Performance

4.1 Introduction: improving productivity

In our second year of operating services alongside the ongoing level of healthcare demand from COVID-19, teams have continued to rise to the challenge of restoring services, reducing the backlog of care that is a direct consequence of the pandemic, whilst also meeting the demands for transforming the way we deliver safe, high-quality services for our community.

In 2023/24, it's crucial that we continue our resolve to ensure the highest clinical priority patients are prioritised, we complete any outstanding work for cancer recovery against our ambitions and we continue reforms to urgent and emergency care.

Speciality level plans have been developed for every speciality within the Trust and are the building blocks of our Annual Plan (Appendix 1).

4.2 Organisational Performance and Challenges

From 1 July 2022 integrated care boards (ICBs) became responsible for the performance and oversight of NHS services within their integrated care system. The NHS Oversight Framework 2022/23 describes the approach to oversight and a set of performance metrics aligned to the 2022/23 priorities for the NHS.

Performance management is integral to our Corporate Governance structure. We have agreed a broad range of Key Performance Indicators (KPI's) which form the basis of our performance management framework. These KPI's are aligned to our Strategic Priorities and take into account all NHS constitutional patient access targets and statutory obligations, along with targets we have agreed locally to support the delivery of our overarching vision, enabling strategies and to address key areas of risk.

How we have performed during 2022/23

Referral to Treatment

In 2022/23 our waiting list from referral to treatment increased in size by 30% (16,732 patients). Referral levels increased post the pandemic more quickly than recovery of hospital activity levels. The waiting list however has shown an overall reduction in the most recent six months.

The national target is that at least 92% of patients should be waiting for treatment no more than 18 weeks from their referral to hospital. Our performance has deteriorated from 61% in March 2022 to 53.8% at the end of March 2023. Our performance has been similar to that experienced across trusts in England.

The position that some patients wait significantly longer than the 18 week target has been an area of focus in the Trust during 2022/23. UHD achieved the elimination of waiting times greater than 104 weeks in February 2023 and reduced waits greater than 78 weeks by 87%, to 96 at the end of March 23. The patients who typically wait longest for treatment continue to be those who require admission for surgical procedures in specialities such as Colorectal surgery, Upper Gastrointestinal surgery and Ear, Nose and Throat specialities. Continuation of the Theatre Improvement programme across UHD is a cornerstone for increasing elective capacity, efficiency, and productivity. Alongside this in May 2023, we will launch the new theatre complex at Poole, including the provision of Barn theatres.

Diagnostic waiting times

Our diagnostic waiting times performance has been one of the best in the South West Region reducing to 7% of patients waiting more than 6 weeks for a diagnostic test in March 2023. There has been an overall 56% reduction in the proportion of patients waiting greater than 6 weeks for a diagnostic test during 2022/23.

Cancer Waiting Times

The timeliness of urgent services for patients with suspected cancer has improved during 2022/23 with the Trust delivering a level of performance in line with the national Faster Diagnosis Standard (75%) and the Trust continue to benchmark well against the national average for the 62 cancer standard, although the level of performance achieved has declined overall between March 22 and March 23. Against the national 62 day target to provide first definitive treatment to at least 85% of patients with cancer within 62 days of referral to hospital the Trust achieved 65% (provisional) in March 2023. We have faced a range of challenges in relation to cancer demand including a large increase in the number of referrals for investigations, an increase in the complexity of treatment required by new and existing patients and the impact of recent industrial action on treatment capacity.

Urgent and Emergency Care

Poole Hospital was one of the 14 Trusts selected to take part in national field test of the proposed Urgent & Emergency Care Review of Standards (UEC CRS) in 2019 and Bournemouth joined the pilot following the Trust's merger. This approach measured the mean time in the department. In 23/24 all Trusts have been asked to return to the 4-hour access standard for emergency departments approach, which will require significant operational and cultural change. This states 76% of emergency patients should be seen, treated if necessary, and either discharged or admitted, within four hours of arrival in an

Emergency Department (ED). The Trust is working hard to identify areas which will support delivery of the 4-hour standard, enable monitoring against the standard and support staff education and cultural change.

Below is a summary of the key clinical performance indicators for the UHD.

Performance Metric	Target	UHD Performance 31 March 2023
Mean wait time in Emergency Dept	200	358
Diagnostic 6 week standard - % greater than 6 weeks	1%	7.0%
Referral to Treatment - % patients within 18 weeks	92%	53.8%
Referral to Treatment - number of patients waiting >52 weeks : Trust target March 2023	1,860	4,100
Referral to Treatment - number of patients waiting >78 weeks : Trust target March 2023	123	96
Referral to Treatment - number of patients waiting >104 weeks	0	0
Referral to Treatment - number of pathways	51,491	72,770
28 day Faster Diagnosis Standard	75%	75.0% (provisional)
31 day Cancer Standard - % patients diagnosed being treated within 31 days	96%	96.2% (provisional)
62 day Cancer Standard - % patients being seen 62 days from urgent GP referrals	85%	65.0% (provisional)

4.3 Urgent and Emergency Care

Key Challenges

Approximately 30% of patients attending one of our Emergency Departments (ED) will require admission to a hospital bed. Whilst Covid has reduced its prevalence, there is still an impact on the actions we continue to take to prevent the spread of infection, which impacts hospital flow.

At any time, more than 20% of UHD beds continue to be occupied by patients that are medically fit for discharge but who have an ongoing health or social care need that requires support. This may be physical rehabilitation or support to undertake daily activities at home. The lack of availability of resources to care for people out of hospital often delays patients' discharge, sometimes for a considerable period. This pressure is felt throughout the Urgent and Emergency Care Pathway, and manifests as crowded Emergency Departments and delayed Ambulances in the departments.

UHD has been a pilot site for a suite of new Urgent and Emergency Care metrics over recent years. As part of this pilot, we have not reported against the 4-hour standard that most Trusts nationally have continued to report. This pilot will end in Q1 2023/4 and UHD will return to reporting against the 4-hour standard. The work to return to the 4-hour standard is significant, both in terms of system and process redesign and

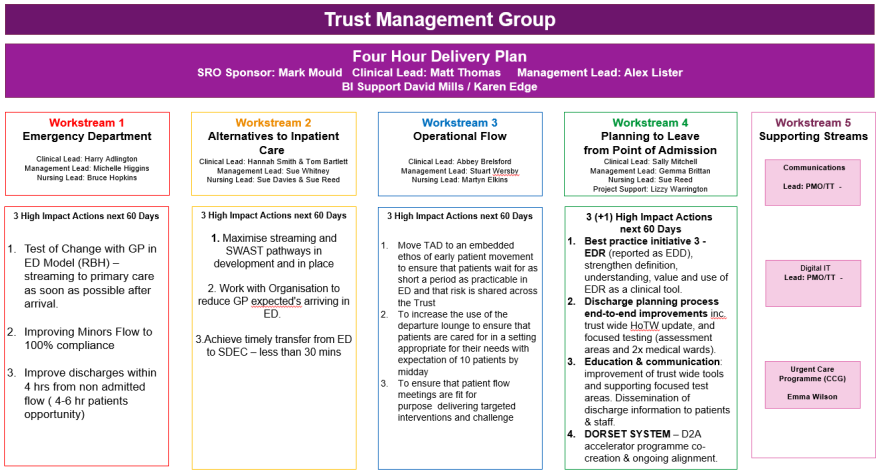
cultural realignment to a different way of working. This will be an area of whole system focus in 2023/4.

The challenges faced by UHD are not unique and sites with Emergency Care Pathways throughout England are facing similar issues. The National UEC Delivery Plan for Recovering Urgent and Emergency Care Services was published at the end of January 2023 which links plans for the NHS with those of the Department of Health and Social Care. Many of the actions in the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services focus on challenges and factors outside of the Acute Hospital. UHD is committed to working as part of the Integrated Care System and with our partners from Local Authorities and other sectors to achieve the benefits for our patients as laid out in the plan.

For the in-hospital actions the existing UHD Hospital Flow Improvement Group, which reports to our Executive led Trust Management Group will continue to lead our recovery actions and the re-implementation of the 4-hour standard. There are four improvement Group workstreams – ED, SDEC, Operational Flow and Discharge report to a single steering group. Each workstream is led by a senior team that are accountable for delivering transformational change required to achieve the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services.

Additionally, UHD will continue to use ECIST to support its recovery programme. Each workstream has detailed action plans and governance in place to ensure these are tracked and delivered.

UEC 4 Hour standard Delivery Plan at-a-glance



Hospital Flow Improvement Programmes

Key actions

Reduce 12-hour waits in EDs

The number of patients spending more than 12 hours in our Emergency Departments reached unprecedented levels in 2022/23, which is again reflected nationally. Addressing 12 hour waits in ED is a core element of the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services.

A significant number of the patients spending more than 12 hours in our Emergency Departments were waiting for an inpatient bed. Achieving the actions laid out in the National UEC Delivery Plan will support flow and reduce these delays.

In late 2022 UHD implemented a continuous flow model. This means that during core hours patients are transferred to downstream wards potentially before the bed space is available. This is a model being used widely nationally to create earlier flow and balance risks across the organisation, rather than resting solely with our Emergency Departments and Ambulance partners. While there are specific challenges around some of the UHD estate and staffing, there are areas where this has been implemented well, and in 2023/4 we will seek to embed this further as a key element of our response to pressure and delays in our Emergency Departments.

Additional actions and pathways for those patients that could be discharged earlier has been enabled by significant investment in Same Day Emergency Care provision in 2022/3 and virtual ward expansion. Recruitment and training delays have impacted the full benefit of this investment, but this will continue to grow in 2023/4.

Getting ambulances to patients quicker

Ambulance handover delays have become a challenge in UHD when the EDs become overcrowded. The Trust will continue to develop and refine both escalation triggers and responses (internally and externally) to reduce the risk of ambulance delays in order to make a meaningful reduction in the numbers of ambulances that are unable to hand over to the ED within 15 minutes. This will support our Ambulance Service partners to achieve the recovery of the Category 2 response time to an average of 30 minutes over 2023/24 and return to pre-pandemic levels in 2024/25.

Same day Emergency Care (SDEC) is available 7 days per week, 12 hours per day.

The second workstream of the Improving Hospital Flow Programme is specifically tasked with ensuring local SDEC provision meets national recommendations for accessibility both in terms of time, and breadth of pathways.

UHD has made significant investment in SDEC provision in 2022 and will realise the benefits of this investment in 2023/4. The first 7-day SDEC service commences in March 2023, with plans to increase the services available, and the pathways to access these services ahead of winter 2023/24.

Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

The reconfiguration of clinical services in Dorset provides for an Urgent Treatment Centre at both Poole and the Royal Bournemouth Hospital after end state reconfiguration in 2025.

Currently the UTCs at Poole and the Royal Bournemouth Hospital provide urgent appointments for over 35,000 patients a year, a third of which are booked from NHS111 directly.

UHD, with the support of the ICS and system partners will develop and further integrate the UTCs into the core UEC front door in 2023, in preparation for the full reconfiguration of emergency care that is now planned for 2025.

Growing the workforce

UHD has made unprecedented commitments to growing the workforce that supports the Urgent and Emergency Care Pathway.

Investments of almost £4m have been made recurrent in 2023/24 budgets to allow both medical and nursing workforces to recruit substantively into posts based on detailed capacity and demand modelling that has been undertaken by the teams, along with £1.9m of investment in creating capacity outside the Emergency Departments, including SDEC, support teams and escalation beds.

Risks and Issues

- Change management requirements to return to the 4-hour standard
- Face to Face Access in Primary Care, and access to primary care appointments from NHS111 or from UHD.
- Workforce recruitment into newly funded posts of all types
- Capacity and technology to divert patients to Minor Injuries Units (MIUs) or other appropriate services
- Timely availability of booked appointments
- Increase in minors' attendances over the Summer
- Increasing NHS111 disposition to Emergency Department
- Ability of partners to respond to demand pressures and avoid additional impact on UHD
- Cultural shift from 'ED work' to 'system work' (internal and external to organisations).

Assumptions

- System plans are developed to deliver The National UEC Delivery Plan for Recovering Urgent and Emergency Care Services
- UTCs are funded and are able to fully integrate into the core Urgent and Emergency Care front door in 2023/24
- Transformation initiatives and funding support for schemes will facilitate deliverables, safe care and progress against key standards.

4.4 Patient Flow & Bed Capacity

In 2022/23, investment was made in key areas to improve flow and increase inpatient capacity. System support was given to increasing SDEC services across both sites, introducing Departure Lounges, recruitment of Discharge Facilitators and funding additional beds on a seasonal basis. Trialling of a rapid discharge teams (Tiger Team) has shown that a targeted team of professionals focusing on discharge in the evening and at weekends can reduce length of stay (LOS) and improve the discharge rate. In 2023/24, the teams aim to enhance and develop the services further.

Underpinning the Trust's surge and capacity planning is our bed modelling. The model demonstrates the need for 'escalation' beds, above core for initial months post winter pressures. A key assumption in our modelling, as well as our bed gap mitigation plans, is the role of the system-wide community capacity and the Pathway to Home programme. In addition to supporting our system-wide work, internally, our focus is on planning for discharge from admission and Pathway 0 discharges, which form 88% of all discharges.

Further work continues with clinical teams to develop flow across the hospitals:

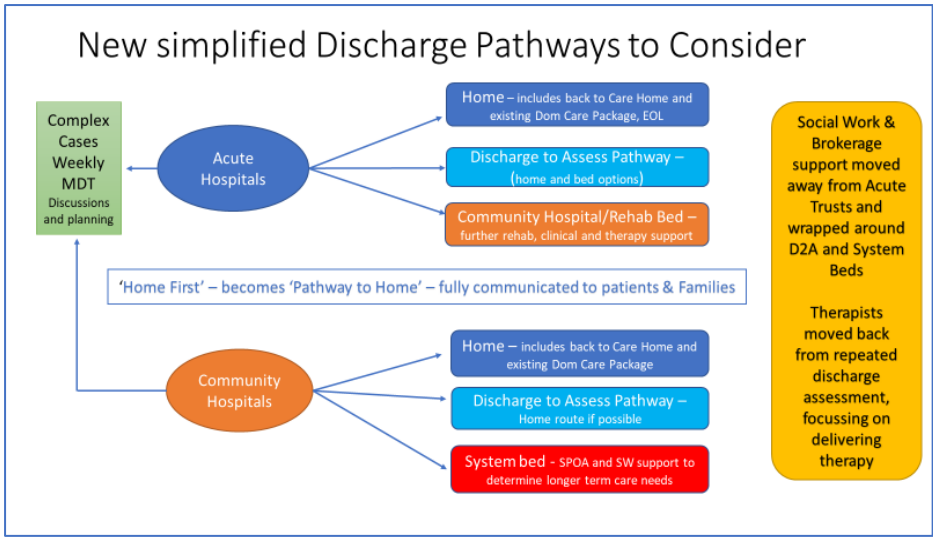
- Review of speciality pathways and cross site bed capacity demands for opportunities to optimise bed capacity
- Alternative care models which support admission avoidance, including Same Day Emergency Care (SDEC) to avoid unnecessary overnight stays and/or reduced length of stay for patients.
- Work internally and with Dorset System partners to optimise the Criteria to Reside framework and Pathway to Home programme
- Review and refinement of our UHD-wide escalation (OPEL) plans and associated risk assessments.

Pathway to Home

The Dorset system have agreed to implement a new simplified discharge pathway. This will be supported by a Discharge to Assess (D2A) model for those patients who are unable to be discharged to their usual place of residence due to new care needs. The model aims to optimise patient rehabilitation and recovery and complete assessments for their longer term needs outside of the acute hospital.

We will work with our system partners on workforce plans to support the D2A model. This requires registered professional and non-registered skills to support the range of patients' needs both in a bedded setting and at home.

This work includes streamlining assessment processes and releasing our therapists to focus on delivering therapy to our patients and reducing their longer-term care needs. We also continue to develop roles such as Assistant Practitioners, OT apprenticeships and new nursing roles. Ongoing joint work across teams at UHD as well as with our system partners will continue to be key as we develop new Dorset pathways and capacity. D2A bed capacity has been secured for 23/24, with a minimum of 50 beds provided in care homes alongside our local community hospitals.



Key Benefits

- It is good for patients – helps to ensure right care, best place at the right time. Reduces the clinical risk of hospital acquired infection and deconditioning by reducing unnecessary longer stays in hospital, supporting best patient outcomes.
- It allows patients to optimise their rehabilitation and recovery and allow the assessment of their longer term needs to take place in a more appropriate setting.
- It reduces pressure on staff, wards and the front door; allowing our sickest patients to be admitted more quickly.

Further system-wide improvement work includes:

- Continuing to expand community capacity, supported by national funding.
- Review of pathways and commissioning for complex and specialist patient needs.
- 'Front door' pathways for unnecessary admission avoidance.
- 7-day discharge planning and discharges.
- Transport services that support discharge.
- Planning for the high level and increasing number of frail older patients in Dorset, including over 85s.

Transforming Hospital Flow Programme – Planning to leave from point of admission

Our internal work on early planning and reduced discharge delays is being driven by our Planning to Leave from Point of Admission workstream. This is overseen by the Trust's Transforming Hospital Flow Programme. The workstream's next phase of work is focused on:

- Estimated Date of Readiness (EDR) - rollout of our Best Practice Toolkit for early and effective discharge planning and processes, supported by developments to our Health of the Ward bed management system. This aims to optimise the time our patients spend in our hospitals, reduce long lengths of stay, increase P0 discharges and provide early information to our system partners to support discharges and capacity planning.

- Developing pathways and processes on our wards that support the new system simplified discharge pathway and specifically the Discharge to Assess (D2A) model.
- 7-day discharges/discharge planning so patients are discharged when they are medically optimised.
- Streamlining assessment and referral pathways including the development of digital solutions that release time to therapy.
- Develop our Health of the Ward bed management system as central conduit for digitally sharing timely information and to support our data driven intelligence and reporting internally, across the system and nationally.

Risks and Issues

- Demand (non-elective and/or elective) exceeds bed modelling scenario assumptions.
- 'Staycations' and visitors to Dorset result in surge demand at peak periods.
- Increase in the number of patients ready to leave requiring step down to community services.
- Pathway to Home and Discharge to Assess capacity and pathways are unable to deliver further reductions in Length of Stay to offset the acute bed capacity gap.
- Ability and capacity to support engagement and delivery across all clinical and ward teams in the Estimated Date of Readiness and associated Criteria to Reside framework
- Further waves of infection, prevention and control impact, outstripping planning assumptions.
- Workforce gaps, particularly in therapy and care capacity, impacting on service and system delivery.

4.5 Elective Care

Elective care covers a broad range of non-urgent services, from diagnostic tests and scans to outpatient care, surgery and cancer treatment.

Our Elective Care Programme focuses on the post-COVID pandemic recovery of elective care through pathway redesign, maximising productivity, and optimising elective capacity, including reducing health inequalities. The programme is closely aligned to the Hospital Flow programme ambitions to reduce the average length of stay, bed occupancy and the number of patients in hospital with no criteria to reside. It is also aligned to the ICP three strategic priorities: prevention and early help, thriving communities and working better together.

Progress made during 2022/23

Considerable strides forward have been made during 2022/23 in support of recovery of elective care. The following are some examples of the progress we made in delivering against the operational plan for 2022/23 and the NHS Long-term Plan ambitions.

Further development of clinical networks across the Dorset system has taken place in the six-high volume, low complexity (HCLV) specialties with system wide clinical leads appointed. Progress was recognised in the visit to Dorset by the national GIRFT team in December 2022.

The Trust was spotlighted for its 'wait-in-line' (WIL) initiative during the national 'Super September' focus on reducing outpatient waits and introduced validation hubs across a range of specialities. Both initiatives have had a positive impact on reducing the length of time people wait and improved booking efficiency.

We expanded the roll out of high flow outpatient assessment clinics at the Dorset Health Village (Outpatient Assessment Centre) to include 13 specialities including physiotherapy, dermatology, maternity and colorectal surgery.

The Trust has seen the progression of digital outpatient transformation in 22/23 with the launch of a patient portal (DrDoctor), installation of virtual consulting pods, extension of Bookwise room booking capability for Christchurch and Poole, and introduction of InTouch Digital check in at Bournemouth and Christchurch Hospitals.

Our Theatre Improvement Programme saw the Trust partner with Foureyes Insight to deliver a reduction in the case opportunity and increased theatre utilisation. Implementation of a smart theatres scheduling tool and cluster theatre planning meetings for specialities supported this improvement.

Health Inequalities

During 2022, the Dorset Elective Health Inequalities Group was established, together with specific working groups. Progress this year has included:

- Waiting list management: tracking new elective patients with a learning disability flag in the Trust with the aim to ensure first outpatient appointments are held within 18 weeks. We have also sought feedback from the learning disability network on communication received and experience of OP appointments to improve the experience of patients.

- Analytics and data intelligence: working with the Dorset Intelligence and Information Service (DiiS) to build upon the population health data available to monitor the impact of our elective recovery programmes on patients' access, experience and outcomes.

Key challenges

All patients referred to the Trust for elective care since 1 January 2023 will require their referral to treatment pathway to the completed by March 2024 in order to meet the national ambition to eliminate waits over 65 weeks. This is over 67,000 patients.

The absence of optimised hospital flow, high numbers of beds occupied by patients with no criteria to reside, an increase in non-elective length of stay and high staff vacancy rates across key areas, including outpatients and theatres, reduces capacity for elective care, exacerbating long waits for elective care.

The most challenged services are those reliant upon theatre capacity including General surgery; Urology; Colorectal surgery; Upper Gastro surgery; Trauma and Orthopaedics; ENT; Oral surgery and Gynaecology. Gastroenterology, Dermatology and some paediatric services also have high numbers of patients waiting to be seen or treated.

Elective Recovery Funding (ERF) supported the return to pre-Covid levels of activity in 2022/23 across inpatients and first outpatient appointments at an organisational level, however variation in levels of recovery was seen at speciality level. Specialties will need to deliver significant productivity and efficiency in order to reach the level of recovery required in 2023/24 (109%).

Continued reliance on the independent sector to provide additional capacity across outpatients and theatres, inevitably brings an additional pull on the finite resources within our booking and admissions teams and is delivered at higher costs.

The elective workforce is stretched and has been operating at pace for a considerable period, thus impacting resilience and wellbeing. Workforce shortages relating to clinical and support staff within key areas are exacerbating elective gaps, and ongoing operational pressures inhibit the ability of our clinical and operational leadership to fully engage in service improvements at times.

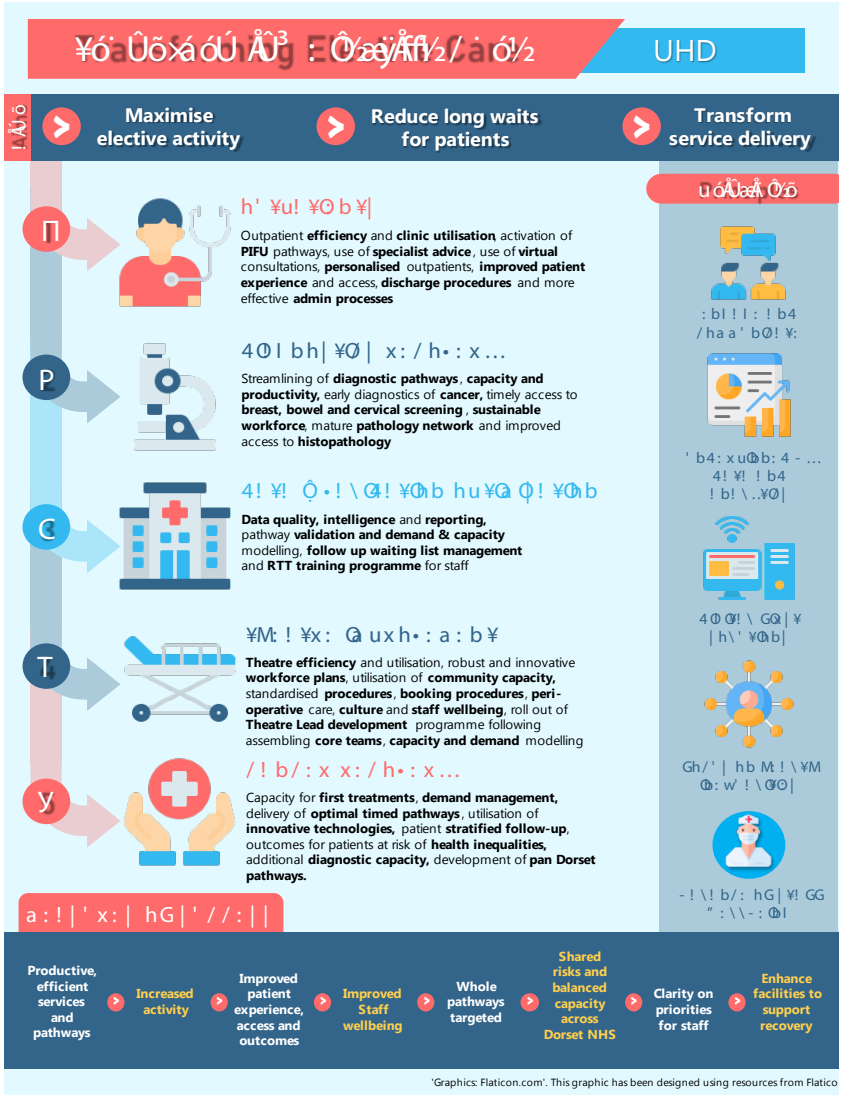
Plans for key service reconfiguration in 2024 and beyond, as part of the major build programmes, including the new Theatre block at Poole Hospital, will challenge operational teams' capacity to focus on both the here and now delivery and important transformation for the future.

Our plan for elective care in 2023/24

The plan is centred around recovering core services and regaining lost productivity, progressing delivery of the Long-term plan key ambitions and continuing to transform for the future. Key areas of delivery are:

- Transforming outpatient care
- Increasing productivity, including theatre utilisation
- Offering meaningful choice for patients.

The existing UHD Transforming Elective Care Portfolio Programme Board, which reports to our Executive led Trust Management Group will continue to lead our recovery actions with an extended scope in 2023/24. There are five programmes included within the portfolio - Outpatients, Cancer, Diagnostics, Data Validation & Optimisation and Theatre improvement. Each programme is led by a senior team that are responsible for leading on transformational change required to achieve the Trust's elective care recovery ambitions. A new delivery Programme for Community Diagnostic Centres will be established in 2023/4 and link closely with the diagnostic element of the Transforming Elective Programme.



Transforming Outpatient Care

We aim to:

- Further expand high flow outpatient clinics in Orthopaedics, Vascular services and Ophthalmology in Q1 and to continue to grow capacity and pathway innovation across all specialities. This aligns to the community diagnostics centres programme to increase access to diagnostics closer to home.
- Improve booking and clinic outcoming capacity and efficiency through a range of measures including standardising appointment guidelines, delivering digital transformation including a 2-way booking portal, standardisation and movement towards e-outcoming, and widespread deployment of digital dictation and speech recognition software. Funding has also been secured through the national Patient Engagement Portal (PEP) Programme to expand the reach of the DrDoctor platform into radiology and cardiology.
- Approach DNA rates proactively to accelerate a reduction in the Trust's overall DNA rate to 5%, including analysis of DNA rates by patients' index of multiple deprivation (IMD) and ethnicity and developing interventions to level up access to elective care.
- Complete a review of clinical session templates to optimise utilisation to achieve a 4% improvement in utilisation rate.
- Introduce greater use of personalised follow ups by increasing patient initiated follow up (PIFU) and ensuring clinically appropriate first to follow up ratios to support effective use of follow up capacity for patients who need to be seen. We aim to deliver an overall reduction in outpatient follow-up appointments (OPFU) against the 2019/20 baseline by March 2024, recognising that the Trust has a backlog of patient waiting a follow up appointment and our ambition is to produce a month-on-month reduction in overdue follow ups in 2023/2024. Significant validation is required to support this programme.
- Support specialties in referral optimisation to deliver 16 specialist advice requests, including Advice & Guidance, per 100 outpatient first attendances through enabling eRS to ePR integration. We will focus on targeting improvement in services with a high discharge rate after first outpatient appointment.

Increasing productivity, including theatre utilisation

We are committed in 2023/24 to improving productivity and reducing variation across the Trust and Dorset system.

We will:

- Continue to reduce unwarranted variation in clinical standards and outcomes through the adoption of best practice outlined in the Getting It Right First Time (GIRFT) programme.

- Reduce our dependency on agency staff and insourcing/outsourcing encourage workers back into substantive and bank roles.

In 22/23 we completed a review of day case opportunities against the British Association of Day Surgery (BADS) directory for the most appropriate setting for procedures to inform the movement of more cases to day surgery, supported also by GIRFT best practice guidance. In 23/24 we will build on the areas of greatest opportunity including the knee pathway in Orthopaedics and day case rate for trans urethral resection of bladder tumour (TURBT) procedures and Uretoscopy in Urology.

Continuation of the Theatre Improvement programme across UHD is a cornerstone for increasing elective capacity, efficiency, and productivity. Five workstreams provide a focus on: digital transformation, building a sustainable workforce, operational excellence & efficiency, staff wellbeing, understanding demand & capacity and utilisation of data to support benchmarking.

As an outcome of the theatre improvement programme, we are targeting improved theatre efficiency and utilisation to achieve 85% utilisation releasing a total case opportunity of 15%.

Our emphasis in 2023/24 is on building teams and staff development to support theatre improvement. Phase 2 of Theatre Improvement programme is aimed at development for theatre leads in response to staff feedback and assembling speciality-based improvement teams, while continuing to roll out digital solutions.

Building on the roll out of the Care Coordination Solution (CCS) theatre scheduling tool we will launch an ‘on the day tool’ to provide the departmental status and run/over-runs to support efficiency improvement by Q2 and continue to develop system and internal processes. The CCS tool will be extended to other elective services using the waiting list Management Module. We will also implement the virtual platform for pre-op assessment.

In May 2023, we will launch the new theatre complex at Poole, including the provision of Barn theatres. The majority of our trauma lists will be moved into the new theatre complex from existing theatres allowing the Trust to decommission day theatres.

Key to reducing the case opportunity will be the development a workforce strategy which addresses recruitment and retention, supports staff well-being and a promotes a positive culture in the workplace for theatres. As part of this strategy, we will be

launching an ODP apprentice training programme in two cohorts during May and September 2023. Though implementation of the workforce strategy we aim to increase theatre lists running and align capacity with speciality level theatre templates.

The Trust will pay attention to the national and Dorset Evidence-Based Intervention Policies to reduce the number of interventions that are of limited value, inappropriate for some patients, or may do more harm than good to improve the quality of care, reduce variation and ensure resources are used effectively.

Data capture and coding

We will:

- Transition our digital first validation project to business as usual across specialities using the DrDoctor platform.
- Expand our validation team to provide additional administrative and technical validation of our RTT waiting list by becoming part of the Southwest NHSE regional validation pilot between March and August 2023. This will support the validation of the active waiting list and achievement of the 65-week target March 2024.
- Review where there may be opportunities to improve the capture of activity and ensure that activity is coded fully.
- Continue RTT validation hubs in other services and the roll out of wait-in-line approaches to all services.

Offering meaningful choice for patients

We will seek to provide patients with meaningful choice at the point of referral and at subsequent points in their pathway, including using alternative providers if people have been waiting a long time for treatment through local mutual aid within Dorset and use of the Digital Mutual Aid System (DMAS). We will support patients to make decisions about their care by:

- Providing sufficient information and time to consider what's right for them.
- Offering choice in where to have their first appointments.
- Promoting My Planned Care Digital Platform.

Assumptions

As a result of these actions, we are committed to deliver the following performance:

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer).

- Deliver 109% elective ordinary activity, 105%-day case activity, and 109% outpatient first attendances against National 19/20 WDR baseline activity.
- Minimise growth in 52 week waits by March 2024.
- Reduce consultant led OPFU based on 95% of 2019/20 WDR baseline activity.
- Expand PIFU to all major specialties, moving or discharging 5% of all outpatients to PIFU consistently by March 2024.
- Deliver 16 specialties advice request including A&G, per 100 outpatient first attendance by March 2024 across the Dorset system.
- Continue to offer video and telephone consultation for outpatient services.

Risks and Issues

- Demand (non-elective and/or elective) exceeds bed modelling scenario assumptions, reducing capacity for routine elective care.
- Further Covid waves of infection, prevention and control impact, outstripping planning assumptions.
- Ability and capacity to support engagement and delivery of improvement across all clinical and management teams.
- Workforce gaps and fatigue, particularly in theatres, administrative and clinical roles, impacting on service and system delivery.
- Availability of mutual aid or independent sector capacity locally or via DMAS in specialities where capacity is a constraint.
- Funding – our ability to retain additional elective funding to support the elective plan is based on delivery against an equivalent value-based activity target of 109% of the 2019/20 baseline.
- Patient compliance and public anxiety.

Further details of elective care are included within individual specialty plans.

4.6 Diagnostics

A UHD Transformance and Delivery Programme for Community Diagnostic Centres will be established in 2023/4 to encompass the wider the Community Diagnostics Programme (CDC) plans for Dorset.

The diagnostics programme includes radiology, physiological measurement, endoscopy, pathology and other associated diagnostic services. It links into outpatient services and cancer pathway development as well as workforce planning.

The Transforming Elective Care Programme will retain an element of diagnostic recovery and the deliverables that are associated with local recovery plans for DM01 performance and cancer recovery with close links to the CDC programme.

The main programmes currently underway are:

- Community Diagnostic (CDC) Programme
- One Dorset Radiology
- One Dorset Pathology reconfiguration
- Endoscopy expansion
- Cancer pathway development

Progress made during 2022/23

- Approval of the Poole hub CDC business cases.
- Expression of interest submitted for endoscopy expansion strategy. A Project Manager has been appointed to take this work forward.
- Submission at system level of the CDC spokes business case and endoscopy equipment case to the CDC national panel.
- Pathology hub build started. Due for handover Autumn 2023. Estates reconfiguration at UHD is continuing.
- Digital slide scanner in place across Dorset with commissioning and training in progress.

Actions

During 2023/24 we will focus on the following workstreams:

- CDC programme – expansion of diagnostic capacity across Dorset in line with optimal utilisation rates in CDC guidelines.
- Expansion of CT/MRI capacity in Poole by moving to 7 days a week in a phased approach linking into workforce planning.
- Development of Weymouth CT scanner (TLHC funded) and audiology build.
- Development of CT scanner for spoke in AECC in Boscombe.
- Endoscopy - Development of additional endoscopy rooms at the Poole hub site (also part of CDC programme)
- Pathology - Handover of hub building, equipment delivery and validation to be completed by September 23.
- Radiology - One Dorset strategy to be completed.
- IT integration at UHD for AI for TLHC programme CT reporting.
- Development of Echo rooms at Poole and introduce 2 CDC funded training ANP posts

Risks

As for elective care.

Assumptions

Improving performance against the core diagnostics standard; maintaining the percentage of patients receiving diagnostic tests within six weeks in line with the March 25 ambition of 95%

Deliver diagnostic activity based on 22/23 run rates (104% of 2019/20)

4.7 Cancer

The Trust continues to work as an integral part of the Dorset Cancer Partnership (DCP) and Wessex Care Alliance (WCA) to ensure key priorities are met in the post pandemic recovery period.

Key challenges

In 2021/22, the Trust regained referral numbers to meet pre-pandemic levels. 22/23 has seen a further increase by 17% (predicted 7%) since 21/22 with some sites seeing an increase by 35% (Colorectal). This has been due to further patients coming forward for investigations post the pandemic, often at later stages and with complex co-morbidities. Awareness campaigns such as 'Bowel Babe' have also had an impact on referrals.

Capacity to manage areas of high demand has been impacted by diagnostic and treatment capacity as well as the availability of specialist and administrative workforce.

Progress made in 2022/23

Some of the key achievements are as follows:

- Implementation of the FIT <10 pathway to support the increase in Colorectal 2 week wait referrals and to safety net patients in conjunction with Primary Care.
- The upgrade of the HICSS system to improve open cancer pathway reporting.
- Further investment in Cancer Support worker roles within specific tumour sites.
- Introduction of precision point technology for prostate biopsies.
- The launch of Cancer Pathway Navigators to support FDS recovery in 4 priority tumour sites.
- Increasing triage capacity by provision of additional or high flow clinics to clear the backlog of referrals and the introduction of e-triage, to improve performance against timed pathway milestones.
- Implementing personalised patient stratified follow up pathways for breast, bowel, testicular and prostate cancers implemented June 2022, followed by endometrial and haematology by March 2023.

- Streamlining access for patients with vague lump symptoms through implementing a Lymph Node Pathway.
- Delivering on our ongoing commitment to the clinical validation and prioritisation programme, with weekly reviews for those waiting longer than 62 days on a cancer pathway.

Cancer Improvement Programme

The Dorset Cancer Partnership launched a Cancer Recovery and Improvement Programme to address identified challenges that were holding the Partnership back from achieving its ambitions for cancer services as well as delivering transformation opportunities to support improvement.
The programme is underpinned by the three cross cutting themes of addressing health inequalities, digital transformation and innovation and getting the basics right.
We are also committed to make progress against the ambitions in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower.

Delivery of the improvement programme in partnership with the Wessex Cancer Alliance (WCA) aims to improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard and the 28-day faster diagnosis standard.

Actions

In 2023/24 we will:

- Review the FDS recovery plans and officially close down the delivered schemes and reset the high impact actions for 2023/4.
- Implement the Best Practice Timed Pathways, including maintaining priority pathway changes for prostate cancer. This will include implementation of a Urology Investigation Unit (UIU), a reduction in 2ww referrals due to change in PSA referral thresholds and phasing out GA template biopsies.
- Implement Tele-dermatology and triage in Dermatology.
- Implement Targeted Lung Health Checks to start from Spring 2023 with subsequent modelling on longer term impacts on referrals from screening to support earlier and faster diagnosis.
- Relaunch the Personalised Care agenda with clear priorities that have associated long term funding streams.
- Appoint a Personalised Care Lead to drive forward e-Holistic Needs Assessments, Treatment Summaries, Remote Monitoring Services (RMS), Health and Wellbeing events and Cancer Support Worker transformation.

- Evaluate the non-specific pathway pilot and ensure sustainability through the ICB, post transfer from WCA.
- Deliver an improvement plan for colorectal pathways which builds on greater integration across UHD.
- Evaluate the FIT <10 pathway and transfer of the pathway back to Primary Care in 23/24.
- Transform the PMB pathway in gynaecology – completing a system referral guidance review and implement high flow clinics at the Outpatient Assessment Centre, Poole.
- Develop and embed process to identify and support patients on an open cancer pathway who are impacted by health inequalities.
- Support the system priorities to increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Risks and issues

- Awaiting release of CWT standards v12. This is expected to reduce the number of standards down to 3. The dates are currently unknown for consultation, publication and implementation.
- The volume of projects across required by DCP/WCA – need robust prioritisation through the Cancer Strategy Group.
- Capacity of digital teams to integrate new ways of working regarding software solutions and automation e.g., Tele-dermatology, Aidence AI (lung health checks), colorectal e-triage
- Despite the planned 8% increase in referrals, there are some tumour sites that have seen extreme levels of referral increases due to national campaigns and some unknown reasons. This is a potential risk again for this year.

Assumptions

As a result of these actions, we are committed to deliver the following performance:

- To return the number of people waiting for longer than 62 days (including 104 backstops) to 220 (nationally agreed target) and at a level that is 6.4% of the overall PTL.
- Sustainably recover FDS performance to the level of the national standard of 75% by September 2023.
- Recover 62-day performance by March 2024.

5. Finance: Best value from the resources we have

On 23 December 2022, NHS England (NHSE) published the 2023/24 priorities and operational planning guidance. This guidance sets out the key tasks for the next financial year, the most immediate being to recover core services and improve productivity.

Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who are medically ready for discharge. Within the Trust, COVID admissions remain constant; both Emergency departments continue to operate under extreme (Level 4) pressures; and we continue to care for over 250 patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate at Operational Pressures Escalation Level (OPEL) 4 with bed occupancy frequently exceeding 100%.

Operating under this pressure requires a relentless focus from all teams to ensure patients receive safe care. Having to operate under this pressure for such a sustained period has obviated the Trusts ability to progress transformation and efficiency schemes at pace. This has limited the Trusts ability to improve productivity and reduce expenditure and when compounded with the significant workforce challenges and reduced COVID funding, has resulted in a significant recurrent underlying deficit.

Revenue

Considerable financial planning and detailed financial modelling has been undertaken within the Trust. This reflects the national planning guidance together with the agreements reached within the Integrated Care System in relation to the distribution of funding across partner NHS organisations. The outcome of this is an expected budget deficit of £35.7 million, within the expected Dorset ICS aggregate deficit of £45.5 million (inclusive of South Western Ambulance Service). This reflects considerable inflation costs above the funding received, the sustained operational and workforce pressures highlighted above, and a small number of targeted clinical investments.

In addition to this significant deficit, a number of financial risks remain which could, if unmitigated, increase this deficit further.

These include:

- CIP plans currently amount to £14 million against the target of £30 million, representing a risk of £16 million.

- Recovering elective services to the 109% threshold may cost more than the funding available, or funding may be clawed back for failing to achieve this threshold.
- Pay costs have been budgeted based on the substantive cost, with only a small amount budgeted for the premium cost of agency cover. If the current agency expenditure run rate continues there is an additional risk of up to £4 million.

These risks, together with the wider financial governance procedures will be managed through the Trust Management Group (supported by the Financial Planning Group) and assured by the Finance and Performance Committee and ultimately the Board.

Capital

The Trust has a comprehensive medium-term capital programme, developed as part of the acute reconfiguration business case and fully aligned to the outcome of the Dorset Clinical Services Review.

This very significant and ambitious programme totals almost £0.5 billion over the coming four years with budgeted spend of £199 million during 2023/24 (assuming final approval of the New Hospitals Programme business case) comprising three key elements:

1. Estates Development (section 6.3);
2. Digital Transformation (section 6.4); and
3. Medical Equipment replacement programme.

This programme sits within the aggregate Dorset ICS capital programme which lives within the ICS capital allocation.

The Trust has a strong track record of successfully managing its capital budget and this will remain a focus through the Trust Management Group (supported by the Capital Management Group) and assured by the Finance and Performance Committee and ultimately the Board.

Cash

The trust continues to hold a significant cash balance which has been strategically built up over many years and is fully committed, supporting the medium-term capital programme and specifically the unfunded elements of the Dorset Clinical Services Review acute reconfiguration programme.

However, this will be materially depleted if the Trust cannot mitigate the expected revenue deficit, resulting in a requirement to borrow cash in future years.

2023/24 Financial Priorities

The Trust's absolute priority during 2023/24 is to recover the projected revenue deficit thereby mitigating the strategic implications of depleting its cash reserves.

The Trust will continue to develop its detailed financial improvement plans which will be underpinned by strong financial governance and control, both within the Trust and across the ICS.

Throughout these plans there are 9 priority areas that are the focus of productivity and efficiency opportunities in each Speciality, each of which has a detailed plan with specific deliverables:

- Hospital Flow: Admissions Avoidance and Length of Stay and Discharge Optimisation.
- Increasing Productivity & Efficiency: Theatres, Outpatients, Radiology.
- Cross Cutting Themes: Temporary Staffing, Procurement and Non-Pay Spend, Medicines Management, Coding and Data Capture.

In addition to delivering direct financial improvements, making progress in these areas will release clinical and management capacity to focus on further quality improvement, thereby improving productivity and efficiency and reducing waste.

6. Transformation

6.1 Overview

Dorset has been on its ambitious transformation journey since the completion of the Clinical Services Review (CSR) in 2017. For UHD two major capital developments are underway to support the reconfiguration of services into the Planned Hospital site at Poole and the Emergency Hospital site at Bournemouth.

UHD has been awarded STP Wave 1 funding of £201m to establish the BEACH building (Births, Emergency care, And, Critical care and child Health) and additional capital to develop a new theatre block at Poole Hospital. A further investment of £262m as part of the New Hospitals Programme to complete the planned and emergency care model.

The new Theatre block will complete in Poole in May 2023 and the Dorset Pathology Hub is scheduled to open on the RBH site in 2023. Building work has advanced on the BEACH building which is due to open in spring 2025.

During 2022 UHD and partners worked together on the safest way to transition services to implement the CSR. Over a series of workshops, the groups recommended that services move some 18 months earlier than originally planned. This will result in the planned and emergency hospitals being largely established in Spring 2025, with the final service moves completing in 2026/27.

The strategic plan for UHD over the next five years will see delivery of high quality, safe and sustainable services for the population of Dorset in a modern, fit for purpose estate.

6.2 Integration

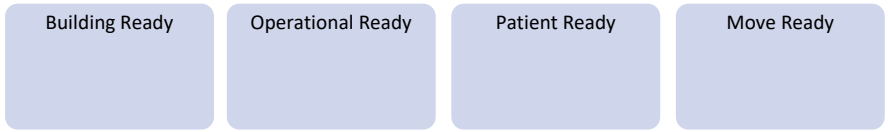
Establishing the Planned and Emergency Hospitals means the majority of services will be delivered from a single site, depending on whether those services are planned services and take place at Poole Hospital or Emergency services and take place at Bournemouth Hospital. This allows each site to concentrate and become a centre of excellence, and to provide better patient care.

This will necessitate the integration of some teams where the same service is currently supplied over both sites. For instance, the current Emergency Department teams delivering services at Poole and Bournemouth Hospitals will form a single, new ED team delivering services from the Bournemouth site with some

staff delivering services from the Urgent Treatment Centre at the Poole site.

The integration of teams usually requires changes to the way teams work in order to adopt a single way of delivering services and could require changes to team staffing structures and staff rotas in order to deliver standardised clinical pathways and operating procedures. There will be engagement and consultation with staff and users over the next two years.

Whilst the building plans require buildings to be ready to be occupied for delivery of services ('build ready'), our new builds also require equipping with the relevant equipment and facilities to deliver services ('operationally ready') and also require existing teams to be operating as a single team using single pathways and protocols before moving into the new buildings, so as to minimise the risk of disrupting services and maximise safety ('patient ready'). It is only at this point that teams can then move and deliver services from the new buildings ('move ready').



There are over 35 specialties at UHD, some of which are already single teams and will not require an integration work programme. However, the majority will be undertaking an integration programme, supported by the Organisational Development Team and the Strategy and Transformation Team throughout 2023/24 in order to progress towards the 'patient ready' stage of the reconfiguration.

Evidence from other reconfigurations is clear that single teams operating in the same way before a move to a new site much reduces clinical risks and allows teams to focus on delivering a safe move to new facilities without being distracted by moving whilst attempting to harmonise differing working practices from legacy teams. 2023/24, therefore, has a major focus on preparing teams to be operationally and patient ready.

6.3 Reconfiguration

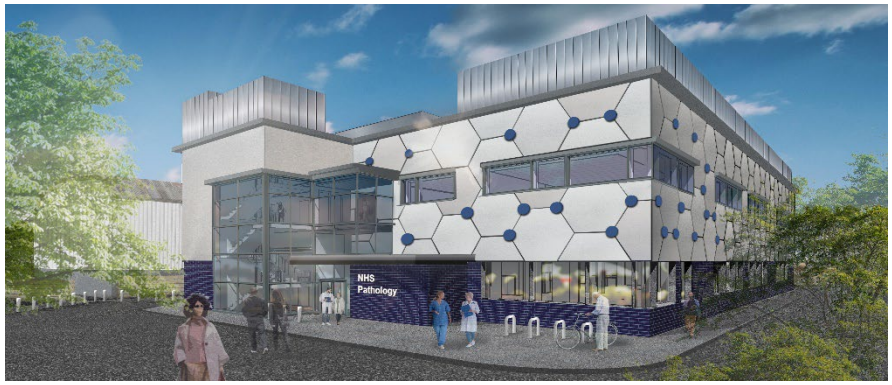
The creation of the planned care hospital at Poole and the emergency hospital at Bournemouth remains the centre piece of the Critical Services Review (CSR) agreed by the Secretary of State for Health in 2019, following three years of public, staff and partner engagement.

The benefits and reconfiguration changes are set out in our Future Hospitals Website: [Investing in our hospitals (uhd.nhs.uk).]

The Estates masterplan provides visuals and the timeline for the major changes that complete in 2026/27. The main set of changes are planned for Spring 2025, with the opening of the BEACH building, providing Births, Emergency Care, Antenatal, Critical Care and Child Health. There are other extensive changes across both Poole & Bournemouth.

In 2023/24, there are five strategic changes:

1. Our **Dorset Pathology Hub** opens. This is a state-of-the-art building with digital Pathology, able to serve the whole of Dorset and beyond.



2. **Stroke rehabilitation** combining on the Bournemouth site. This will provide more seamless care and combine expertise for better patient outcomes. Complex older peoples' rehabilitation will be centred at Poole.

3. **Cardiac Emergency Care**. This will be centred at Bournemouth and allows better cardiac care at both Poole and Bournemouth.

4. **Poole Operating Theatres**. Four brand new theatres in the Orthopaedic Barn open. These will be used to support orthopaedic trauma surgery (until the Poole site becomes all elective and the theatres

are used for routine hip and knees replacements).

5. **Catering.** The Central Production Kitchen (CPK) will open, allowing a totally new, improved catering offer. This will offer more choice, be more sustainable and provide greater resilience.

These are five significant service changes in 2023/24 but across all our sites, building works in preparation for 2025 will continue and step up. The enabling woks for the New Hospital Programme and the Full Business Case will be submitted. Other capital projects will also be progressed, including back log estates works across the Trust.

Taken together the five-year capital programme represents over £500m of investment in Dorset NHS Estates. This is the largest such investment ever, and only comparable to the late 1980s when Royal Bournemouth Hospital was built. All this building work is only an enabler, to support clinical services be reconfigured to deliver integrated teams, better able to provide specialist care seven days a week, and to ringfence planned care, free of emergency care pressures.

Work to ensure the environmental sustainability of the buildings, improved transport, and that information technology is fully harnessed for better patient care, are set out in different parts of this plan.

6.4 Digital Programmes

UHD currently has a Best of Breed approach to deploying systems that meet specific departmental needs and uses messaging and a portal based EPR (Graphnet CareCentric) to share information across the Trust and the wider care environment, via the Dorset Care Record.

The vast majority of our departmental systems send data to EPR and we currently have 5 critical enterprise-wide systems (EDM, Order Comms, EPMA, Dorset Care Record, Radiology PACS) linked to EPR such that the user can launch these systems from within EPR without having to login or find the patient from within that connected system[1]. Work is progressing to deliver another 2 systems within the next 6 months (HICSS (endoscopy and rheumatology) and eNurse Assessment).

All historic paper-based recording of clinical care is now scanned following the inpatient and outpatient event and consequently no “legacy” paper documents are presented to clinicians at the point of care. Graphnet EPR has >180 specific electronic form templates and >300 specific e-forms exist

outside of Graphnet EPR for clinical and non-clinical use. It is difficult to find a clinical department that does not use computer-based recording for at least part of their patient interactions and gradually, albeit slowly, the dependency on paper recording is being eroded, particularly in the non-inpatient settings were clinical staff are finding it easier to make this transition.

Over the last 24 months it had become clear that the best of breed/portal approach is constraining our attempts to improve clinical productivity through digital transformation as it requires clinicians to navigate multiple systems to conduct effective clinical workflow. Graphnet, our EPR portal provider, as part of the System C alliance, has indicated that although there is no threat to the continuation of our existing portal-based system, the future roadmap for that product is to subsume it within the System C EPR.

The UHD board of directors, in the context of working in partnership across the ICS, has agreed an outline business case for a single Acute EPR, shared between UHD and Dorset County Hospital, with advanced linking/interoperability with primary, community and mental health in order to achieve a step change in digital services to support clinical safety and efficiency. The realistic implementation timeline for this major change is around the 2025, 2026 horizon which maps directly onto the time scale for the reorganisation and integration of clinical services as part of the clinical service review changes. Consequently, the selection of the EPR provider is required to support the process of the service review changes in 2024 so we must launch and complete the procurement in 2023.

The UHD current plans are to continue with the tactical deployment and completion of in-flight deployments of best of breed systems with as much integration as possible to our existing clinical ecosystem to provide value to our clinical and operational staff in addressing their objectives until such time as we have an overarching Dorset wide architecture, roadmap and programme of delivery. Some key projects are described below, this is not an exhaustive list.

- Completing deployment of EPMA for inpatient settings
- An interim solution for closed loop result management to reduce the risk of Serious Incidents associated with pathology and radiology results being lost
- Deployment of order comms and results reporting to cardiology and endoscopy
- Implementation of a new Emergency Department system.
- Deployment of Strategic Integrated Image Solution (SIIS) as part of the south-east three diagnostics network
- Continued support for clinical and nursing quality improvements including addition of digital Fluid Balance to the e-Observations system
- Deployment of a range of digital technology to support outpatient productivity (including online booking platform, voice recognition, robotic process automation, business

intelligence tools, workflow enhancement for referral and advice and guidance management)

- Replacement of traditional pagers for routine communication with a portable, Wi-Fi connected device allowing immediate communication by instant message, voice and video
- Removal of all unsupported operating systems and applications in line with meeting our Data Security and Protection Toolkit requirements

These developments will be underpinned by a systematic rolling stock replacement of all layers of our technical Infrastructure and end-user devices and work to achieve a fully compliant Data Security and Protection Toolkit submission.

7. Population and System Working

7.1 NHS Dorset Strategy

The legislative changes to implement the NHS Long Term Plan were completed in July 2022, establishing Integrated Care Systems and Dorset CCG functions transferred to the Dorset Integrated Care Board (NHS Dorset), supported by an Integrated Care Partnership and Provider Collaborative.

Dorset ICS has four key functions:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- supporting broader social and economic development.

The first ICP strategy for Dorset 'forward view' identified 3 key priorities:

1. **Prevention and early help**

   Helping you to stay well by providing prevention support as early as possible.

2. **Thriving communities**

   Investing in communities, building strong networks and developing high quality spaces in the community where we can work together.

3. **Working better together**

   Consider your needs at all stages of your journey through health and care services.

The Joint Strategic Needs Assessment tells us these are the important factors:

- Mental health and wellbeing
- Fairness in access to services, including digital
- Loneliness and social isolation
- Rising cost of living, hidden poverty

- Children's health and social care
- Workforce and ability to help support people with more complex needs
- Lack of maturity in working as one system to improve quality – demand and pressures
- Integrated mental and physical health.

NHS Dorset and its partners, including UHD, will work as part of the ICS and ICB to help deliver the ICP strategy aiming for the following outcomes:

- Joined-up health and wellbeing, for mental and physical health
- Invest in and involve informal care and support
- Care closer to home
- Children's health and best start in life
- Inequality and fairness; in access, outcomes and experience
- Social isolation, loneliness
- Listen and involve people in solutions

Place based partnerships and the Provider Collaborative will help to deliver these outcomes for the people of Dorset

7.2 Bournemouth University (BU) Partnership

Bournemouth University

University Hospitals Dorset NHS Foundation Trust

Our BU-UHD partnership strategy identifies the main areas of focus for the BU-UHD partnership programme:

- strategic alignment – refresh of our partnership strategy
- stimulus for research and innovation – facilitate collaboration, host research events and develop pathways that enable more staff to participate in research
- education and training of future workforce – develop local training opportunities including apprenticeships that meet future workforce training needs
- recruit and retain talent – with joint posts and collaborations that help make both BU and UHD great places to work
- meeting future challenges – working together to better solve future challenges
- wider private and public partnerships – working closely with other partners to the benefit of all.

The strategy promotes a "joint by default" approach between the organisations, complementing the existing work and strategies of each individual organisation, enhancing the work

that is already done together and developing on both organisations' strengths.

The jointly agreed work programme identifies the collaborations planned for the year in order to deliver benefits to patients, students, staff, organisations and wider. Key opportunities in the coming year are:

- to collaborate to develop new roles across the hospital and university attracting new talent
- to work together to increase the number of non-clinical placements for BU students, maintaining the quality of all student's experience at UHD.
- work with other local employers to utilise apprenticeship funding to co-design and co-deliver local training to both attract new staff and support the development of our existing workforce at UHD
- to enable our staff to undertake research to support both improved patient experience and outcomes
- work with AHSN and BU colleagues to evaluate the impact of major NHS programmes on our service users and staff

Both BU and UHD recognise the strength of working more closely together and are committed to this programme in the coming years

7.3 Health Inequality

Covid-19 has shone a light on inequalities and highlighted the urgent need to strengthen action to prevent and manage ill health in deprived and ethnic minority communities. Narrowing the gap in health inequalities and improving health outcomes is a golden thread woven throughout all aspects of our plan.

In 2023/24 we will strengthen our use of population health management to narrow the gap in health inequalities and improve health outcomes. We aim to proactively identify the health inequalities of our population to inform service design and policy development.

We will build upon the strong foundations provided by the Dorset Intelligence and Insight Service (DiiS) population health management (PHM) tools, which give access to comprehensive, good quality data and linked data sets from many care settings including acute care, primary care, mental health and social care.

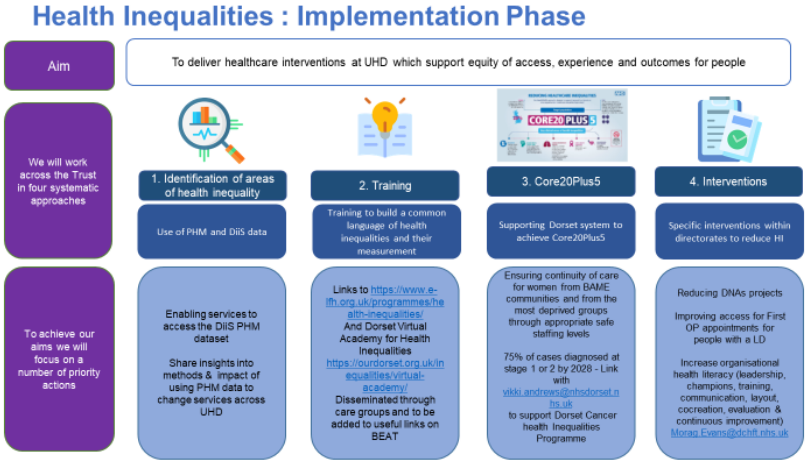
Our approach will be to use this data to identify the needs of our communities' experiencing inequalities in access, experience and outcomes in relation to their health, so that we can respond with tailored strategies for addressing inequalities and track the impact of these strategies.

We will work collaboratively across the Dorset ICP to adopt the Core20PLUS5 approach and to deliver the ICP Working Better Together Strategy. In doing so, we will made specific consideration of Black and minority ethnic populations and the bottom 20% by IMD for clinically prioritised cohorts.

Building on the work undertaken in 2022/23 to evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists we will continue to spread the learning to date to other prioritised cohorts. Including a focus on reducing DNA rates and increasing health literacy.

Our implementation plan includes a focus on four systematic approaches:

1. Identification of areas of health inequality
2. Training for staff
3. Core20Plus 5 assessment and approaches
4. Interventions targeted to reduce health inequalities



Our strategy will relate to addressing health inequalities for both patients and staff. Our Equality, Diversity and Inclusion Group and Healthy Working Lives Group will be asked to set out its priorities in tackling health inequalities as they directly relate to staff and to review the strategy to ensure activities are viewed through a health inequalities lens.

A new Population Health and System Committee has been established to provide oversight of the implementation by the Trust of its responsibilities pursuant to the Our Dorset strategic plan for population health and health inequalities. Accountability for health inequalities will be assured through our Board performance reporting framework. We will move towards outcome reporting, breaking down performance reports by patient ethnicity and IMD quintile, focusing on

unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations.

To reflect our position as one of the biggest employers in Dorset, we will consider adoption of the Anchor Institute approach and be an active member of the Dorset Anchor Institution's Network.

In 2023/24 we will also;

- Review our current patient engagement strategy to ensure we optimise how we understand our communities and the way in which they experience our services through personalised culturally competent approaches to clinical and operational management including participatory community engagement.
- Evaluate the Trust's approach to Equality and Health Inequalities Impact Assessment to ensure its alignment with NHS best practice.
- Support staff to access training on population health management and health inequalities, including the development of technical and analytical capability within the Performance and Business Intelligence service.

7.4 Sustainability

The UHD sustainability strategy aligns with the requirements set out in the NHS national plan, delivering a "Net Zero" national health service and the Health Care Act 2022.

Our green plan can be found on: uhd_green_plan_1.pdf.

The Sustainability Strategy, or Green UHD Plan, maps out the Trust sustainability vision, objectives and governance approach through targets and areas of activity:

- Our vision to provide excellent healthcare
- Our green objectives, healthy lives, healthy community and a healthy environment
- A set of cornerstone targets relating to carbon, clean air, the use of resources, sustainable development goals and staff engagement

To realise our green plan there are twelve areas of activity that cover all the aspects of services within UHD.

- Workforce and leadership
- Sustainable models of care
- Digital transformation
- Travel and transport
- Waste
- Capital projects
- Utilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation
- Greenspace and biodiversity.

We also have two additional 'summary areas of activity' to help roll up, capture and manage the total contribution towards carbon and social value targets.

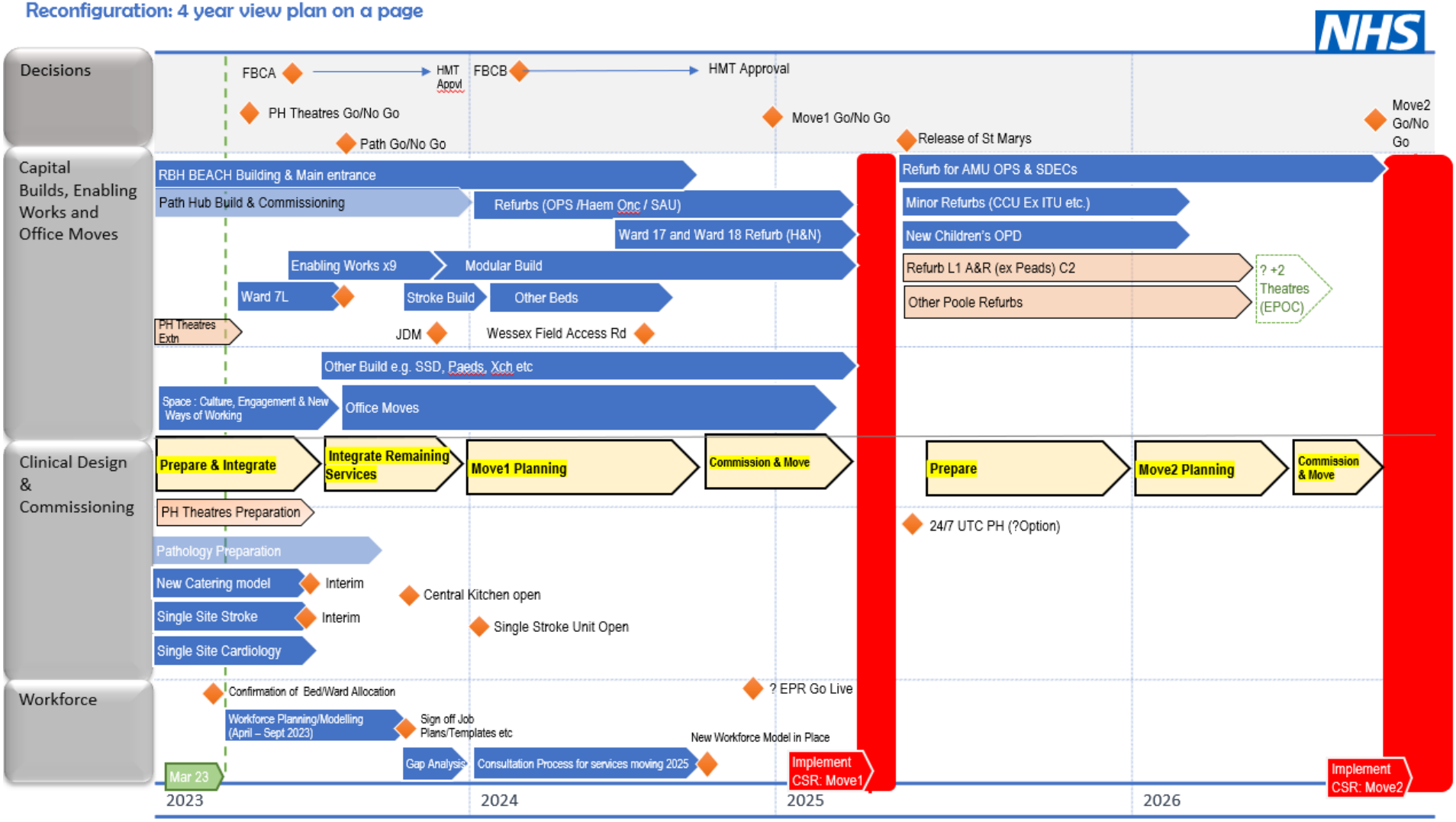
- Carbon
- Social value / anchor institution

The Green Plan aligns the Trust with the NHS aim for an 80% carbon reduction by 2028 and to become a net zero organization by 2040 and contains a framework on which to hang a range of measures designed to progress the Trust towards this and the other targets set out. Given the unprecedented nature of the challenges being addresses, the measures taken and the Green Plan itself will require regular review and revision along this journey.

In 2023/24, two areas will receive the greatest attention:

- **Electrical Infrastructure** and the start of major investment in to decarbonised energy, and more renewables on site.
- **Green Travel** plan to support staff travel and be both easier and more enjoyable (as well as cheaper, healthier and greener).

Appendix A – Reconfiguration 4 Year Plan



Appendix B – Speciality Level Plans

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 8.1

Subject:	Mortality Report
Prepared by:	Sean Weaver/Peter Wilson
Presented by:	Peter Wilson (CMO)

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☐ Use resources efficiently ☐ Be a well led and effective partner ☐ Transform and improve ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Information
Executive Summary:	The SMR over the last 7 months has been increasing across the Trust. January 2023 saw a fall back to 100.7. This is within expected mortality for the Trust. HSMR is higher than expected at December 2022. A new mortality lead was appointed last month. We have started a deep dive into the causes of the increase of SMR. This has revealed: 1. Biggest cohorts for mortality in the Trust are: neoplasm cardiovascular and respiratory. 2. Respiratory is the area where mortality is above national average. 3. Pneumonia is a diagnosis with mortality above national average. 4. Mortality at weekends is greater than mortality during Week. 5. Mortality for the palliative diagnoses is above average. The mortality surveillance group is about to start the next phase of understanding why and creating an action plan- this is part of the Patient First work.
Background:	Mortality is clearly a crucial metric of patient care. Interpreting and responding to the data needs to be supported by clear and robust governance. It is also a late marker of patient safety with data reported 4 or 5 months after the date of death. Trends in data are visible for a period of a year prior to the time the report is visible to the organisation. As a result, responding to a trend in mortality can take time before the efficacy of that response is known. Secondly, mortality measures only

	death rather than factors that may contribute to a lack of effective care making it a relatively crude, if crucial, measure of patient safety.
Key Recommendations:	1. Changes to mortality and clinical governance groups are occurring as part of accountability framework and structure. 2. Undertake work to understand causes of variation. 3. Engagement through clinical governance group to link mortality to quality and safety.
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**
N/A	N/A	N/A

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

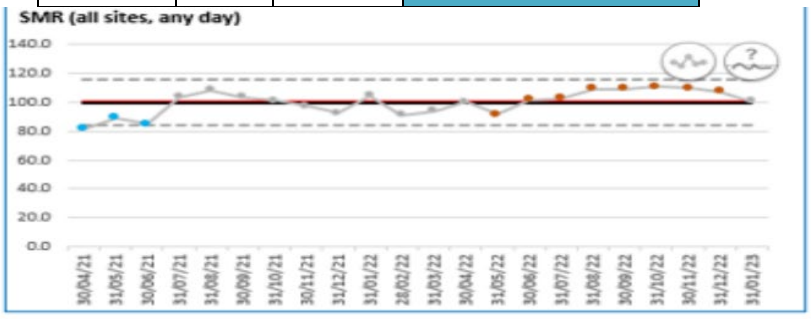
University Hospitals Dorset
NHS Foundation Trust

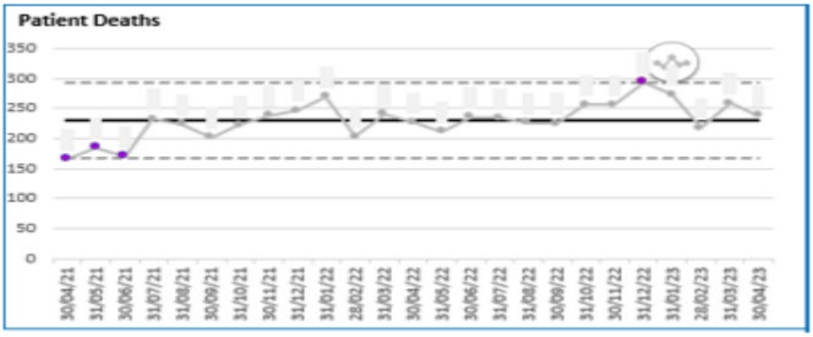
Chief Medical Officer's Report to the Board

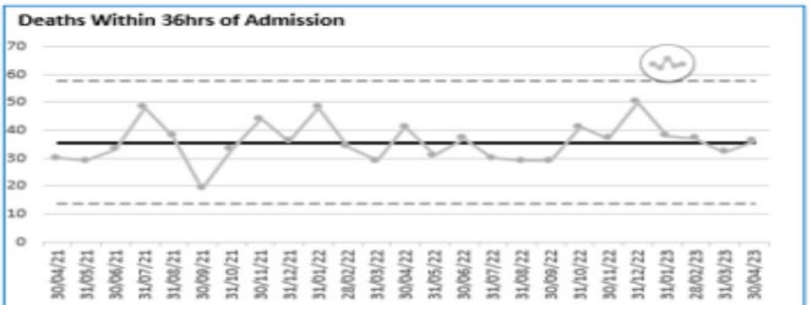
Mortality Update

HSMR January 22 to December 22 (UHD) SHMI February 22 to January 23(Telstra health)

Indicator	Site	Value	Range
HSMR	RBH	102.1	As expected
	Poole	98.1	As expected
	UHD	103.2	Higher than expected
SMR	RBH	99.8	As expected
	Poole	92.3	Better than expected
	UHD	102.4	As expected
SMHI	RBH	87	As expected
	Poole	76	As expected
	UHD	89.6	As expected







Initial Inspection of Mortality Data

1. Biggest cohorts for mortality in UHD are: neoplasm, cardiovascular and respiratory
2. Respiratory is the area where mortality is above national average
3. Pneumonia is a diagnosis with mortality above national average
4. Mortality and weekends is greater than mortality during week
5. Mortality for the palliative diagnoses is above average

Next steps is to understand specific reasons and to test a number of hypotheses created through the data and by clinical inquiry.

Changes in Mortality Leadership

As of 20th April, Sean Weaver was appointed as the new mortality lead. Sean takes over from Dr Divya Tiwari and Dr Adam Wheldon and is keen to thank them and acknowledge all the work they have done. Sean is a gastroenterologist and significant experience in patient safety and quality improvement.

This is an opportunity to review the mortality steering group and how it fits into the merged organisation most effectively. In particular to ensure the membership is appropriate and supports effective dialogue to understand and effectively interpret and respond to the data. From a reporting point of view there was no meeting in April or May due to strikes and the change in leadership with monthly meetings scheduled from June.

Mortality Measures in the Context of Patient safety

Mortality is clearly a crucial metric of patient care. Interpreting and responding to the data needs to be supported by clear and robust governance. It is also a late marker of patient safety with data reported 4 or 5 months after the date of death. Trends in data are visible for a period of a year prior to the time the report is visible to the organisation. As a result, responding to a trend in mortality can take time before the efficacy of that response is known. Secondly, mortality measures only death rather than factors that may contribute to a lack of effective care making it a relatively crude, if crucial, measure of patient safety.

We are therefore keen that mortality governance links in with more current metrics and information. Timely mortality review, medical examiner intelligence and interrogation of known areas of risk (such as response to a deteriorating patient) can give useful timely information to support the improvement of mortality. We will also look for unwarranted variation and will be aiming to look at this across the whole trust rather than persist with site specific reporting.

A safe and effective hospital should have a low mortality; however it is measured. Therefore, it is a crucial metric and should be highlighted in Patient First. Furthermore, the factors influencing it should be key themes in the trusts response to the Patient Safety Incidence Response Framework (PSIRF) against which we will be inspected.

Changes being taken within Mortality reporting and Safety and Governance

The mortality surveillance group has started to undertake a deep-dive to look at areas of concern within mortality. This will form the basis of our Patient First strand for mortality through the whole organisation.

The mortality surveillance group is now linked with the clinical governance group (both will report to Trust Management Board and through to Quality Committee and Board). This will ensure we can start to link thematic reviews from LERNs and the risk register with the data reviews within the mortality surveillance review.

A medical director for quality is being appointed to oversee bringing the strands of mortality, quality and safety together and ensure it is co-ordinated and standardised through both Patient First and PSIRF processes.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 8.2

Subject:	Guardian of Safe Working Hours Report
Prepared by:	Julie Mantell, Head of Medical Education Mike Vassallo, Guardian of Safe Working Hours Paul Froggatt, Guardian of Safe Working Hours
Presented by:	Peter Wilson, CMO

Strategic Objectives that this item supports/impacts:	Continually improve quality ☐ Be a great place to work ☒ Use resources efficiently ☐ Be a well led and effective partner ☐ Transform and improve ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Assurance
Executive Summary:	The number of exception reports raised has decreased from the previous quarter. It is not thought that this is indicative of fewer exceptions occurring. It is likely to be multi-factorial and at present has to be set in the context of the recent industrial action, the current position across the Trust and further afield. There may also be a creeping despondency about exception reporting that will need to be monitored and addressed. Conversely, a lot of work is being put in by directorates to improve staffing so this work may be reflected in this drop. There was one patient safety concern on the RBCH site and 4 at Poole Hospital - all have been addressed. Further details are included in the attached report. Exception reporting is actively encouraged by the Trust.
Background:	The Guardian post was created as part of the 2016 Junior Doctor contract, to ensure hours worked, and levels of supports, are safe for doctors and patients, based on exception reports.
Key Recommendations:	Continue to support the process of exception reporting and therefore identifying problems early. Ongoing presence of executive team for the junior doctors' forum. Monitor changes following filling posts through the medical safer staffing workforce program.

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**
N/A	N/A	N/A

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

University Hospitals Dorset
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

1ST JANUARY 2023 – 31ST MARCH 2023

UNIVERSITY HOSPITALS DORSET

POOLE HOSPITAL OVERVIEW (see page 3 for detail)

There has been a reduction in the number of exception reports his quarter. As ever I don't think this is indicative of fewer exceptions occurring. In reality it is likely multi-factorial and at present (my own personal experience and from discussions with both fellow consultants and doctors in training) has to be set in the context of the recent industrial action. To whit; many doctors in training feel that exception reporting is futile when set against the larger picture of the campaign for pay restitution. I am aware that these comments fall out with the formal GoSW remit and role, however it is clearly germane to the current position across the trust and further afield.

ROYAL BOURNEMOUTH HOSPITAL OVERVIEW (see page 6 for detail)

There were a total of 128 exception reports for the quarter 1st January 2023 to 31st March 2023, a decrease of 129 from the previous quarter. Of the 128 exceptions raised there was one patient safety concern from a foundation year 1 doctor working in OPS. This also reflects a drop. It is not clear why this has occurred. During this time period there were two Junior Doctor strikes (March 13th-15th) and April 11th – 15th). The strike action may have provided an alternative opportunity to exception reporting to raise concerns about hours and conditions of service. There may also be a creeping despondency about Exception Reporting that will need to be monitored and addressed. On the other hand a lot of work is being put in by directorates to improve staffing so this work may be reflected in this drop. Drs Louisa Morris and Mickaela Poree are currently starting part 2 of an audit cycle intended to address barriers for exception reporting. The start of this is very opportune. The results will be presented at the junior doctor committee and the board will be kept informed of progress

Over the next quarter more work needs to be done in monitoring this and address any issues that may be identified. The GOSW will work with the Junior Doctor Committee and other stake holder in addressing these. The committee will be pleased to note that through the JLNC a resolution has been found on the issue of unpaid weekend shifts because of rota anomalies. It is anticipated that the new allocate rota system will be functional from August 2023 (maybe in a phased approach and meaning that the new and the older systems could be running alongside simultaneously), the new system giving junior doctors bespoke and more accurate rotas that are reflective of their work schedules. There has also been another issue regarding some trainees not having the time for admin relating to educational portfolios. This has been resolved.

University Hospitals Dorset: Poole Hospital

High level data

Number of doctors / dentists in training (total): 204.4

Number of doctors / dentists in training on 2016 TCS (total): 204.4

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

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

Exception reports

Speciality	Exceptions raised 1st Jan – 31st Mar 2023	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
General Medicine	33	6	7	20	6
General Surgery	12	0	11	1	0
Haematology	1	0	0	1	0
Oncology	13	2	5	3	5
Geriatrics	49	6	19	25	5
Cardiology	2	0	2	0	0
Respiratory	9	2	0	9	0
Paediatrics	1	0	0	1	0
ENT	2	0	1	1	0
Neurology	8	5	0	8	0
Total	**130**	**21**	**45**	**69**	**16**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There were a total of 130 exception reports for the quarter 1st January 2023 to 31st March 2023, a decrease of 13 from the previous quarter. It is thought this is mostly due to the strike actions coupled with my comments in the Overview.

Of the 130 exceptions raised there were 4 patient safety concern from various grades working in General Surgery, Geriatrics and Haematology.

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

Reasons for Exceptions Raised

9 doctors have reported unable to access natural breaks (registrar and foundation)

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
113	3	3	1	10

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1	IMT2	IMT3/ST3	ST4+
52	41	4	13	9	0	4	7

(Source: Allocate)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Compensation and Work Schedule Review	Outcome Still Awaited
45	56	10	0	2	1	16

(Source: Allocate)

Fines

There were no fines this quarter.

Vacancies

Department	Number of vacancies
Anaesthetics	3.4
ED	0.6
Haematology	1
O&G	1
OMF	3
OPS	1
Oncology	0.6
Paediatrics	2.5
Respiratory	1.4
T&O	1

Locum Bookings via Bank

Locum bookings (Bank) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked

Emergency Medicine	624	312	5,946	2,992
Anaesthetics	2	2	16	111
ENT	69	44	721	397
General Surgery	61	30	603	357
Medicine	509	349	4,807	3,389
Obstetrics and Gynaecology	33	26	275	238
Oncology	56	46	399	323
Orthopaedic Surgery	650	610	5,860	5,016
Psychiatry	0	0	0	0
Paediatrics	55	32	538	261
TOTAL	**2,059**	**1,451**	**19,164**	**13,083**

(Source Temp Staffing Office)

Of note approximately 300 shifts were unfilled in Emergency Medicine and 140 shifts unfilled in General Medicine.

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	29	28	209	391
F2	16	9	75	283
ST/CMT1/2	1,533	1,087	14,340	9,987
ST3+	481	327	4,540	2,421
TOTAL	**2,059**	**1,451**	**19,164**	**13,083**

(Source Temp Staffing Office)

Of note approximately 500 shifts at IMT1-2/ST1 level were unfilled

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts worked**	**Number of hours Requested**	**Number of hours Worked**
7 day Pilot	3	1	28	12
Adhoc	238	238	1,869	1,869
Annual Leave	9	7	71	74
Coronavirus	17	7	147	92
Deanery Vacancy	185	103	1,772	1,075
Escalations	47	20	410	220
LTFT Cover	13	10	116	80

Maternity/Paternity Leave	0	0	0	0
Service Demand (e.g winter pressures)	142	77	1,540	848
Sickness	251	163	2,493	1,628
Study Leave	21	16	162	116
Trust vacancy	1,007	722	9,359	6,242
Urgent Clinical Need	124	85	1,187	815
Waiting List Initiative	2	2	12	12
TOTAL	**2,059**	**1,451**	**19,164**	**13,083**

(Source Temp Staffing Office)

Locum Bookings via Agency

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	1	0
Foundation Year 2	63	50
ST1/2 - CT1/2	0	0
ST3	103	67
ST4	71	71
ST5	**66**	65
TOTALS	**304**	**253**

(Source Temp Staffing Office)

University Hospitals Dorset: Royal Bournemouth Hospital

High level data

Number of doctors / dentists in training (total): 173

Number of doctors / dentists in training on 2016 TCS (total): 173

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

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

Exception reports

Speciality	Exceptions raised 1st Oct – 31st Dec 2022	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Acute	14	0	0	14	0
A&E	5	0	1	4	0
General Medicine	26	3	8	16	2
General Surgery	13	0	4	8	1
Geriatrics	16	0	3	8	5
Cardiology	14	3	1	12	1
Respiratory	4	0	0	4	0
Gastroenterology	21	0	3	17	1
Ophthalmology	10	0	3	7	0
Urology	2	0	1	1	0
Vascular	3	0	1	2	0
Total	**128**	**6**	**25**	**93**	**10**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There were a total of 128 exception reports for the quarter 1st January 2023 to 31st March 2023, a decrease of 129 from the previous quarter. This is likely due to recent strike action.

Of the 128 exceptions raised there was one patient safety concern from a foundation year 1 doctor working in OPS.

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

Reasons for Exceptions Raised

10 doctors have reported unable to access natural breaks and 9 not able to access education opportunities

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
98	9	6	5	10

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1	IMT2	IMT3/ST3	ST4+
64	35	9	4	2	5	0	9

(Source: Allocate)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Compensation and Work Schedule Review	Outcome Still Awaited
100	0	16	1	0	0	11

(Source: Allocate

Vacancies

Department	Number of vacancies
Acute	0.6
Anaesthetics	1.6
Cardiology	0.4
Dermatology	0.5
D&E	2.2
ED	1.2
Gastro	1.2
Histo	1
O&G	2.2
OPS	1.4
Oncology	2.2
Ophthalmology	2
Palliative	1.6
Psychiatry	0.5
Respiratory	1.3
Stroke	0.4
Surgery	3.4

Fines

There were no fines this quarter.

Locum Bookings Via Bank

Locum bookings (Bank) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Anaesthetics	12	11	150	151
Emergency Medicine	690	443	6,272	4,013
Surgery	224	136	2,262	1,850
Medicine	1,037	647	9,285	6,018
Oncology	12	9	100	76
Ophthalmic	14	14	321	321
Orthodontic	**0**	**0**	**0**	**0**
Orthopaedic	14	13	95	80
TOTAL	**2,061**	**1,320**	**18,854**	**12,799**

(Source Temp Staffing Office)

Of note approximately 3,000 hours were unfilled for Medicine and 2,000 hours unfilled for Emergency Medicine

Locum bookings (Bank) by Grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	6	6	56	538
F2	36	25	258	560
ST/CMT1/2	985	650	9,402	8,133
ST3+	978	594	8,792	3,303
TOTAL	**2,076**	**1,328**	**18,996**	**12,890**

(Source Temp Staffing Office)

Of note approximately: 300 hrs were unfilled at F2 level
1,200 hrs were unfilled at IMT/ST ½ level
5,500 hrs were unfilled at ST3+ level

Locum Bookings (Bank) by Reason				
Reason	Number of shifts Requested	Number of shifts worked	Number of hours Requested	Number of hours Worked
Ad-hoc	186	186	1,899	1,899
Annual Leave	15	13	117	89

Coronavirus	0	0	0	0
Escalations	36	30	208	162
Service Demand	370	181	3,047	1,507
Sickness	146	100	1,324	954
Deanery Vacancy	221	129	2,147	1,302
Study Leave	1	0	11	9
Urgent Clinical Needs	61	23	529	216
7-day Pilot	4	1	40	16
Trust vacancy	1,013	650	9,490	6,608
Leave - Emergency	1	1	4	4
LTFT Cover	2	2	25	25
WLI - Waiting List Initiative	6	5	33	29
TOTAL	**2,062**	**1,321**	**18,874**	**12,820**

(Source Temp Staffing Office)

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	128	116
Foundation Year 2	58	47
ST1/2 - CT1/2	0	0
Specialty Registrar	**21**	10
TOTALS	**207**	**173**

(Source Temp Staffing Office)

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 9.1.1

Subject:	Key Issues and Assurance Report - Finance and Performance Committee Meeting held on: 17 April 2023
Presented by:	Philip Green, Chair of the Finance and Performance Committee

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

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

Items rated Green		
Item	**Rationale for rating**	**Actions/outcome**
Operational Performance: new risks/increased risk	The Committee received an assurance report which included: • That there were no new Operations & Performance Group risks added and no risks increased since the previous report. Two risks had decreased and a number of risks had been closed. • The delivery of reduction in referral to treatment waiters exceeded the planned trajectory.	The Committee noted the Operational Performance report.
2022/23 Financial Performance Month 12	The Committee received a report on the Trust's financial performance for the year ending 31 March 2023. The Trust had delivered a surplus of £188,000 against the breakeven control total.	

Sustainability Update	The Committee received an assurance report which included updates in relation to an internal audit report on the Trust's sustainability programme, climate adaptation and various cornerstone targets.	The Committee noted the Sustainability Update.

Items rated Amber		
Item	**Rationale for rating**	**Actions/outcome**
Operational Performance	The Committee received an assurance report which included: • An alert in relation to medically ready to leave patients. The reduction delivered not at a level to achieve reduction in funded bed occupancy. • Time lost to ambulance handover delays and handovers > 60 minutes. There had been improvement since February 2023, but this remained above trajectory. • February 2023's validated cancer waiting times performance showed a reduction against the 62-day standard. • February 2023's validated cancer waiting times performance showed significant improved delivery in relation to the Faster Diagnostic Standard. • An update in relation to the 2023/24 planning requirement on organization 4-hour safety standard. • The fractured neck of femur pathway had shown an improved position in March 2023.	Key actions being taken were reported to the Committee. The Committee noted the Operational Performance report.
Private Patients Strategy	The Committee received a report in relation to the Trust's private patients' strategy.	The Committee would receive the proposed Trust's private patients' strategy by its July 2023 meeting.

Productivity and Efficiency Report – Month 12 including Cost Improvement Programme	The Committee received a report in relation to the Trust's cost improvement programme, including the in-year shortfall. The recurrent shortfall placed a significant pressure on the financial position for 2023/24.	The Committee noted the Productivity and Efficiency Report – Month 12.
Estates Improvement	The Committee received an assurance report which included: • Updates in relation to the estates backlog of works, reactive works key performance indicators, workforce matters and significant estates issues that had occurred in the previous quarter. • Progress update on compliance matters.	Key actions being taken were reported to the Committee, including by reference to the Trust's capital plan. The Committee noted the Estates Improvement report.
Sustainability Update	The Committee received an assurance report which included: alerts in relation to the Cornerstone Target – Decarbonisation: Estate-Wide Decarbonisation Plan and Funding; and the Cornerstone Target – Clean Air Framework.	The Committee noted the Sustainability Update.
SIRO Information Governance Report	The Committee received an assurance report which included: • Details of a reprimand issued by the Information Commissioner's Office. • An update in relation to the Data Security and Protection Toolkit.	Remedial action taken in relation to the Information Commissioner's Office reprimand was presented to the Committee. Areas requiring additional focus in relation to the Data Security and Protection Toolkit were reported to the Committee. The Committee noted the SIRO Information Governance Report.
Digital Strategy Update	The Committee received an update on the Digital Transformation Strategy.	The Committee noted the Digital Transformation Strategy which would be updated and presented by the December 2023

		meeting of the Committee.

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

Items not rated		
Item	**Comments**	**Actions/outcome**
Annual Operational Budget 2023/24 (update)	The Committee received an updated Operational Budget 2023/24, which it was asked to recommend for approval to the Board of Directors.	The Committee endorsed the Operational Budget 2023/24, which would be presented to the Board for approval.
Consultancy Commitments	The Committee was informed that there were no consultancy commitments to report.	The Committee noted the update in relation to consultancy commitments.
Contract Decision Timetable	The Committee received the contract decision timetable report.	The Committee noted the contract decision timetable report.
The Committee considered items that were presented to it for information. It also received recommendations for approval/endorsement and certain contract/business case updates.		

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 9.1.2

Subject:	Key Issues and Assurance Report - Finance and Performance Committee Meeting held on: 15 May 2023
Presented by:	Philip Green, Chair of the Finance and Performance Committee

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

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

Items rated Green		
Item	**Rationale for rating**	**Actions/outcome**
Operational Performance: new risks/increased risk	The Committee received an assurance report which included: • That there were two new Operations & Performance Group risks added since the previous report. Taking into account the controls in place, the Committee considered that it had received substantial assurance. • No risks had increased since the previous report. One risk had decreased and another had been closed.	The Committee noted the Operational Performance report.
Operational Performance	The Committee received an assurance report which included: • An alert in relation to the 2023/24 planning requirement against the organization 4-hour safety standard.	Key actions being taken were reported to the Committee. The Committee noted the Operational Performance report.

	• An alert in relation to the four-day industrial action by junior doctors in April 2023 which had resulted in a high number of cancellations across inpatients, day cases and outpatient appointments. This impacted on cancer and referral to treatment performance. (One of the new risks presented to the Committee was linked to industrial action). • The Committee was advised of key mitigations in relation to medically ready to leave patients, with the reduction delivered not being at a level to achieve reduction in funded bed occupancy. • The Committee was advised that timely fractured neck of femur pathway performance had reduced in April 2023 compared to March 2023. Key mitigants were presented. • It was reported to the Committee that March 2023's validated cancer waiting times performance confirmed achievement of the Faster Diagnostic Standard and an increase in performance against the 62-day standard. • It was reported to the Committee that time lost to ambulance handover delays and handovers > 60 minutes showed an improvement since March 2023.	
2023/24 Financial Performance Month 1	The Committee received a report on the Trust's month 1 financial performance for the year 2023-24. The Trust had reported a deficit of £2.3m against a planned deficit of £1.4m. This was driven by energy cost inflation above the national planning assumptions, the net cost of the junior doctors' strike together with premium cost pay overspends in the care groups; part of these had been offset.	The Committee noted the 2023/24 Financial Performance Month 1 report.

	Cost improvement programme savings of £1.3m had been achieved during April 2023 against an equivalent target. The full year savings requirement was £33.3m, representing a significant challenge. Mitigating the shortfall of current savings plans continued to be a key financial focus for the Trust. Other areas covered by the report presented to the Committee included in relation to the Trust's capital position and cash balances. The opening of the Financial Control Total 2023-2024 risk (Risk ID 1881) was noted by the Committee.	
Capital Programme Report (Q4)	The Committee received an assurance report in relation to the capital programme for Q4 2022-23. There were no concerns raised to the Committee on the 2022-2023 spend.	The Committee noted the Capital Programme Report (Q4).

Items rated Amber		
Item	**Rationale for rating**	**Actions/outcome**
Operational Revenue Budget Risks and Mitigations	The Committee received an assurance report in relation to the Trust's operational revenue budget.	Key actions to be taken were reported to the Committee. The Committee noted the Operational Revenue Budget Risks and Mitigations report.
Productivity and Efficiency Report – Month 1	The Committee received a report in relation to the Trust's cost improvement programme, including the in-year shortfall.	Key actions to be taken were reported to the Committee. The Committee noted the Productivity and Efficiency Report – Month 1.
Estates Improvement	The Committee received an assurance report which included: • Updates in relation to staff resourcing, fire safety and the call bell system in Poole hospital. • A summary of unplanned estates issues that had occurred. • Update on compliance matters.	The Committee noted the Estates Improvement report.
Transformation Update	The Committee received an assurance report including in relation to the New Hospitals Programme, delays in approvals	The Committee noted the Transformation Update.

	and the impact of these. It was reported to the Committee that a plan was in place to address each of the areas where there were off-track deliverables.	

Items rated Red		
Item	**Rationale for rating**	**Actions/outcome**
Risk Registers	It was noted that enhancements were needed to the risk registers provide clearer information of the controls and mitigants in place for each risk.	Enhancements were being made to the risk registers to provide clearer information of the controls and mitigants in place for each risk.

Items not rated		
Item	**Comments**	**Actions/outcome**
Update from the Dorset Integrated Care System	The Committee received an update from the Dorset Integrated Care Board Director of Finance. This included a focus upon workforce, productivity and efficiency from a financial perspective as well as the underlying Dorset system position.	The Committee noted the update from the Dorset Integrated Care System.
Draft Annual Accounts	The Committee was presented with the Trust's draft annual accounts for 2022/23 for information.	The Committee noted the draft annual accounts.
Contract Decision Timetable	The Committee received the contract decision timetable report.	The Committee noted the contract decision timetable report.
The Committee received recommendations for approval/endorsement and certain contract/business case updates.		

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION FINANCE AND PEFORMANCE COMMITTEE

Meeting Date: April 2023

INFORMATION GOVERNANCE (IG) REPORT – QUARTER 4

1. Overview

The aim of imbedding good Information Governance practice throughout the Trust is to provide assurance to patients and to the Board that information is managed in a legally compliant fashion. This remains a priority for the Trust for 2023/24.

The events of the last two years – specifically the COVID-19 pandemic recovery, the prevalence of OPEL 4 status, and the creation of University Hospitals Dorset – continue to affect the ability of the Information Governance department to provide the assurance required at both a local and national level, as work continues to support healthcare services to be compliant and safe by keeping information confidential and secure.

Regrettably within this paper we report a reprimand from the Information Commissioner's Office which is the first such event for UHD.

2. Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSP Toolkit) is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital annually. The purpose of the DSP Toolkit is to assure an organisation's IG practices through the provision of evidence around 10 Data Security Standards, each of which has numerous mandatory individual requirements, known as "assertions". This is the most significant single piece of work regularly undertaken by the Information Governance department. As well as submission to NHS Digital, compliance also forms an aspect of the contract with commissioners.

The 2022/23 DSP Toolkit assessment submission deadline is 30 June 2023, for which there are 112 mandatory assertions (some with multiple elements) against which assurance must be provided, and an action plan to assure against these is being documented. A review of requirements has been carried out to note those where the assurance required has been updated for this year, and to mark as complete those which are already satisfied. Each requirement has been designated an owner who is responsible for ensuring its completion.

The chart below shows the current position. Blue segments indicate where work is In Progress (63 tasks in total), green segments indicate Complete requirements (57 tasks in total), and grey segments indicate areas where work has yet to begin (14 tasks in total). Of these, the amount of work varies significantly and not all require equal effort. Equally there are some requirements which cannot be completed until nearer the end of the year, such as where a total number of events for the period is required to be entered. A number of these are directly reliant on Information Asset Assurance (section 3) work being completed. BDO are currently undertaking an internal audit into the self-

assessment of 49 of the 112 assertions.

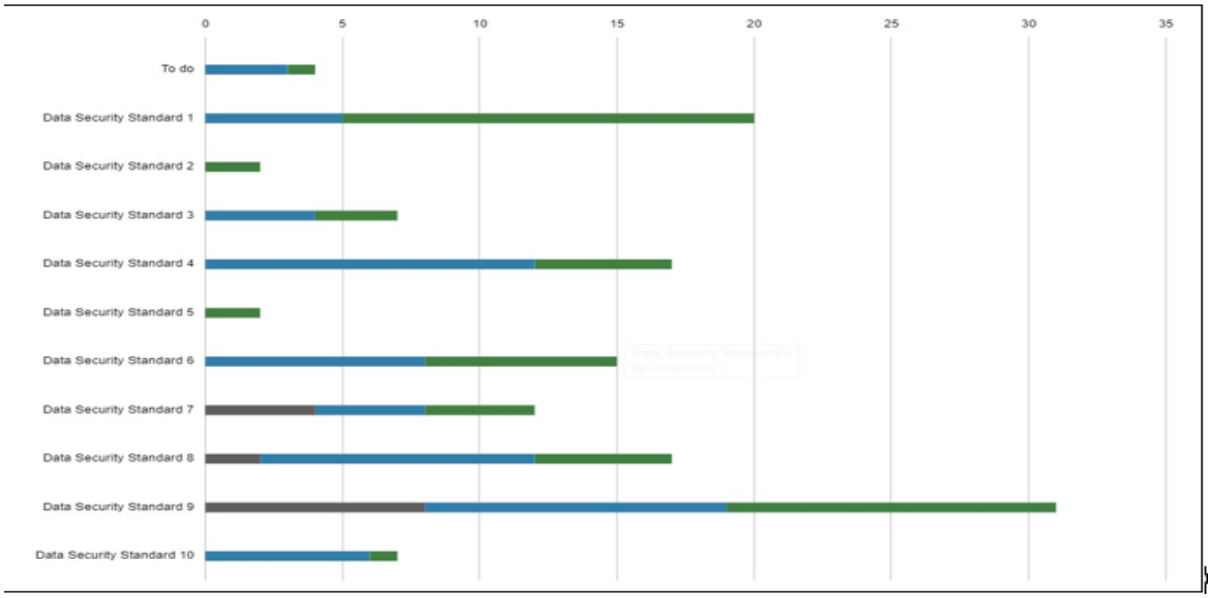


Figure 1: Overall progress against the DSPT requirements

3. Information Asset Assurance

The Trust is obliged to maintain a record of its key systems and data held within these systems. This forms part of the DSP Toolkit submission and is also required as a provision of Data Protection legislation, under which the Trust must maintain a "Record of Processing Activities". The means that the Trust uses for this is its Information Asset Register (IAR). Compliance levels are shown in the figure below, indicating at 15% there is a significant amount of work to undertake within the next 3 months:

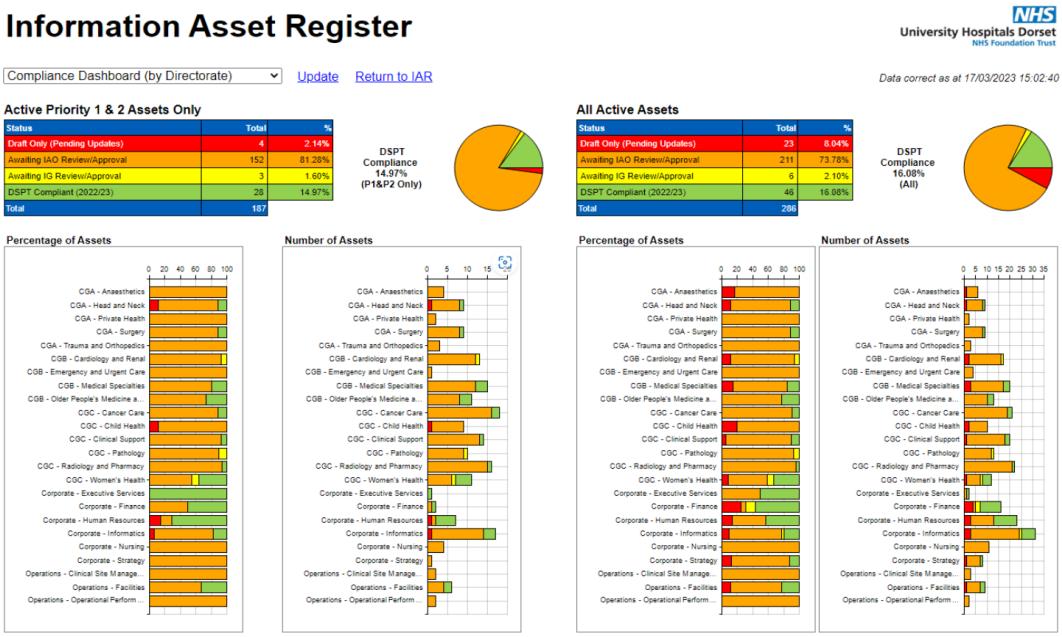


Figure 2: Information Asset compliance (at 17 Mar 2023)

4. Freedom of Information

In spite of the well-documented pressures that the NHS has been under in the last two years, the number of FOI requests received overall remains steady.

The Information Commissioner's Office require that compliance with the 20-working day deadline to respond to FOI requests be 90% or greater; the figures below show that UHD is distanced from this target, but with compliance remaining relatively high.

FOI compliance will continue to be monitored through the Information Governance Steering Group, reporting to the TMG. Compliance is also included in the monthly Informatics submission to the Integrated Performance Report, and performance is actively monitored within directorates which received a significant portion of the requests.

Count of Compliance	Breach		Breach Total	In Time	In Time Total	Cancelled	Grand Total	Compliance %
Row Labels	Completed	Underway		Completed				
October	9	0	9	41	41	1	51	82%
November	12	1	13	43	43	0	56	77%
December	14	1	15	28	28	2	45	67%
January	7	5	12	43	43	4	59	80%

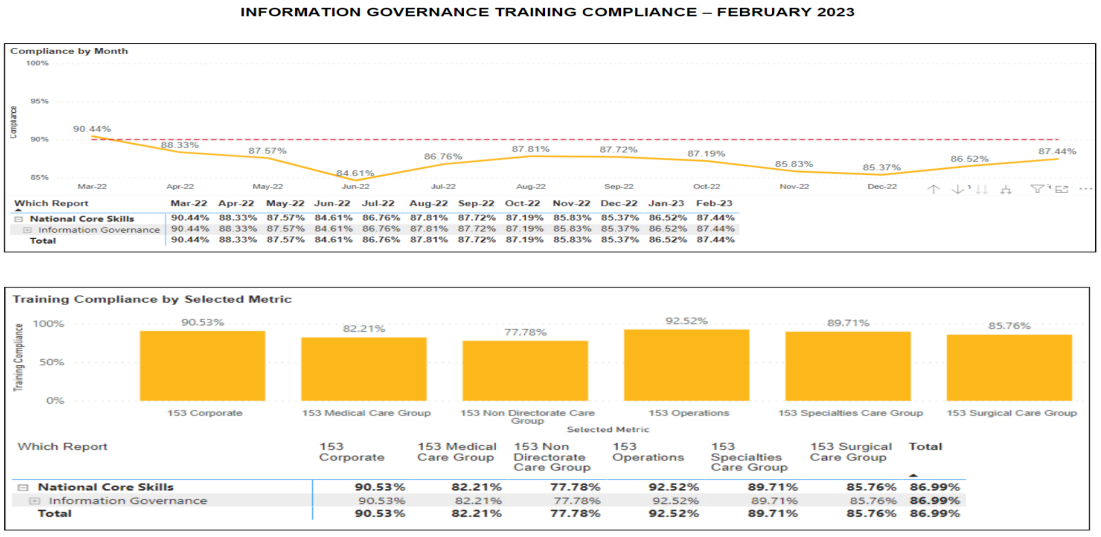
Figure 3: FOI compliance to Jan 2023

5. IG Training

Information Governance training compliance has remained relatively consistent during last year, which is positive given that it is the only annually updated competency on the BEAT VLE. However, the DSP Toolkit explicitly states the target required:

> *Have at least 95% of all staff, completed their annual Data Security awareness training in the period 1 July to 30 June?*

In support of the standard reminders, a concerted campaign of chasing individuals staff members who remained non-compliant via weekly emails to GDOs was implemented as part of the DSP Toolkit action plan. As at end February 2023, the Trust's combined compliance over the last 12-month period was 87.4%; the chart provided below provides the position split by care Group.



Which Report	153 Corporate	153 Medical Care Group	153 Non Directorate Care Group	153 Operations	153 Specialties Care Group	153 Surgical Care Group	Total
National Core Skills	90.53%	82.21%	77.78%	92.52%	89.71%	85.76%	86.99%
Information Governance	90.53%	82.21%	77.78%	92.52%	89.71%	85.76%	86.99%
Total	90.53%	82.21%	77.78%	92.52%	89.71%	85.76%	86.99%

Figure 4: IG training compliance at end Feb 2023

6. Incidents

The Trust uses a comprehensive approach to IG incident reporting, meaning that incidents are captured which may have an IG element to them, but which may not be considered exclusively IG incidents.

With the additional resource available as a result of scaling back the intensive 1-1 support given to IAOs, more work is underway to review IG incidents and map trends to identify any recurrent issues and training needs. The incidents are also scrutinised on a monthly basis by the IG Steering Group.

During March we were notified that the ICO has issued a reprimand to UHD relating to incident that took place in Sep 2022: a letter was sent to the mother of a child patient including the address of the child's father. The parents are separated and the father has actively not disclosed his new address to the child's mother owing to allegations of criminal damage, accusations and emotional abuse. The full details are attached as an appendix. This incident has been subject to a Serious Incident Panel and an action plan is in progress within the Child Health directorate.

7. Conclusion

Progress is being made to embed changes to legislation and assurance mechanisms required across the new organisation; however, there is still a lot of work to do.

It must be recognised that the assurance work undertaken through the DSP Toolkit is ongoing and requires continual update and maintenance to ensure that compliance with the relevant legislation and national standards can be sustained. While the initial drive to begin to imbed this initiative is perhaps the most difficult, it is essential that this momentum is sustained to avoid a retrograde slump, negating any achievements realised. Support is required from the organisation as a whole to ensure that this work is given the necessary priority on an ongoing basis.

Camilla Axtell Information Governance Manager and Data Protection Officer March 2023

Appendix 1: ICO reprimand

DATA PROTECTION ACT 2018 AND UK GENERAL DATA PROTECTION REGULATION

NOTICE OF INTENT TO ISSUE A REPRIMAND

The Information Commissioner (the Commissioner) intends to issue a reprimand to University Hospitals Dorset NHS Foundation Trust (the
Trust) in accordance with Article 58(2)(b) of the UK General Data Protection Regulation in respect of certain alleged infringements of the UK GDPR.

The proposed reprimand

The Commissioner has provisionally decided to issue a reprimand to the Trust in respect of the following alleged infringements of the UK GDPR:

- Article 5(1)(f) of the UK GDPR which states: "appropriate technical and organisational measures to be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data."

The reasons for the Commissioner's provisional findings are set out below.

The Trust had a procedure in place that when issuing correspondence by letter would include the full postal address of other recipients of that letter without obtaining their consent to do so. This was done by way of cc at the bottom of the letter. Appropriate consideration had not been paid to the risk of this standard practice in relation to data protection and the potential impact that a disclosure could have on a data subject.

In this case, an address was disclosed to an ex-partner of the data subject, something they particularly wished to be withheld following previous allegations of abuse. The data subject had not advised the Trust that his address should not be disclosed to his ex-partner. However, it is considered that it would not be in his reasonable expectation that personal information would be disclosed without permission being sought. While the data subject has made no further complaint to the Trust, there is now a risk of unwanted contact which will remain.

In addition, the Trust did not have a clear process in place for managing such situations where there are parental disputes. It was noted that the Trust admitted that it did not have any formal system to flag patients for this kind of scenario, to ensure that personal data is not shared and remains restricted. It was also noted that there was no formal training provided to the administration staff involved for dealing with correspondence in these circumstances.

However, the primary concern was that the Trust had a process in place, which posed significant risk due to proactive disclosure of the data subject's personal data. It is the fact that this risk was not considered or identified, and that a formal process to obtain consent was not in place, that it is considered that this matter warrants a reprimand.

Mitigating factors

We have noted that the Trust stated that prior to the incident there had been no instance where one parent had objected to their details being shared with the other, in the way this situation occurred.

It is also noted that no formal complaint was made by the data subject at the time. There has been no evidence seen that a formal complaint been made since, or that any request has been made to escalate the issue to a formal complaint.

It is also recognised that the Trust's intent by this practice was to prevent any errors when manually writing addresses on envelopes when posting to the third parties concerned.

Remedial steps taken by the Trust

The Commissioner has also considered and welcomes the remedial steps taken by the Trust in the light of this incident.

In particular, that in the immediate aftermath of the incident, an apology was issued to the data subject, in person from a doctor and from the Directorate Manager. The Trust also began a thorough investigation into the matter and an action plan implemented to ensure that remedial measures were completed.

It has been noted that the Trust has undertaken a benchmarking exercise with other organisations in order to set a clear policy position for the Child Health directorate for handling situations where there may be parental disputes. This benchmarking exercise should help the Trust in establishing good practices going forward.

The Commissioner welcomes the efforts made by the Trust to implement practices where similar situations can be more immediately recognised. Such as the procedure proposed by the Trust where, when requested by a parent, a clinician dictating a letter would note that a duplicate letter should be blind copied to the other parent.

These remedial measures, when fully implemented by the Trust should ensure that a similar incident is much less likely to occur in the future.

Provisional decision to issue reprimand

Taking into account all the circumstances of this case, including the mitigating factors and remedial steps, the Commissioner has provisionally decided to issue a reprimand to the Trust in relation to the alleged infringements of Article 5(1)(f) of the UK GDPR set out above.

Further Action Recommended

The Commissioner recommends that the Trust should take certain steps to ensure its compliance with UK GDPR. With particular reference to Article 5(1)(f) of the UK GDPR, the following steps are recommended:

1. It is recommended that the Trust complete a review of its practices, incorporating any relevant learnings from the benchmarking exercise to identify any further areas of risk.

2. The Trust should also ensure that areas identified by the action plan are fully implemented and subject to regular review.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 9.2.1

Subject:	Key Issues and Assurance Report - Quality Committee Meeting held on: 18 April 2023
Presented by:	Cliff Shearman, Chair of the Quality Committee

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

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

Items rated Green		
Item	**Rationale for rating**	**Actions/outcome**
Actions: APGAR score of less than seven in five minutes	The Director of Midwifery provided an update on the review undertaken. This followed on from a previous action at the Committee; for those cases that had been re-scored, a comparison was to be made to identify whether this brought the Trust's scoring in line with the national median. The data for January, February and March 2023 had been reviewed and were within the national criteria. For April 2023, the data was slightly above.	Ongoing monitoring would continue.
Care Group reporting: Specialties Care Group	The Care Group reported no areas needing to be "alerted" to the Committee. The Committee received reporting in relation to moderate patient safety incidents. In addition, the Committee was "advised" of infection control	The Committee noted the Specialties Care Group report.

	compliance, complaints and early resolutions in March 2023.	
Care Group reporting: Medical Care Group	The Care Group reported upon use of departure lounges by patients awaiting their onward discharge.	The Committee noted the Medical Care Group report.
Care Group reporting: Surgical Care Group	The Care Group reported no harm having been reported in March 2023 relating to fractured neck of femur. 67% of patients had been to theatre within 36 hours of being fit. A decrease in the number of pressure ulcers, falls and complaints was reported. Improvements across the Surgical Care Group had been supported through the implementation of the fifteen steps challenge observation guide.	The Committee noted the Surgical Care Group report.
National Standards for Healthcare Food and Drink	The Committee received an update on the National Standards for Healthcare Food and Drink, with the Trust being compliant against eight key requirements.	The Committee noted the update on National Standards for Healthcare Food and Drink.

Items rated Amber		
Item	**Rationale for rating**	**Actions/outcome**
CQC Update	The Committee received an update following CQC inspection reports for maternity, surgery and medical care (including older people's services). This included assurance provided to the Committee that the risk register had been reviewed, with further actions in progress, to ensure that all issues raised in the CQC reports were documented. For those findings that had associated risks on the register, it was confirmed that learning would be reviewed including, for example, relating to the appropriate associated controls being in place and timely completion of actions.	Overarching progress with CQC action plans would be monitored and reported at Trust Management Group, with oversight of the process being presented at the Committee. The Committee would receive an update on the full CQC action plans at its next meeting. Learning would be identified for those findings that had associated risks on the Trust's risk register. A deep dive would be carried out into each area to assess whether any new risks were required. In relation to fridge monitoring, an assurance audit had been planned for May 2023.

		The CQC Update was noted by the Committee.
Emergency Department Deep Dive	The Committee received an assurance report in relation to the management and audit of quality within the emergency departments and urgent treatment centres at Poole and Bournemouth hospitals. Particular areas highlighted to the Committee included: • The "Saving Lives Audit" and reporting process; • Patient Safety Checklist (SHINE) compliance (a continuous check of care delivery in the emergency department that is used in many trusts nationally in place of written care plans/reports); and • Audit checks on resus (emergency) trolleys.	The Committee received an overview of the action plans in place, with comment made on areas of prompt remediation being required. The Committee noted the Emergency Department Deep Dive.
Maternity Report	The Director of Midwifery presented the Maternity Report highlighting areas from the dashboard "red areas" and explaining the rationale for these not being of considerable concern, particularly in relation to obstetric haemorrhage >1.5L, term admissions to NICU and APGAR scores. Mandatory training continued to remain a concern.	The Committee noted the Maternity Report.
Care Group reporting: Medical Care Group	The Care Group reported: • An out of date medications review had been undertaken. The actions taken were noted. The Committee was alerted to the review undertaken; however, further details were required on actions being taken going forward. • Peer reviews having been undertaken in paper form, with some data not uploaded to the relevant system. The Committee was informed of the status of plans going forward.	The Committee noted the Medical Care Group report.

	• Ligature risk assessments were being carried out.	
Care Group reporting: Surgical Care Group	The Care Group provided an update that: • Staffing levels remained a challenge in theatres, trauma and ward 2; • Consent, mental capacity and Deprivation of Liberty Safeguards would be an area of focus; • Cancellation of elective activity was continuing due to bed pressures and a large number of medically ready for discharge patients across the organisation.	The Committee noted the Surgical Care Group report.

Items rated Red		
Item	**Rationale for rating**	**Actions/outcome**
Risk Register	Two new risks rated 12+ were presented for consideration: • Impact of industrial action on the provision of services (proposed grading of 12) (Risk ID1863); and • Patient Flow: Risk to patient safety, statutory/performance compliance and reputation – downstream capacity/front door crowding. This risk would replace two existing risks (proposed grading of 20) (Risk ID1872). A risk related to Covid had been closed. Further information in relation to controls/mitigants when risks were being presented to the Committee was requested.	The Committee approved the two new risks.
VTE Report	The Committee was presented with the VTE Report. Concern was expressed about there being insufficient assurance on the number of patients who were being assessed. It was noted that improvements were needed in capturing the risk assessment data for the Poole hospital site.	The Chief Medical Officer would review the data presented to the Committee to provide greater assurance.

Items not rated		
Item	**Comments**	**Actions/outcome**
Action: Integrated Performance Report – rationale for selection of confidence intervals	Following an action from the last meeting of the Committee, it was confirmed that the confidence intervals had been selected using statistical derivation.	Enhancements would be made to the reporting to the Committee going forward.
Integrated Performance Report	It was noted that although the standardised mortality ratio had risen slightly over the previous months, this remained within two standard deviations and the Trust was not an outlier when compared nationally.	The Committee noted the Integrated Performance Report.
Committee Governance Cycle	It was reported that work was ongoing to map the Committee's updated terms of reference to produce a revised governance cycle.	The Committee approved the continuation of its existing governance cycle pending completion of the revised governance cycle.
Amendment to Quality Committee Terms of Reference	An increase to four of the number of Non-Executive members of the Committee was proposed.	The Committee endorsed the amendment to its Terms of Reference.
LERN Report	The LERN report was presented to the Committee.	The Committee noted the LERN report.
Exception Reports from Sub-Groups	The Committee received exception reports from the Medicines Governance Group and Clinical Governance Group.	The Committee noted the exception reports.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 9.2.2

Subject:	Key Issues and Assurance Report - Quality Committee Meeting held on: 16 May 2023
Presented by:	Cliff Shearman, Chair of the Quality Committee

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

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

Items rated Green		
Item	**Rationale for rating**	**Actions/outcome**
Integrated Performance Report – Quality View	The Committee received the Integrated Performance Report – Quality View. The full Integrated Performance Report document would be presented to the meeting of the Board of Directors on 24 May 2023.	The Committee noted the Integrated Performance Report.
Care Group reporting: Specialties Care Group	The Care Group reported positive progress over several months in relation to infection control within outpatients. Recommendations from learning of investigations completed in April 2023 were also reported.	The Committee noted the Specialties Care Group Report.
Care Group reporting: Medical Care Group	The Care Group reported that work had been completed on the works to provide a ligature light environment for mental health patients at the Poole hospital emergency department. Further works would be undertaken to provide the same	The Committee noted the Medical Care Group Report.

	environment at the Bournemouth site.	
Risk Register	Four new risks rated 12+ were presented for consideration. One of these (Risk ID 1881) related to the Financial Control Total 2023/23, with Risk ID 1739 Financial Control Total 2022/23 having been considered at the Finance and Performance Committee and closed. In addition, the following risks: • Increased waiting list for SACT treatment/capacity on day units (Risk ID 1697); • Staff vacancies and skill mix deficit – Theatres (Risk ID 1811); and • Older People's Services outlying patients (Risk ID 1840) were considered by the Committee, including the controls/mitigants and summary of action plans presented. The Committee also noted two risks that had a proposed change to their risk rating but remained 12+.	The Committee endorsed the new risks being included on the Trust's Risk Register, which would be recommended to the Board for approval.
CQC Update – Fractured Neck of Femur	The Committee was reminded of several improvements having been made to date. An embedded process was in place to oversee each patient waiting for surgery as well as oversight at a specialty level with input by ortho-geriatricians to manage and mitigate risk for each period. Data was presented for March 2023 in relation to those patients achieving surgery within 36 hours of admission and those within 36 hours of being fit.	The Committee noted the CQC Update.

Items rated Amber		
Item	**Rationale for rating**	**Actions/outcome**
CQC Update - inspections and monitoring of action plans	It was reported that Care Group leads had reported progress as at 28 April 2023 with no concerns escalated and all actions on target to achieve the required deadlines. An assurance report would be provided to the Committee in June	The Committee noted the CQC Update.

	2023 (this being the reason for the amber rating within this report).	
Maternity Report	The Committee received a report to provide assurance of maternity quality and safety and effectiveness of patient care. This included (among other areas) activity levels, incidents and external investigations, training compliance, friends and family test results, updates to the risk register and infection prevention and control practice. In relation to the APGAR score of less than seven in five minutes, it would be necessary for further trending to be monitored. As part of the CQC Update provided to the Committee, it was reported to the Committee that staffing had strengthened for triage services. There had been investment in additional obstetric staffing and recruitment was underway.	The Committee noted the Maternity Report.
Care Group reporting: Medical Care Group	The Care Group reported: • A potential increase in needlestick injuries. Analysis had been undertaken of the highest reason for this. It was reported that the Care Group would seek to improve staff education. • Following on from the last meeting of the Committee, the Care Group provided an update on peer review compliance. • An overview of the emergency department peer review quality audit by CQC domain. The data provided delineated between the Bournemouth and Poole sites. • A routine inspection by the CQC of the mobile endoscopy unit (not UHD) had taken place, with the final report awaited.	The Committee noted the Medical Care Group Report.

Care Group reporting: Surgical Care Group	The Care Group reported on learning from incidents and associated actions being taken. There was discussion regarding consistency of documentation of assessments and the process for this. Work is underway reviewing the eNA platform to streamline this.	The Committee noted the Surgical Care Group Report.
Care Group reporting: Specialties Care Group	The Care Group reported, in relation to infection control audit, that overall only one element had decreased in compliance, PVC, due to the documentation related to the care rather than the peripheral line care itself.	The Committee noted the Specialties Care Group Report.
Claims and Litigation Report	The Committee was presented with the Claims and Litigation Report, including learning identified within it. Reference was made to the *Learning from Litigation Claims GIRFT and NHS Resolution guide* and the significance of early clinical engagement. The Committee discussed the potential risks associated with having a hybrid of paper and electronic documentation, this being an area of key learning and themes. It was planned to migrate to paperless.	The Committee noted the Claims and Litigation Report.
LERN Report	The LERN report was presented to the Committee. A recommendation was presented for the establishment of a task and finish group in relation to diagnostics/delayed results.	The Committee noted the LERN Report.

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

Items not rated		
Item	**Comments**	**Actions/outcome**
Board Assurance Framework 2022/23	The Committee received the Board Assurance Framework document for 2022/23, which would be reviewed at the meeting of the Audit	The Committee noted the Board Assurance Framework 2022/23.

	Committee taking place on 18 May 2023 and at the meeting of the Board of Directors on 24 May 2023.	
Annual Review of Committee Effectiveness	The Committee was presented with an overview of survey responses from Committee members and attendees about the Committee's effectiveness.	The Committee noted the Annual Review of Committee Effectiveness survey responses.
Claims Policy	The Committee was presented with the Claims Management Policy.	The Committee approved the Claims Policy, subject to an amendment being made in relation to early clinician involvement.
Committee Annual Report to Board	The Committee received the draft review of its compliance with its own terms of reference.	The Committee approved the Committee Annual Report to Board.
Health and Safety Group Report	The Committee received an exception report from the Health and Safety Group, with certain issues within it also discussed in the context of other reporting to the meeting.	The Committee noted the Health and Safety Group Report.

Gender Pay Gap Report 2023

1. Background

1.1 It became mandatory from 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The results must be published on a government website, as well as the employer's own website (and remain there for 3 years).

1.2 Gender pay reporting presents data on the difference between men and women's average pay within an organisation. It is important to highlight the distinction between this and equal pay reporting, which is instead concerned with men and women earning equal pay for the same (or equivalent) work. Across the country, average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. Whilst a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower. The Regulations have been brought in to highlight this imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it. (NHS Employers. *Briefing Note: Gender Pay Gap Reporting retrieved* 2021-06)

1.3 University Hospitals Dorset NHS Trust published reports in March 2021 and March 2023. This data was taken from a snapshot date of 31 March 2022.

1.4 The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows Trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. The Gender Pay Gap Six Indicators

2.1 An employer must publish six calculations showing their:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

Under national guidance, medical staff clinical excellence awards are included within bonus pay.

3. Methodology

3.1 The statutory calculations have been undertaken at the snapshot date of 31 March 2022, using the national Electronic Staff Record (ESR) Business Intelligence standard report. In line with NHS Employers guidance Clinical Excellence Awards and the approach taken to award them at UHD have been categorised as bonuses.

3.2 Pay includes: basic pay, full paid leave including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances and shift premium pay. (**Note: bonus pay is included, but only as a separate metric as one of the 6 key indicators we need to produce. The gender pay gap figure is calculated from hourly pay – which can only be ordinary pay, bonus pay is not hourly).**

3.3 Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child care vouchers), redundancy pay and tax credits.

4. UHD Workforce Context

4.1 The gender split within the overall workforce is 75.5% female and 24.5% male. The breakdown of the proportion of females and males in each banding is as set out below:

Pay Band	Female headcount	Male headcount	Total headcount	Female	Male
Band 1	22	29	51	43.1%	56.9%
Band 2	1312	447	1759	74.6%	25.4%
Band 3	943	204	1147	82.2%	17.8%
Band 4	579	104	683	84.8%	15.2%
Band 5	1330	297	1627	81.7%	18.3%
Band 6	1255	232	1487	84.4%	15.6%
Band 7	741	161	902	82.2%	17.8%
Band 8a	158	83	241	65.6%	34.4%
Band 8b	79	39	118	66.9%	33.1%
Band 8c	17	12	29	58.6%	41.4%
Band 8d	12	10	22	54.5%	45.5%
VSM	11	18	29	37.9%	62.1%
Medical & Dental	557	633	1190	46.8%	53.2%
Other	2	4	6	33.3%	66.7%
Grand Total	**7018**	**2273**	**9291**	**75.5%**	**24.5%**

5. Results for UHD - 31 March 2022 snapshot

5.1 Gender Pay Gap Results

- Our headcount has decreased by 82 to 9291 since last year with 149 less female and 67 more males across UHD (31st March 2021 vs. 31st March 2022).

- This year our Gender Pay Gap is 5.33%.

- This is an improvement on last year's reported figure of 6.62% and continues the positive trend following the organisational merger in 2020.

- There is an increase in representation at senior Manager level (8b, 8c and VSM) of female staff. This is a positive move towards equitable representation with our workforce demographics.

Mean and Median Pay Gap

- The gender pay gap for the Trust overall, is 5.33%. This has slightly decreased from 6.62% reported last year.
- The **mean gender pay gap** for the Trust overall is 20.95%. This has decreased by 0.86% from 21.81% reported last time.
- If the Medical and Dental workforce are excluded from the calculation, the Trust's mean gender hourly pay gap would be 0.41%, compared to 20.95%. The Trust's median gender pay gap would be 8.96% in favour of female staff.

a) Average gender pay gap as a <u>mean</u> average

Overall

	Male	Female	% difference
Mean hourly rate	£22.20	£17.55	20.93%

Agenda for Change

	Male (AFC)	Female (AFC)	% difference
Mean hourly rate	£16.14	£16.20	0.41%

Medical

	Male (medical)	Female (medical)	% difference
Mean hourly rate	£38.56	£34.13	11.49%

b) Average gender pay gap as a <u>median</u> average

Overall

	Male	Female	% difference
Median hourly rate	£16.95	£16.07	5.19%

(Note small variation from published overall GPG figure, due to recalculating with the staff group breakdown)

Agenda for Change

	Male (AFC)	Female (AFC)	% difference
Median hourly rate	£13.80	£15.16	8.96%

Medical

	Male (medical)	Female (medical)	% difference
Median hourly rate	£37.93	£28.62	24.54%

5.2 Clinical Excellence Awards Bonus Payments

5.2.1 Local Clinical Excellence Award's (LCEA) recognise and reward NHS consultants in England, who perform over and above the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions.

5.2.2 Overall, there is a large differential between the amount of CEA bonus pay for medical staff with 20.06% of male medics receiving CEA pay in comparison to 10.14% of female medics. The average annual CEA pay being just over £11,679 for male medics compared to £7,617 a slight increase for female medics.

The payment of existing CEA awards is pro-rata. However, agreement was reached with the Joint Local Negotiating Committee that non-consolidated payments would not be pro-rata. The lower payments received by some female medics relate to long term sick leave, maternity leave and leaving UHD part way through the year.

In the 2021 round of Local Clinical Excellence Awards which we implemented in February 2022 salaries, an agreement has been reached on the calculations for the minimum investment, and we expect that payment should be made to eligible consultants in February 2023. The amount (£3790.07) is not pro-rata and all eligible consultants should receive an equal share.

c) Average Clinical Excellence Awards bonus gender pay gap as a mean average (medical)

	Male (Medical)	Female (Medical)	% difference
Mean bonus pay	£11,679	£7,617	34.78%

d) Average Clinical Excellence Awards bonus gender pay gap as a median average (medical)

	Male (Medical)	Female (Medical)	% difference
Median bonus pay	£9048	£4976.40	45.0%

e) Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

Male proportion receiving bonus	Male medical staff overall	%	Female proportion receiving bonus	Female medical staff overall	%
126	628	20.06%	56	552	10.14%

5.3 Proportion of Males and Females in each Quartile Pay Band

5.3.1 At the time the snapshot was taken the percentage of female staff was 75.96% female and 24.04% male.

f) Proportion of males and females <u>in all staff groups</u> when divided into four groups ordered from lowest to highest pay

	Male %	Female %
1. Lower	22.57%	77.43%
2. Lower Middle	21.89%	78.11%
3. Upper Middle	17.13%	82.87%
4. Top	34.57%	65.43%

g) Proportion of <u>Agenda for Change</u> males and females when divided into four groups ordered from lowest to highest pay

	Male %	Female %
1. Lower	22.77%	77.23%
2. Lower Middle	21.75%	78.25%
3. Upper Middle	16.98%	83.02%
4. Top	18.43%	81.57%

h) Proportion of Medical staff males and females when divided into four groups ordered from lowest to highest pay

	Male %	Female %
1. Lower	47.18%	52.82%
2. Lower Middle	45.10%	54.90%
3. Upper Middle	55.75%	44.25%
4. Top	64.69%	35.31%

For Medical and Dental staff, there are a higher proportion of males in the highest paid quartile.

i) Average (mean) Gender Pay Gap per quartile – Medical and Dental

	Male	Female	% difference
1. Lower	£19.33	£18.97	1.83%
2. Lower Middle	£27.09	£27.19	-0.36%
3. Upper Middle	£42.43	£42.03	0.93%
4. Top	£56.62	£56.88	-0.46%

j) Median Gender Pay Gap per quartile – Medical and Dental

	Male	Female	% difference
1. Lower	£20.92	£19.87	5.02%
2. Lower Middle	£26.99	£27.66	-2.49%
3. Upper Middle	£43.90	£43.48	0.97%
4. Top	£54.66	£53.10	2.86%

6. Conclusion

6.1 The Trust is required to report on snapshot data as at 31 March 2022. This data demonstrates that there could be greater female representation in its senior clinical roles. The position is consistent with previous snapshot data taken from 31 March 2021 data. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles.

6.2 It should be noted that the 2020 data was first published in March 2021, and this latest data snapshot took place on 31 March 2022, as per the regulations. Therefore, it will take some time for the impact of any actions to reduce the gender pay gap

6.3 Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and gender representation.

6.4 Comparing the median hourly pay gap, women earn 95p for every £1 that men earn. Their median hourly pay is 5.3% lower than men's.

6.5 Comparing the median bonus pay gap women earn 55p for every £1 that men earn. When comparing mean (average) bonus pay, women's mean bonus pay is 34.8% lower than men.

7. Update on Action Plan from 2021 and 2022

7.1 The following actions continue to support closing the gender pay gap:

	Action Plan	**Progress**
1.	Share Gender Pay Gap information across the Trust	Published on intranet and internet. Shared with Care Groups
2.	Develop a values proposition for employee life cycle/support	This is part of a wider project, still in development phase
3.	Commit to values based shortlisting and interview questions	Now embedded into the recruitment process
4.	Refreshed recruitment and selection training to include values and more details unconscious bias content	Implemented in 2021, staff inclusion networks consulted and contributed to the training programme
5.	Continue the Trust's commitment to an equitable workforce	Demonstrated in our Trust objectives and values and the wider EDI action plan
6.	Continue equitable access to trust leadership training and development	On-going leadership programmes and additional capacity through the Dorset Integrated Care System for underrepresented groups
7.	Support all staff in protected groups through living our Trust values and implementing our people strategy	Trust objectives and values. Staff inclusion networks People Strategy Flexible Working policy
8.	Flexible working – Raising the profile of the benefits of Flexible Working across UHD through a range of methods, including communication briefings, inclusive leadership conversations	A new UHD Flexible Working Policy was created in January 2022 and is also being promoted via the Space Allocation Group to support the Reconfiguration strategy.
9	Career Progression - Accessible bite sized and online training will continue, to ensure development can be accessed by those working part time and flexible work patterns.	Increased access to online leadership training modules. These rotate so they are on different days and times to increase accessibility.

	Bias awareness is included in new leadership and development modules.	More modules that can be worked on independently in own time. Managers' induction launched introducing compassionate, inclusive leadership and bias awareness.
10	A Women's network is being scoped, with interest from staff across the organisation.	Launched and working to expand reach and influence
11	CEA awards – Once national guidance is received on the reform of LCEA's a new award process will be developed for UHD. This will be more inclusive, transparent and fair and will reward excellence and improvement, underpinning the delivery of local priorities.	The National Guidance was received in late February and we are now in the process of arranging task and finish groups to outline the new LCEA process

8. Next Steps

8.1 The following actions are in place to further support the gender pay gap during 2023:

8.1.1 We are increasing the internal leadership development opportunities and encouraging our managers to have values based appraisal and personal development discussions. This will impact the amount of UHD women who are ready for promotion to senior roles. We are recording and reporting on protected characteristics of delegates in all UHD programmes

8.1.2 Recruitment actions include more diverse recruitment panels for senior vacancies.

8.1.3 We will further develop and raise the profile of the UHD Women's network.

8.2 The Chief People Officer and Director of OD will continue to work with the Executive team to support the identified actions. Delivery of these will be supported by the Trust's Equality, Diversity and Inclusion Group (EDIG) and assured through the People and Culture Committee.

March 2023

Tracy Mack-Nava, Senior OD Practitioner

Useful Abbreviations;

- BAME - Black, Asian and Minority Ethnic
- BME - Black Minority Ethnic
- EDI - Equality Diversity and inclusion
- EDIG - Equality Diversity and Inclusion Group
- WRES - Work Race Equality Standards
- WDES - Work Disability Equality Standards
- ICS – Integrated Care System

Appendix A

Figures taken as of 31 March 2022

Story of our Gender Pay Gap

We fully support the equality of opportunity and recognise that further work is needed to achieve this. Female staff are represented in many senior positions but we acknowledge there are still significant gaps e.g. in senior clinical roles, which drive the greatest variances in our results.

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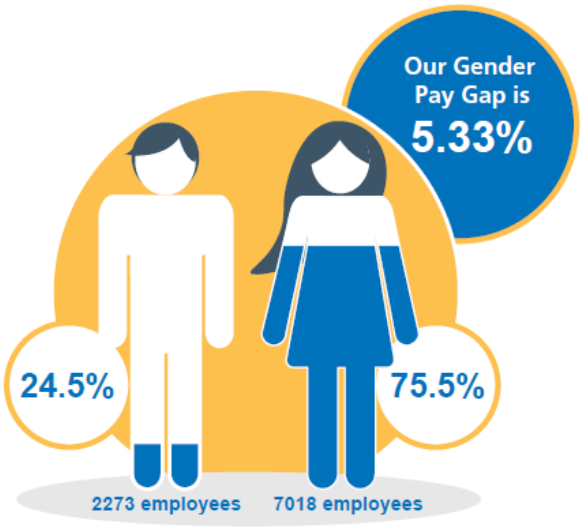
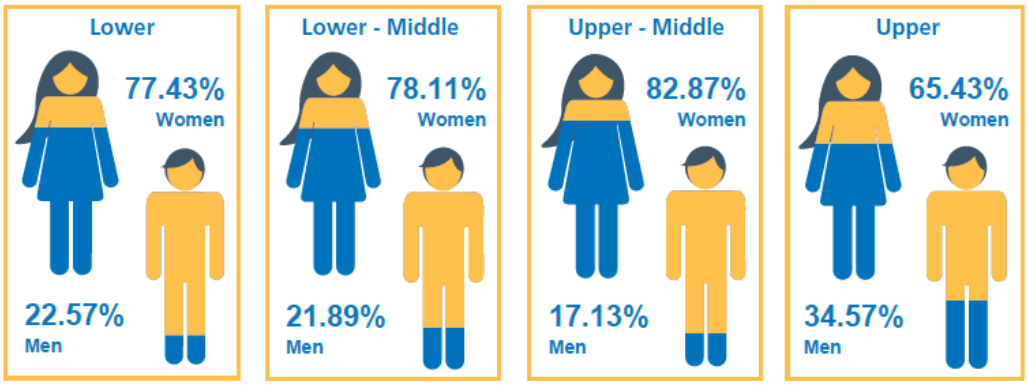
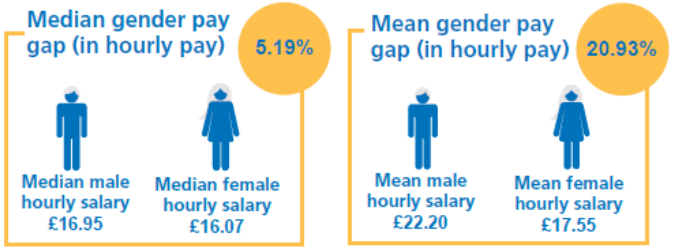


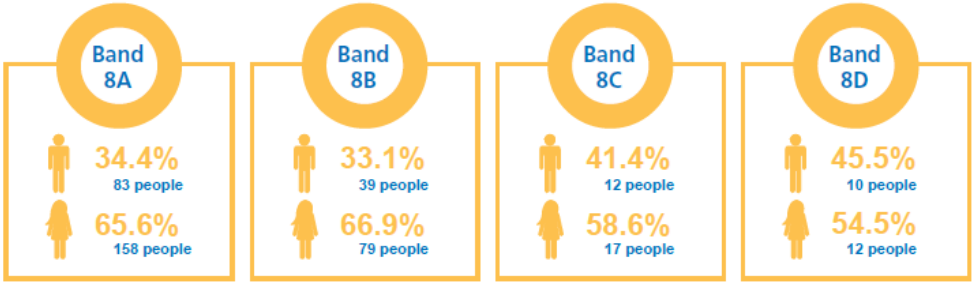
Proportion of males and females in each pay quartile



Our Workforce has an employee base that is predominantly female.



Senior agenda for change grades



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 9.4

Subject:	Key Issues and Assurance Report - Population Health and System Meeting held on: 28 April 2023
Presented by:	Caroline Tapster, Chair of the Population Health and System Committee

Background:	The reports received by the Committee at its meeting referred to above are set out below. This was the inaugural meeting of the Committee.

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

Items rated Green		
Item	**Rationale for rating**	**Actions/outcome**
N/A		

Items rated Amber		
Item	**Rationale for rating**	**Actions/outcome**
N/A		

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

Items not rated		
Item	**Comments**	**Actions/outcome**
Population Health and System Committee Terms of Reference.	There was broad discussion in relation to the Committee's agenda. It was noted that the Committee's terms of reference had been approved by the Board.	The Committee endorsed its Terms of Reference.

Dorset Integrated Care Partnership Strategy	The Committee received a presentation summarising key elements of the Dorset Integrated Care Partnership Strategy. It was noted that the Board of Directors had also received a presentation from the Chair and Chief Executive of NHS Dorset on the strategy that week.	The Committee noted the Dorset Integrated Care Partnership Strategy.
Review of Trust activity	The Committee received a presentation in relation to the Trust's activity. This included a summary of the Trust's discovery phase in relation to health inequalities and its delivery plan, including particular reference to the requirements of the Core20PLUS5.	The Committee noted the Review of Trust Activity.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 9.5.1

Subject:	2023/24 Annual Certificates (G6 and CoS7)
Prepared by:	Pete Papworth, Chief Finance Officer
Presented by:	Pete Papworth, Chief Finance Officer

Strategic Objectives that this item supports/impacts:	Continually improve quality ☐ Be a great place to work ☐ Use resources efficiently ☒ Be a well led and effective partner ☒ Transform and improve ☐
BAF/Corporate Risk Register: (if applicable)	Risk 1881: Financial Control Total 2023/24 Risk 1595: Medium Term Financial Sustainability
Purpose of paper:	Decision/Approval
Executive Summary:	The completed self-certification is attached confirming compliance with General Condition 6 and confirming compliance with a supporting statement for Continuity of Services condition 7. Assurance and supporting information for these statements has been considered and approved by the Finance and Performance Committee and Board of Directors in the form of the Month 12 Finance Report and draft annual accounts, and the 2022/23 Operational Budget. Whilst the Trust has set a balanced financial plan for 2023/24, this contains very considerable financial risk. However, the Trust currently has sufficient cash reserves to cover these financial risks whilst a comprehensive financial recovery plan is developed and embedded across the Dorset ICS.
Background:	The Trust is required to make the following self-certifications: • Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence; and • Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence.
Key Recommendations:	Members are asked to consider and if thought fit approve the attached certifications.

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	18/05/2023	Meeting has not yet 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	☐ ☐ ☐ ☐

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2022/23 | OK

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account i particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available t it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Consistent with the wider-NHS the Trust faces a very challenging year as it continues to recover services and reduce elective waiting times in the wake of the COVID-19 pandemic. Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who no longer meet the criteria to reside.

The Dorset ICS has submitted an operational plan which includes a balanced financial position. Within this, the Trust has approved a balanced financial operational plan. However, both the Trust and the wider-ICS plans contain very considerable financial risk and mitigating actions continue to be identified and developed to safeguard the in-year financial performance. This risk reflects the very significant operational pressues still present together with the recurrent impact of not being able to achieve recurrent efficiencies during and in the wake of the pandemic.

The risks to the availability of required resources consistent with operating within this context have been highlighted in the Trust's annual plan. These risks have been recorded in the Trust's risk register and are regularly monitored and reviewed together with the associated plans to mitigate these risks.

In approving its annual plan the Board of Directors has taken into account the reserves of the Trust, which would enable it to allocate additional resources as required, and has agreed contracts in place with commissioners for the provision of

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Rob Whiteman	**Name**	Siobhan Harrington
Capacity	Chair	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

University Hospitals Dorset NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2022/23**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust maintains a working register of the principles and provisions from NHS England's (formerly Monitor's) Code of Governance, identifying compliance or where explanation is required. The register is reviewed annually by the Audit Committee and by the Board of Directors. Any areas requiring explanation are reported in the Trust's Annual Report. Following on from the changes to the Code of Governance and provider licence from April 2023, the Trust will continue with implementation action during 2023/24 and continue to evolve its role in system working.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Compliance with NHS England's Code of Governance is reviewed annually and areas requiring explanation highlighted in the Trust's annual report. The Trust is a member of NHS Providers and as such is updated regularly on policy updates and takes account of new guidance. A regular Board meeting cycle is in place along with Board seminars and development sessions.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The terms of reference of its Board committees are reviewed on an annual basis (during the period, a review and update of each of the Trust's Board committees and their terms of reference was concluded). Following on from this, a review is in progress of the governance cycles of the Board committees. Standardised regular committee chair reports to Board introduced. Committees report to the Board on an annual basis in relation to compliance with their terms of reference. In addition, an annual review of its own effectiveness is to be undertaken by the Board. Enabling Accountability Framework is in place which has been recently reviewed and updated. This includes an updated governance map to give visibility of the Trust's governance arrangements, with the Executive Led groups and those aligned to Care Groups also having been reviewed. Further implementation action will take place following on from those updates.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	In addition to 1 & 2 above, the Trust maintains a register of its assessment of compliance with conditions of its licence. The register is reviewed by the Trust's Audit Committee and also comes before the Board annually. The Trust maintains an Annual Governance Statement and its work is supported by internal and external audit. The Trust maintains an active Risk Management Reporting system. Review of and enhancements to its form of Board Assurance Framework document are in progress. The board meets on a bi monthly basis in public and monthly for urgent business in private, with standing or specific reports at its public meetings to monitor performance on an integrated basis for each of quality , finance, activity, operational performance, workforce and informatics. Under its terms of reference, the Quality Committee is to monitor the Trust's responses to relevant external assessment reports and the progress of their implementation, including the reports of the CQC. The Quality Committee has reviewed CQC reports undertaken in the last year and will continue to oversee action plans produced in response to the inspections. Financial plans are in place and approved by the Board of Directors. Cost improvement programme agreed with Care Groups. Financial performance scrutinised through the Finance and Performance Committee with commitee chair's report to Board.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust ensures capable leadership and clear organisational accountability for quality of care provided are in place at Board level and through the triumverate leadership model of medical /nursing and midwifery / operational management at a Care Group and Directorate level. Quality sits at the core of the Trust's business and is reflected in its business and transformational planning. The Trust has adopted Patient First, a process of continuous improvement, with Phase 1 having been completed at the end of January 2023. As part of Phase 2 (Strategy Development), five key strategic themes have been agreed: patient experience, quality (outcomes and safety), our people, sustainable services and systems and partnerships. These will guide where the Trust focuses its continuous improvement efforts. The Quality Committee receives reporting on the quality of care, from sources including the Care Group reporting, and this information is taken into account by the Board in measuring performance and decision making. The Trust and staff actively engage in improving quality of care with patients and others. Patient stories are heard at the Board. The main surveys of staff and patients have been heard at committees of the Board and the Board receives an annual patient experience report. The results of the friends & family test are reported via the Integrated Performance Report to the Board. Oversight is provided on these activities, through the quality governance framework and reporting to the Quality Committee.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Risk in relation to sufficient staffing levels. However, the Trust utilises bank, locum and agency staff. There is regular Board and Committee reporting on the Trust's establishment along with recruitment and retention initiatives to support safe staffing. Succession planning at Board level has been reviewed as part of Board development discussions. Established RemComs in place for Non-Executive Director and Executive Director appointments.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	Signature
Name Rob Whiteman	Name Siobhan Harrington

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A N/A

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 10.1

Subject:	Enabling Accountability Framework
Prepared by:	Executive Directors, Judith May, Director of Operational Performance and Oversight Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Mark Mould, Chief Operating Officer supported by Executive Directors

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☒ Use resources efficiently ☒ Be a well led and effective partner ☒ Transform and improve ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The current Enabling Accountability Framework document has been reviewed and updated to recognise changes in structure or processes. A draft for consultation was produced, with feedback having been requested from the Trust Management Group in January 2023. The attached version has been updated in light of feedback received and further review.
Background:	The Enabling Accountability Framework provides an overview of the mechanisms, processes and lines of accountability within the Trust to illustrate how performance will be monitored and managed against the Trust's strategic objectives. It provides details of the framework for oversight, escalation, and guidance and support to enable an organisational focus on quality of care and ensuring services are sustainable.
Key Recommendations:	To consider and if thought fit to approve the draft Enabling Accountability Framework.
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**
Executive Team Meeting	09/01/2023	Process supported.
Trust Management Group	10/01/2023	Draft presented to Trust Management Group and feedback requested.
Board of Directors	25/01/2023	Draft presented to Board of Directors and feedback requested.
Trust Management Group	09/05/2023	Draft presented to Trust Management Group and supported.

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

NHS
University Hospitals Dorset
NHS Foundation Trust



ENABLING ACCOUNTABILITY FRAMEWORK

Version:	Master Version – V 5
This version issued:	May 2023
Next Review date:	May 2024
Primary Authors:	Judith May, Director of Operational Performance and Oversight and Yasmin Dossabhoy, Associate Director of Corporate Governance

CONTENTS

Appendices

Part A: Overview

1. Introduction

1.1 Good governance is essential to the provision of safe, sustainable and high-quality care for patients. Accountability and performance management are core components of our governance framework and enable the Board to fulfil our obligations in the effective management of the organisation.

1.2 Our Enabling Accountability Framework is critical in supporting the delivery of University Hospitals Dorset NHS Foundation Trust's Organisational Strategy (Annual Operational Plan). This framework sets out the key enabling structures and processes to support the delivery and achievement of our vision and strategic objectives, our Annual Operational Plan and our key enabling strategies.

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1.3 The framework enables us to support leaders, managers and staff in the delivery of continuous improvement, to achieve high class services and outcomes for our service users, patients and the local communities we serve.

2. Accountability and Responsibility

The main difference between responsibility and accountability is that responsibility can be shared whilst accountability cannot.

The accountable person is the individual who is ultimately answerable for the activity or decision. This includes 'yes' or 'no' authority and 'veto' power. Only one accountable person can be assigned to an action.

The responsible person is the individual/s who complete the task. The responsible person is responsible for action / implementation and this responsibility can be shared. The degree of responsibility is determined by the individual with accountability.

3. The Framework

3.1 The Accountability Framework has been prepared taking account of the national *NHS Oversight Framework 2022/23* (June 2022[1]) and NHS England guidance on *Developmental reviews of leadership and governance using the well-led framework*[2] to ensure the Trust is focused on managing its NHS resources to deliver high quality, sustainable care.

3.2 The objective of this framework is to ensure that information is available which enables the Board of Directors and other key personnel to understand, monitor and assess the Trust's quality and performance, enabling appropriate action to be taken when performance against set targets deteriorates. It is also recognised that this

[1] NHS Oversight Framework 2022/23

[2] Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts, June 2017

Accountability Framework will need to be reviewed and updated going forward as the approach to system-led working continues to evolve.

3.3 The table below describes how this Accountability Framework will support us to monitor, assure and improve performance against the Well Led Framework.

Well Led Key line of enquiry	Impact of Accountability Framework
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	• Accountabilities and responsibilities are clearly defined for individuals and enable effective delegation. • Leaders understand the challenges to quality and sustainability. • Clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership are understood.
2. Is there a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver?	• Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence to show this. • The Vision, Values and Strategy have been developed using a structured planning process in collaboration with staff, people who use services and external partners.
3. Is there a culture of high quality, sustainable care?	• Action is taken to address behaviour and performance that is inconsistent with the Vision and Values, regardless of seniority. • Staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively.
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	• Effective structures, processes and systems of accountability are in place to support the delivery of the strategy, and these are regularly reviewed and improved. • Staff at all levels are clear about their roles and they understand what they are accountable for and to whom.
5. Are there clear and effective processes for managing risks, issues and performance?	• There are comprehensive assurance systems and performance issues are escalated appropriately through clear structures and processes. • There are processes to manage current and future performance. These are reviewed and improved.
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	• There is a holistic understanding of performance, which covers and integrates people's views with information on quality, operations and finances. • There are clear and robust service performance measures which are reported and monitored.
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	• There are positive and collaborative relationships with external partners which build a shared understanding of challenges within the system and the needs of the relevant population and to deliver services to meet those needs. • There is transparency and openness with all stakeholders about performance.
8. Are there robust systems and processes for learning, continuous improvement and innovation?	• Participation in and learning from internal and external reviews – learning is shared effectively and used to make improvements. • All staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance – this leads to improvements and innovation.

3.4 The deployment of the accountability framework aims to be:

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

4 Mission, Vision, Values and Strategic Priorities

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

4.2 The accountability framework sits within the context of:

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

4.3 Our Mission statement is:

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

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

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

4.4 The Trust's strategic objectives until recently have been:

To be a great place to work by creating a positive and open culture and supporting and developing staff across the Trust so that they are able to realise their potential and give of their best.

To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets.

To continually improve the quality of care so that services are safe, compassionate, timely and responsive, achieving consistently good outcomes and an excellent patient experience.

To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.

To transform and improve our services in line with the Dorset ICS (Integrated Care Systems) Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.

As part of our Patient First and Reconfiguration – One Team programmes, a review has been undertaken. Going forward, we will align our goals to 5 strategic themes.

4.5 Our strategic themes:

Our strategic goals are at Trust level and focus on where we most want to see significant improvements delivered in a sustained way over the next 3 years. These fit within our Dorset-wide role in the health and care system. They are aligned to the following 5 strategic themes:

- Population Health & System
- Our People
- Patient Experience
- Quality (Outcome and Safety)
- Sustainable Services

4.6 The annual objectives for 2023/24 are summarized below:

Strategic Theme	Goal
Population Health & System working	To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value
Our People	To significantly improve staff experience, engagement and retention [with NHS Staff Survey results in top 20% of comparator trusts]
Patient Experience	Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD (UNIVERSITY HOSPITALS DORSET) receive quality care, which results in a positive experience for them, their families and/or carers [with UHD's inpatient survey results to be in top 20% for the quality of care provided]
Quality (Outcome and Safety)	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
Sustainable Services	To return to recurrent financial surplus from 2026/27
Patient First Programme	To successfully and sustainably adopt the Patient First approach across UHD
One Team (Patient Ready reconfiguration)	To integrate teams and services, then to reconfigure, and to create the planned and emergency hospitals

5 Organisational Strategy (Annual Operational Plan)

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

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

6 Our Structure and People

6.1 The Trust manages three hospital sites in East Dorset. Poole Hospital site, Royal Bournemouth site and Christchurch Hospital site that are organised into care groups and corporate directorates under the leadership of the Chief Executive. Each of the corporate directorates are headed by an Executive Director. The operational management of the Trust is delivered through 3 Care Groups (Surgical, Medical and Women, Children, Cancer and Support Services) and an Operational Support Group, with clinical directorates feeding into the relevant care groups supported by the corporate functions.

6.2 Equality, Diversity and Inclusion – As a major employer and health service provider, we are committed to building an inclusive workforce which is valued and whose diversity reflects the community we serve. An Equality, Diversity & Inclusion group (EDIG) meets quarterly and is chaired by an Executive Director. This is attended by representatives from across the Trust, including senior managers, union representatives and governors. An update report and tracker on key EDI deliverables are presented regularly to the People and Culture Committee. The responsibility of EDIG is to provide advice to the Chief Executive and Executive Directors on equality, diversity and inclusion matters. It will also monitor the delivery of the Trust's ED&I strategy, advising and agreeing any mitigating or corrective action and/or interventions as appropriate.

Part B: Corporate Governance

7 Policies, Procedures and Standing Orders

7.1 There are several core governance policies and procedures which have been set by the Board of Directors, defining how we operate at an organisational level, in accordance with the regulatory framework. The enabling accountability framework should be read in conjunction with:

- Standing Orders
- Scheme of Matters Reserved to the Board / Scheme of Delegation[3]
- Code of Conduct
- Standing Financial Instructions[4]
- Risk Management Strategy[5]
- Quality Strategy

8 Board Assurance Framework (BAF)

8.1 The Board Assurance Framework (BAF) provides a structure and process which enables the Board of Directors to focus on the key strategic risks which might compromise the achievement of our Strategic Objectives. The BAF is scrutinised by the Board of Directors on a six-monthly basis and quarterly by the Audit Committee.

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

8.3 The Risk Register – The Trust uses a risk register to record, prioritise and monitor risks across the organisation. Risks that are scored in excess of the Board of Directors' risk appetite are presented to the Executive Directors and Committees in accordance with the relevant Governance cycles.

9 Corporate Governance structure

9.1 Our Corporate Governance Structure was refreshed in October 2020 following the merger of the former organisations and the establishment of University Hospitals Dorset and subsequently reviewed and updated. The structure defines the arrangements through which we monitor and seek assurance, from an operational

[3] The Scheme of Delegation will be reviewed and updated in 2023 (including to take account of changes in the Board Committees since it was last approved).
[4] The Standing Financial Instructions will be reviewed and updated.
[5] The Risk Management Strategy will be reviewed and updated (including to take account of changes in the Board Committees since it was last approved).

level through to the Board of Directors.

9.2 The Board of Directors is responsible for setting the overall strategic direction of the Trust. The matters that the Board of Directors has reserved to itself and those which have been delegated to individual directors or committees are documented within a Scheme of Delegation.

9.3 The organisation is to operate in accordance with financial rules agreed by the Board of Directors set out in Standing Financial Instructions.

9.4 The Board of Directors has established a number of committees for oversight and to seek assurance in specified areas. A diagram illustrating the Trust's governance structure is included in Appendix 1. The structure has been designed to provide effective governance over business activities.

10 Committees of the Board of Directors

10.1 The Board of Directors operates a well-established committee structure to strengthen its focus on quality, finance, people, and performance. The committees receive assurance on behalf of the Board.

10.2 Each Board Committee has Terms of Reference approved by the Board of Directors and an agreed annual governance cycle. Other than the Appointments and Remuneration Committee, the Board Committees each may have up to two Governors attending as an observer. This provision has been written into the relevant Committees' Terms of Reference.

10.3 All Board Committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Appointments and Remuneration Committee, whose membership (in accordance with NHS guidance) comprises Non-Executive Directors exclusively. In line with good corporate governance, the Chair of the Trust is not a member of the Audit Committee and does not normally attend its meetings.

10.4 The Chairs of our Board Committees report to the Board of Directors at meetings held in public on the assurance received by such Committees and key issues discussed. This report identifies:

- Areas where assurance (substantial, partial or limited) has been received by the Committee.
- Key actions agreed / work underway that have been reported to the Committee.

The report also identifies other items reported to the Committee, but which have not been rated in the manner described above and includes the outcomes from those discussions.

Committee	Responsibility
Appointments and Remuneration Committee	• The primary purpose of the Appointments and Remuneration Committee is to identify and appoint candidates to fill Executive Director positions on the Board of Directors and to determine the remuneration and other conditions of service for the Chief Officers and Very Senior Managers.
Audit Committee	• The Audit Committee meets at least four times in each financial year and at such other times as necessary. Its terms of reference are aligned with the Healthcare Financial Management NHS Audit Committee Handbook. • It provides an independent and objective review of financial and corporate governance, assurance processes and risk management. This includes reviewing the adequacy and effectiveness of risk and control related disclosure statements prior to submission to the Board of Directors. It considers the provision of the internal service and considers the appointment and performance of the external auditors.
Charitable Funds Committee	• The Charitable Funds Committee is formally established as a committee of the Trust as corporate trustee of the University Hospitals Dorset NHS Foundation Trust Charity. The Board of Directors of the Trust acts as the Board of the Trustee. The Committee provides the Trust Board with a means of assurance regarding the administration of the charity in accordance with applicable legislation.
Finance and Performance Committee	• The Finance and Performance Committee meets monthly and obtains assurance on the implementation of the Annual Operating Plan, the Productivity and Efficiency Plan, Estates Strategy and Sustainability Strategy. This includes oversight of the Trust's revenue and capital position and monitoring against key national performance standards, such as access times.
People & Culture Committee	• The People & Culture Committee meets quarterly. Its purpose includes providing input and recommendations to the Board of Directors for the development of the People Strategy and the Equality, Diversity and Inclusion Strategy and obtaining assurance on the implementation of such strategies.

Population Health and System Committee	• The Population Health and System Committee meets quarterly and was established in 2023. Its principal purpose includes:
	  ○ To obtain assurance that the Trust's delivery plan aligns with the Dorset Integrated Care Board strategy and/or relevant aspects of the Core20 plus 5 approach; and
	  ○ To obtain assurance that significant strategic change programmes deliver a positive impact, where possible, on reducing variation in outcomes between groups with protected characteristics and other vulnerable groups and services are adapted to meet the needs of those groups appropriately.

Quality Committee	• The Quality Committee meets monthly and oversees that there are robust management systems and processes in place for ensuring high standards for quality of care. • It serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely, cost-effective manner across a number of relevant areas. • Acts as a means of internal assurance for compliance against the CQC (Care Quality Commission) regulating and inspection compliance framework.

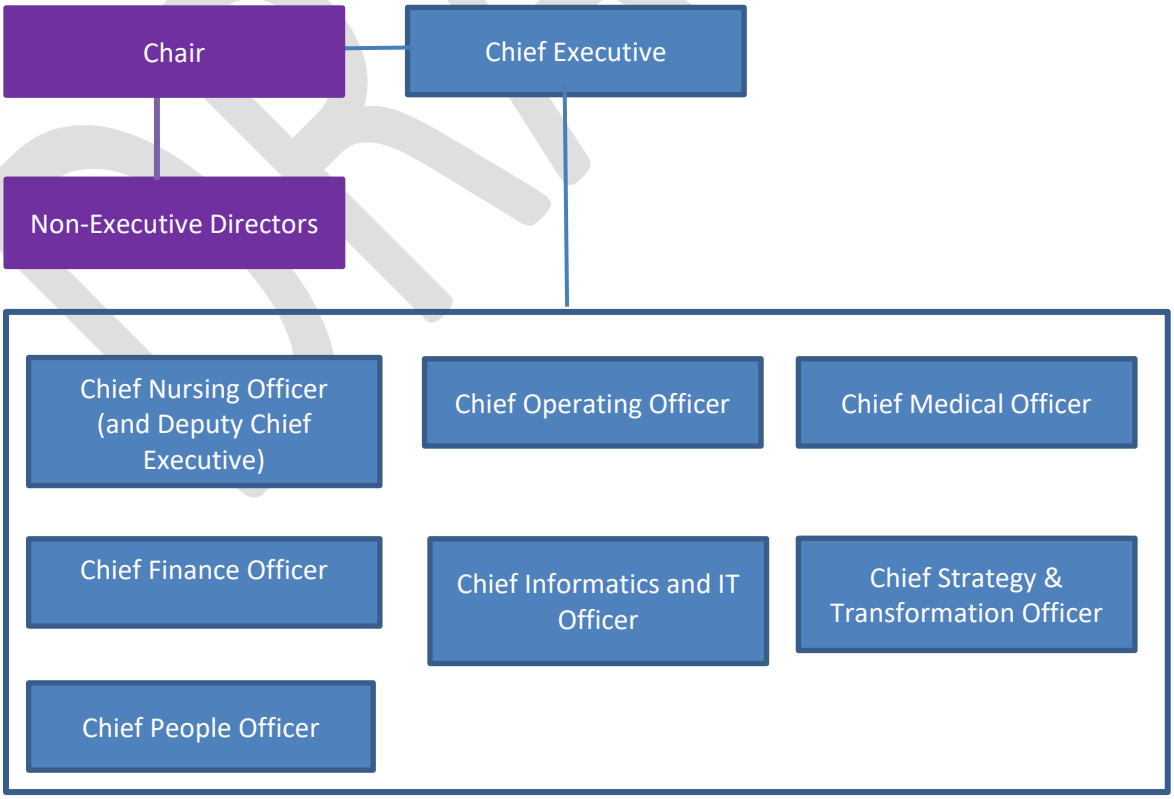
Part C: Accountability

11 Trust Board Accountability

11.1 The Board of Directors plays a key role in shaping the strategy, vision and purpose of the organisation. It holds the Chief Executive and the Executive Team to account for the delivery of the strategy and ensure value for money. It is also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. The Board of Directors is led by an independent chair and composed of a mixture of both executive and non-executive directors; the Board of Directors is a unitary Board which make decisions as a single group, sharing responsibility and liability for all Board of Directors decisions, with collective responsibility for the performance of the organisation.

11.2 The Board of Directors is held to account by the Council of Governors. The general duties of the Governors are to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and, to represent the interests of the members of the Trust as a whole and the interests of the public.

Trust Board of Directors



The table below highlights the distinction between the roles of Executive Directors and Non-Executive Directors.

	Chair	Chief executive	Non-executive director	Executive director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose	Leads strategy development process	Brings independence, external skills and perspectives, and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CE to account for delivery of strategy Ensures board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the board's behaviour and decision making Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the board for whistle-blowers	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour
Context	Ensures all board members are well briefed on external context	Ensures all board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely & clear information to board/ directors (and governors for FTs) are clear to executive	Ensures provision of accurate, timely & clear information to board/ directors (and governors for FTs)	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the board
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and Staff • Key institutional stakeholders • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional stakeholders • Regulators	Ensures board acts in best interests of the public Senior independent director is available to members and governors if there are unresolved concerns (FTs)	Leads on engagement with specific internal or external stakeholder groups

11.3 Trust Chair

The Chair is accountable for leading the Board of Directors and is responsible for its overall effectiveness in directing the Trust. The Chair is accountable to the Secretary of State, through NHS England, for giving leadership to the Board of Directors, ensuring the Trust provides high quality, safe services and value for money within NHS resources.

This includes:

- Promoting the highest standards of integrity, probity and corporate governance throughout the organisation and particularly the Board of Directors.
- Promoting a culture of openness and transparency for the organisation.
- Upholding the values of the Trust, visibly leading by example, and ensuring that the organization promotes equality and diversity and inclusion for all its patients, staff and other stakeholders.
- Leading the Board of Directors in establishing effective decision-making processes and acting as the guardian of due process.
- In conjunction with the Chief Executive, providing strong leadership for the Trust, including representing the Trust as part of the Dorset Integrated Care

System and working with partners to deliver the Dorset Sustainability and Transformation Plan and the recommendations of the Dorset Clinical Services Review.

11.4 Non-Executive Directors

Non-Executive Directors are not involved in the day to day running of the Trust's business but are instead guardians of the governance process and monitor executive activity as well as contribute to the development of strategy. Non-Executive Directors have a particular role in ensuring appropriate challenge is raised. They are appointed to the Board of Directors to bring wide experience, expertise and support the Trust in delivering better outcomes for the public.

11.5 Chief Executive Officer

The Chief Executive Officer is accountable for:

- Maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding public funds and departmental assets.
- Ensuring that the Trust is administered prudently and economically, that resources are applied efficiently and effectively and that there are adequate arrangements in place for the discharge of statutory functions.
- Ensuring that there is robust risk management across all organisational, financial and clinical activities.

The Chief Executive is accountable to the Board of Directors for meeting their objectives and as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation. The Chief Executive helps create the strategy and vision for the Board of Directors and the organisation to modernise and improve services and is responsible for ensuring that the Board of Directors' plans and objectives are implemented and that progress towards implementation is regularly reported to the Board of Directors using accurate systems of measurement and data management. The Chief Executive also agrees the objectives of the senior executive team and reviews their performance.

11.6 Executive Director Leadership and Oversight

The Chief Executive leads a team of Executive Directors who (i) provide professional advice and support (ii) take functional responsibilities that have been delegated to them. An Executive Directors' meeting occurs weekly whose purpose is to ensure all executives are up to date on issues that affect the Trust internally and externally and to ensure there is robust strategic development and operational plans in place to facilitate the achievement of the Trust's objectives and Board of Directors' decisions. The role of Executive Directors is not to take decisions that should properly go to the Board Committees.

The table below outlines the key areas of accountability and responsibility for the Trust's Executives.

Executive Director	Accountability and Responsibility
Chief Strategy & Transformation Officer	• Leading the development and delivery of the organisation wide strategy, incorporating the Clinical Services Strategy and a coherence annual planning and business development strategy. • Co-ordination, production and oversight of the delivery of enabling strategies, business cases and annual plans. • Lead executive for system wide working.
Chief Nursing Officer	• Quality and patient safety including the systems, processes and behaviours by which quality is governed. • Contributes to the development and implementation of key objectives to deliver efficient services and effective, high quality patient care and ensure equality, diversity and inclusion. • Professional leadership of nurses / midwives and AHPs (Allied Health professionals). • Provision of professional advice and assurance to the Board of Directors for: infection prevention and control, public and patient experience, safeguarding compliance with Care Quality Commission standards. • Driving professional accountability in delivering key performance indicators and engendering effective clinical leadership.
Chief Finance Officer	• Financial strategy and ensuring effective financial management and control • Providing financial leadership by setting, evaluating and developing organisation wide service and financial frameworks within which operational services can be delivered. • Effective operation of the financial performance, performance reporting and accountability framework.
Chief Operating Officer	• Development and implementation of key objectives to deliver services that provide optimum patient care, efficient use of resources and promotion of a culture that is progressive, inclusive and values driven. • Providing operational leadership through setting, evaluating and developing effective systems and processes which ensure the smooth running of the organisation and achievement of NHS constitutional targets. • Accountability for the management and performance of care groups.
Chief Medical Officer	• Quality and patient safety, including the systems, processes and behaviours by which quality is governed. • Contributes to the development and implementation of key objectives to deliver efficient services and effective, high quality patient care and ensure equality, diversity and inclusion. • Professional leadership of the medical workforce and for medicines optimisation, including accountability for the Clinical Director of Pharmacy and Chief Scientists including radiation protection. • Provision of professional advice and assurance to the Board of Directors for: clinical outcomes, mortality, clinical governance and effectiveness • Driving professional accountability in delivering key performance indicators and engendering effective medical leadership.
Chief People Officer	• Leading the development and delivery of strategies relating to all aspects of employment, workforce and organisational development, ensuring these link into other strategies and are aimed at enhancing clinical care and outcomes and ensuring equality, diversity and inclusion. • Provide workforce advice to the Board, ensuring compliance with all legal and social obligations to employees. • Shaping and implementing the strategic direction of the Trust through the introduction, development and maintenance of human resource practices.
Chief Informatics and IT Officer	• Leading the development of the Digital Transformation strategy and service, providing innovative solutions to improving the efficiency and effectiveness of the Trust's operation. • Developing the infrastructure to support the delivery of ICT systems across the Trust • Influence and support the delivery of ICT systems across the Dorset ICP. • Senior Information Risk Owner (SIRO) with responsibility for the management of information related risks.

11.7 **Trust Management Board**

The Trust Management Board (TMB) is the main executive leadership group of the Trust. It is the main "engine room" of the organisation, making recommendations to the Board of Directors through the Chief Executive on matters relating to the strategy of the Trust and the management of its operational services. It ensures that the three Care Groups are fully involved in corporate decision-making, and that the voice of clinicians and professionals from across the organisation is fully considered.

11.8 Reporting into our TMB are a series of groups which provide oversight and/or ensure delivery against specific priorities and objectives.

11.9 Terms of Reference and Membership are expected to be in place for all groups identified within our structure, which define their objectives and responsibilities.

12 Care Group Accountability

The Trust subdivides the operational accountability of its clinical services into 3 Care Groups and an Operational Support Group supported by corporate services. Within each Care Group, a leadership triumvirate has been established. This is with the exception of the Women's, Children, Cancer and Support Services Care Group where the role of the Director of Maternity is an integral part of a quadrumvirate at Care Group Level and the individual holding this role is also an attendee of the Trust Quality Committee. The structure has been designed to support the delivery of the vision and strategic objectives for the Trust through devolving leadership and accountability to a local level, at the same time as ensuring that there is a mechanism for driving standardisation across hospital sites and that there is appropriate Trust level oversight. Clinical services delivered through the Care Groups are viewed as *one service in multiple sites* with a single leadership team. The team's role is to ensure the delivery of services and performance across all sites within the Trust and include services that are provided across Dorset.

It is intended that the main axis of accountability for line management, service and budgetary performance will be vertically through the Care Groups and directorates, with the horizontal responsibilities of all Care Groups being for standard setting, quality assurance and ensuring consistency of service across the organisation.

12.1 Care Group Leadership (Tri/Quadrumvirate)

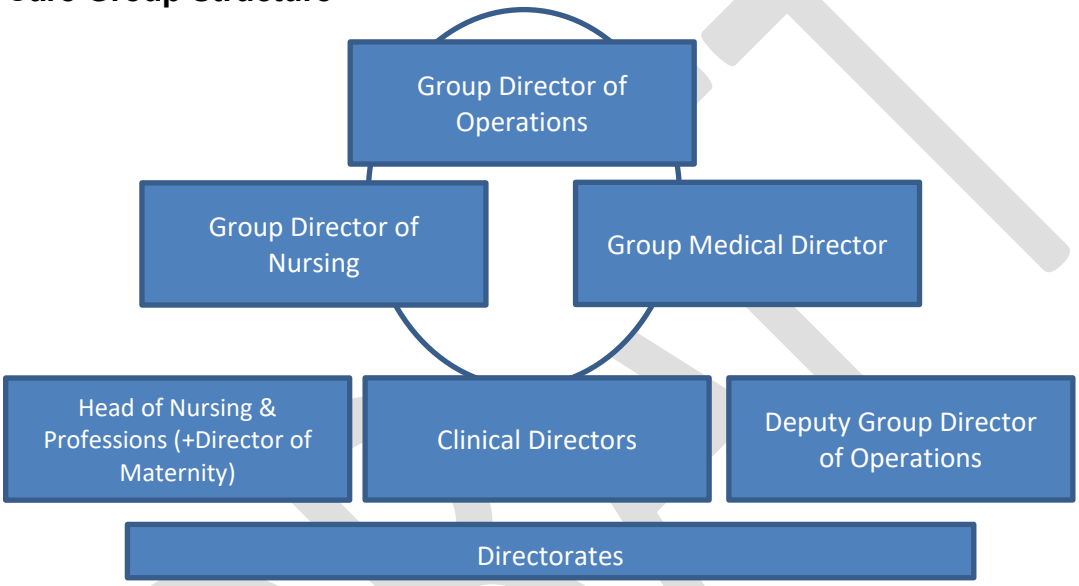
(Care Group Director of Operations, Care Group Medical Director, Care Group Director of Nursing)

Our Care Groups are managed by clinically led tri/quadrumvirates comprised of a Care Group Director of Operations (GDO), Care Group Medical Director (GMD), and Care Group Director of Nursing (GDoN) as well as leads from Human Resources, Finance, Operations, Information, Transformation and Informatics. The GMD and GDoN will be managerially accountable to the GDO. All tri/quadrumvirate individuals have responsibility and accountability for all aspects of their Care Group performance (quality and safety, finance, workforce and operational performance). Each of the Care Groups is accountable under 'collective managerial and professional leadership' to the Chief Operating Officer, Chief Nursing Officer and

Chief Medical Officer who hold the tri/quadrumvirate leaders in each Care Group to account for the delivery of Care Group specific key performance indicators. Although the professional lines of accountability as follows, also exist:

- Care Group Medical Directors are professionally accountable to the Chief Medical Officer,
    - Appraisal and objective meetings will be jointly carried out by the Chief Medical Officer and the Group Director of Operations
- Care Group Directors of Nursing are professionally accountable to the Chief Nursing Officer.
    - Appraisal and objective meetings will be jointly carried out by the Chief Nursing Officer and the Group Director of Operations

Care Group Structure



Care Groups are held accountable through Performance Management Review Meetings, which are led by the Executive Team. The tri/quadrumvirate have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight and co-ordination of performance within and across all Groups / Directorates. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Executive Team key areas of risk that may affect delivery of organisational objectives and strategy.

12.2 Care Group Leadership

(Deputy CG (Care Group) Director of Operations, Heads of Nursing & Professions, Clinical Directors)

Supporting our Care Group tri/quadrumvirate and overseeing our Directorate Teams is our Care Group Leadership comprising Heads of Nursing and Professions, Clinical Directors and Deputy Directors of Operations. These individuals have responsibility and accountability for specific aspects / services within the Divisional portfolio (as well as deputising for Care Group Leadership). They are directly accountable to the Care Group Tri/quadrumvirate.

12.3 Directorate Leadership
(Clinical Directors, Senior Matrons, Divisional Managers)

Each of our Directorates is led by a Clinical Director, Senior Matron and /General Manager. They have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics, and the governance, oversight and co-ordination of performance within and across their Directorate. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Care Group Leadership Team key areas of risk that may affect delivery of organisational objectives and strategy. Clinical Directors and Senior Matrons have designated leadership roles in relation to health and care professionals at a specialty level. They have key responsibilities and accountability for ensuring effective clinical and quality governance and that the values and professional standards are instilled within their workforce. They ensure that their teams are aware of and contribute to the organisation wide ambitions and promote essential standards to be delivered. Directorates are held accountable through Directorate Performance Management Review Meetings, which are led by the Care Group Tri/quadrumvirate. The Directorate Leadership Team is accountable for supporting managers / leaders within individual wards and departments, who manage and lead our frontline staff on a day-to-day basis.

- Directorate Clinical Directors are professionally accountable to the Care Group Medical Director
    - Appraisal and objective meetings will be jointly carried out by the Care Group Medical Director and the Group Director of Operations
- Directorate senior matrons are professionally accountable to the Head of Nursing & Professions.
    - Appraisal and objective meetings will be jointly carried out by the Head of Nursing and Group Director of Nursing

12.4 All Staff

All staff have a responsibility for performance management and improvement, relevant to their role and are supported to identify improvement opportunities and to act as required. Specific and generic roles and responsibilities are outlined within all job descriptions.

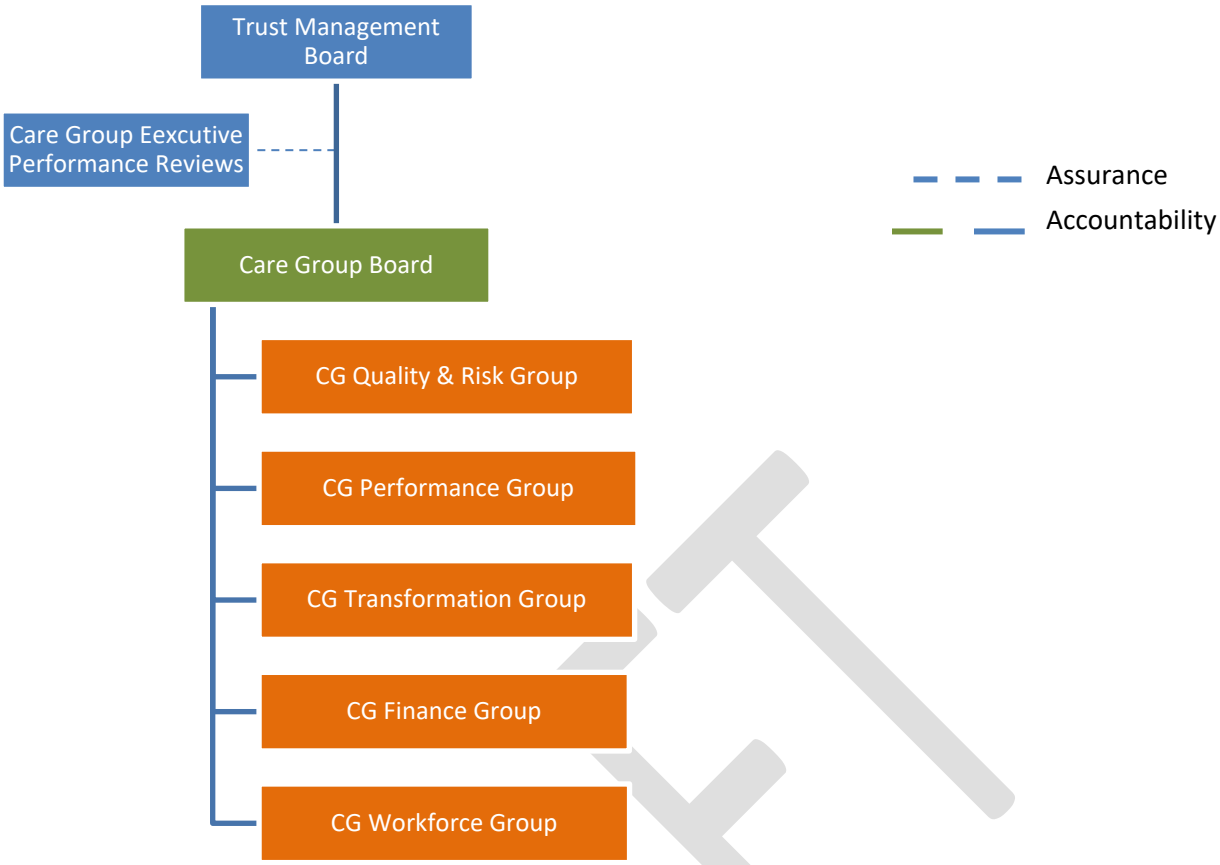
Part D: Care Group Governance

13 Care Group Governance Structure

13.1 Care Groups are expected to have a clear and cohesive structure in place which sets out the framework within which the performance of the Care Group is governed. Whilst it is recognised that Care Group structures need to be tailored to meet the governance needs of each Care Group, as a minimum they must have:

- A clear line of accountability into the Executive Directors through the Care Group Performance Management Reviews and Executive Groups as appropriate.
- A fully constituted Care Group Board comprising the Divisional Management Team, with documented and approved Terms of Reference and Membership, with meetings being held monthly covering all aspects of Care Group strategy, performance, risk, workforce, culture, and governance, aligned with our Strategic Priorities (a template can be found at Appendix 2)
- The following forums held monthly:
    - A Care Group Quality and Risk Group
    - Transformation Group
    - Finance Group
    - Performance Group
    - Workforce Group
- All Groups should have documented and agreed Terms of Reference and membership and are directly accountable to the Care Group Board.
- A forum within which Health & Safety matters are considered, with assurance being provided to the Trust Health and Safety Group. Health and safety may be included in the Care Group's Quality & Risk agenda, rather than a separate meeting.
- A documented and approved process for the management, escalation and oversight of risk, in accordance with the Risk Management Strategy.
- Directorate Performance Management Reviews, which align with the Performance Management Framework set out within this document.
- Arrangements to ensure consideration of reports from relevant Executive or Trust-wide Groups to ensure effective flows of information.

The minimum structure required is illustrated below:



13.2 Care Group Board – Core Responsibilities

The Care Group Boards have delegated decision-making responsibility for defined areas, within the parameters of annual operating plans agreed by the TMB (and the Trust's Standing Financial Instructions). They provide assurance to TMB about progress and performance in defined areas and do the work-up on recommendations to TMB about policy, resource allocation and change plans.

To ensure consistency across the organisation, each Care Group Board should have a core set of responsibilities which enable the effective oversight and scrutiny of their Care Group. These are outlined below and are covered within the template Terms of Reference (Appendix 2).

Strategy

- Oversee development and implementation of strategy and operational plans at a Care Group level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available.
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Trust operational planning process and Patient First.
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures and protocols and monitor their implementation, where relevant, at a Care Group level.
- Oversee the annual business planning process and advisee the Board of Directors via TMB on the distribution of available resources.

- Review progress in delivering the Trust's transformation programme.
- Review and agree specific strategies prior to submission to TMB for approval. This may include the following:
    - The development of clinical services. /Trust's strategy on research and innovation.
    - Relationship managements with external partners.

Performance

- Overseeing the delivery of the annual corporate objectives of the Trust, including the delivery of all financial, quality, access and other targets and standards.
- Receive assurance on the delivery of strategy and relevant key performance metrics, ensuring the appropriate allocation of resource.
- Monitor the operational systems and processes which ensure competent management within the Care Group.
- Identify, delegate and review relevant actions to improve performance.
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Performance Management Review process.

Risk Management

- Where relevant, monitor Root Cause Analysis / trends relating to adverse incidents, ensuring that appropriate action is taken and lessons are learned (this may be delegated to the Care Group Quality & Risk Group although the Care Group Board will retain responsibility for oversight).
- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Policy.

Governance

- Review clinical governance arrangements and performance, including meeting required clinical standards and recommend appropriate action.
- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate.
- Oversee / monitor implementation of actions plans arising from internal / external review, audit, assessment or accreditation.
- Approve business cases prior to their submission to the Finance and Planning Group and subsequently submission to the Trust Management Board or Trust Board where necessary.
- Undertake an annual self-assessment of effectiveness to inform any changes to Terms of Reference and Membership.

Part E: Performance Management Framework

14 Performance Management

Performance management is integral to our Corporate Governance Structure. We have agreed a broad range of Key Performance Indicators (KPI's) which form the basis of our performance management framework. These KPI's are aligned to our Strategic Priorities and consider all NHS constitutional patient access targets and statutory obligations, along with targets we have agreed locally to support the delivery of our overarching vision, enabling strategies and to address key areas of risk.

A range of analytical techniques will be used, prioritising Statistical Process Control (SPC) where appropriate. We use SPC in our performance reporting to:

- Alert us to a situation that may be deteriorating.
- Show if a situation is improving.
- Demonstrate how capable a system is of delivering a standard or target.
- Show if a process that we depend upon is reliable and in control.

We have adopted a model of SPC reporting within our Integrated Performance Report which enables us to draw two main observations of our performance data: the degree or areas of variation and level of assurance of consistently meeting each target.

14.1 Board/Committee/Executive Oversight, Scrutiny and Accountability

Effective scrutiny relies primarily on the provision of clear comprehensive summary information through a range of documents, including:

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

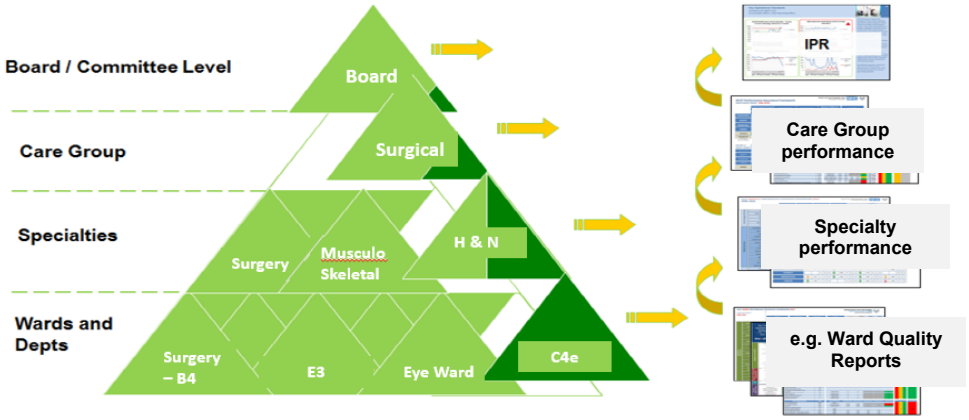
The graphic below illustrates, at a high-level, the 'Ward to Board' reporting structures which reflect the clinical services of the Trust and the performance reporting arrangements that support the scrutiny of performance within each tier of the organisation.

The **Board's** responsibility for the performance of the organization is enacted through scrutiny and monitoring of performance documented within the **Integrated Performance Report (IPR)**.

The Integrated Performance Report is owned by the Executive Directors and is presented to the Trust Board each month. This, along with a selection of other

assurance reports agreed by the Board as part of their annual Business Cycle, form the basis upon which Executive Directors are held to account. The full selection of KPI's included within our Integrated Performance Report to the Board can be found at appendix 3.

The Trust's Reporting Framework



For **Committees** reporting to the Board, reporting specific to each element of our strategy is considered (i.e., quality, great place to work, efficient use of resources, transformation and improvement and well governed). These are monitored by each of our core Committees and are owned by the lead Executive Director/s and again presented for oversight and scrutiny, along with a selection of additional 'assurance reports'. These reports (or the information within them) are scrutinised in the first instance through our Groups, according to their Terms of Reference.

14.2 Performance Management Reviews - Care Group and Directorates

Formal Performance Management Reviews (PMR) between the Care Group Leadership Team and the Executive Directors are the formal checkpoint at which Care Groups are held to account for delivery of the annual plan. The reviews seek to ensure that each Care Group is balancing patient safety and staff wellbeing with financial and operational delivery and the overall sustained transformation and improvement of the Care Group.

An annual operational planning process is run between Executive Directors and Care Groups. The purpose of the annual operational planning process is to agree areas for delivery, improvement and transformation, and the underlying metrics that will form the basis of Care Group Performance Management Reviews / Directorate Performance Management Reports. Performance reviews also consider a summary of risks being managed by the Care Group.

Performance management review meetings are held quarterly with each Care Group tri/quadrumvirate, chaired by the Chief Executive and involve the Chief Operating Officer , Chief Finance Officer, Chief Nursing Officer, Chief Medical Officer, Chief Strategy and Transformation Officer, Chief Informatics and IT Officer and Chief People Officer. The purpose of these meetings is to scrutinise Care Group performance in the round. Critical issues will be escalated to the relevant forum if required, including quality and safety, operational performance, workforce

and finance. Where additional improvement support is triggered the frequency of meetings will move to monthly enhanced support meetings.

14.3 Overview of Performance Management Framework

Performance management forum	Accountability	Frequency	Performance information
Trust Board	Non-Executive Directors hold Executive Directors to account	Monthly	Integrated Performance Report (IPR)
Trust Board Committees	Non-Executive Directors hold Executive Directors to account supported by subject matter leads	Monthly/Quarterly	Quality, People and Culture, Finance and operational performance reports – as appropriate to the remit of the Committee
Care Group Performance Review	Executive Directors hold Care Group Boards to account	Quarterly and additional Monthly Enhanced Support Meetings as required	Care Group Performance Management reports
Care Group Boards	Care Group Boards scrutinise performance information and agree actions as appropriate	Monthly	Care Group Performance Management Report, including: Quality, workforce, transformation and finance reports as appropriate
Directorate/Specialty Performance Review Process	Care Group Boards hold directorate/ speciality teams to account	Monthly	Care Group Performance Management Report

14.4 Performance Management from Ward to Board

A range of Care Group performance reports are used for monitoring key performance indicators by the Care Group operational and clinical management team. They highlight Care Group performance against key targets and identify both:

- Areas of performance to be actively worked on to improve, achieve and sustain an identified target, and
- Areas of performance which still require monitoring and reporting and will continue to be addressed through 'Business as Usual (BAU)' but not actively 'problem solved' as a team unless the business rules dictate a change.

The principle of having focus on specific metrics is in recognition of limits to our resource and therefore this ensures that by identifying a smaller number of priorities we can ensure sufficient focus on addressing root causes and implementation of sustainable solutions. services doing well and those requiring further improvement and escalation to the Executive Team.

Performance against key national and local quality, operational, finance and workforce targets is reviewed at Care Group Board meetings as well as key Trust-wide groups. For example, Care Groups' operational performance against key constitutional standards is reviewed at the Operations and Performance Group monthly. Performance at service, department and ward level remains the responsibility of the senior management teams, through the service managers, matrons and specialty leads. The performance reports at Care Group and directorate/specialty level are the key tools for celebrating success and escalating issues to the quarterly performance review meetings (PRM) held with each Care Group.

14.5 Quality, Safety and Risk

The Trust has an established governance structure which is outlined in the Trust Quality Strategy and Risk Management Strategy. Quality reporting through these structures supports review, analysis and delivery of key metrics related to patient experience, safety and effectiveness of services up to the Board. Quality reporting is based on the CQC key lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led). Board and Board Committee reporting supports and integrates with wider quality assurance processes such as peer review, annual self-assessment and internal and external audit.

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

- Risk issues, mitigations and action plans.
- National requirements and performance against them.
- Investigation and learning reports (Trends – current and future risk, assurance and quality issues, Exception reporting and any associated risk based narrative commentary).
- Internal comparisons and external benchmarks where available.
- Directorate, specialty, ward and consultant level data where appropriate.

14.6 Finance

Achievement of the agreed financial plan is an important annual objective for the Trust and devolving responsibility for income and expenditure to Care Groups and Corporate Directorates is an appropriate and fundamental component. The Financial Management Accountability Framework which is attached at appendix 4 supports the Trust performance management and accountability framework to formalise and more clearly define what is expected of Care Groups and Directorates in terms of the signoff of their annual budgets and their in-year management. Importantly, it also details how the performance management regime will operate, noting how adverse performance from plan will be handled.

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

14.7 Workforce

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

14.8 Transformation and Improvement

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

There will be a Gateway Review process for every service reconfiguring, that follows a standard, evidence-based approach to ensure staff and services are patient ready to move in.

14.9 Operational Performance

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

- Cancer Performance Standards
- Emergency/Urgent care Standards
- Diagnostics (DM01)
- Referral to Treatment (RTT)
- Organisational flow
- Activity

15 Escalation, Oversight, Intervention and Support

15.1 The table below sets out the framework that we are working towards to ensure a consistent approach to escalation, oversight, intervention and support. This requires corporate teams to ensure the timeliness and accuracy of information to support Care Group Performance Management Reviews. This is aligned to our model of SPC and should be replicated at a Care Group level, by Care Group Boards.

15.2 Where performance is within the identified thresholds, management of any adverse performance remains within the remit of the Care Group Tri/quadrumvirate supported by the Care Group Board. Where performance is adverse, escalation, which may include additional oversight, intervention or support should be enacted.

Performance level	Characteristics of a Care Group/ Directorate at this level	Oversight frequency	Intervention to support recovery	Support provided
Low intensity support	Consistent delivery of KPI's across all domains of Quality, Workforce, Operations and Finance No 'special causes of concerning nature' (variation) or 'variation indicating consistent failing of targets' identified in SPC performance monitoring. Executive Team have confidence in the capacity to respond to and deliver any improvements required Review Meetings	Quarterly Executive Performance Management Monthly OPG assurance of operational performance Weekly Exec review of Operational Tracker for escalation issues	Earned autonomy. No interventions at this level, standard governance / performance management arrangements will apply.	Support if required, focussed on development opportunities
Medium intensity support	Delivery issues identified against some KPI's across the domains of Quality, Workforce, Operations and Finance Variation indicates 'inconsistent passing of targets'	Executive Performance Management Review Meetings Oversight of individual performance areas by relevant Executive Lead via monthly Executive Groups. Weekly Exec review of Operational Tracker for escalation issues	Interventions likely to be focused on supporting improvement in particular areas. Broader intervention may be deployed as deemed appropriate by the Executive Director / Care Group	Support focussed on specific improvement issues. Support may involve any of the points below – dependent upon the nature and level of risk

High intensity support	Consistent indications of 'special causes of concerning nature' or 'consistent falling short of targets' Likely to require significant support to achieve recovery. Executive team have limited confidence in the capacity/ability to deliver improvement without additional support and challenge	Executive Performance Management Review Meetings Oversight of individual performance areas by relevant Executive Lead via monthly Executive Groups with escalation to the relevant Committee as appropriate. Weekly meetings with the relevant Executive Lead/s as appropriate. Weekly Exec review of Operational Tracker for escalation issues	Development of comprehensive improvement plan, for approval of Executive Team Intensive oversight arrangements (as deemed appropriate / proportionate) Potential loss of autonomy Potential service / capability review	Support focussed on rapid quality / operational improvement. Lead Executive Director working with the team. Divisional triumvirate coached by Executive counterpart. Partnering with another high performer Support from corporate functions, i.e., Transformation, Performance, Quality Teams where appropriate External support / coaching where appropriate

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

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

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

15.4 Corporate functions - performance management

The Corporate Directors including Operations are held to account for their individual portfolios and objectives by the Chief Executive. Corporate functions' performance is measured through existing performance reporting at a corporate level e.g. financial and workforce information. The Corporate Directors are held to account by other Corporate functions as part of the whole Trust response to key indicators such as budget monitoring, vacancy control and absence management information. Corporate Services will be formally reviewed on a quarterly basis, in the same way as other clinical services/Care Groups. On request, Corporate Directorates may be required to present their performance and achievements directly to any of the Trust's relevant Committees

Appendix 1 - A diagram illustrating the Trust's governance structure

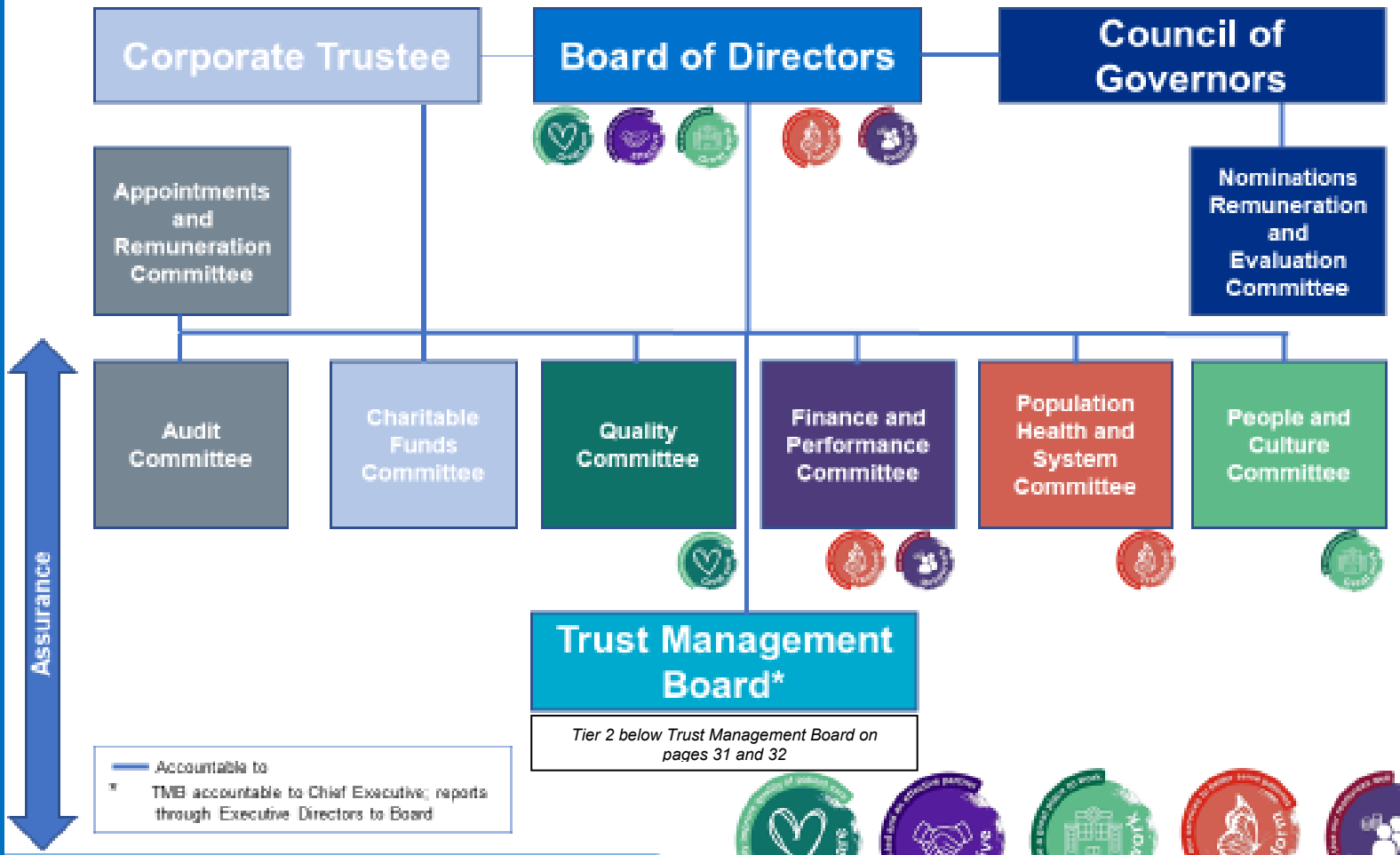
NHS
University Hospitals Dorset
NHS Foundation Trust

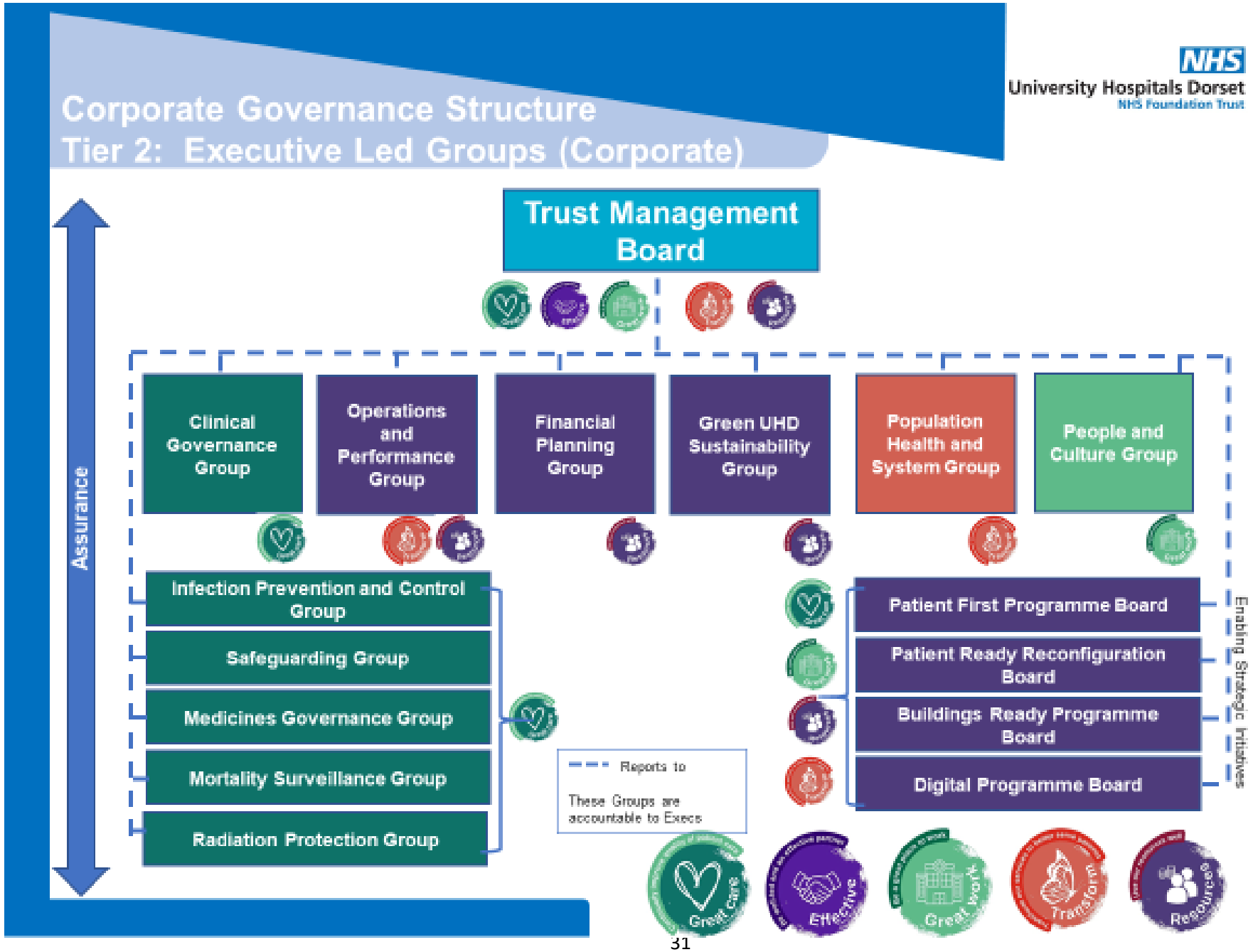
Corporate Governance Structure

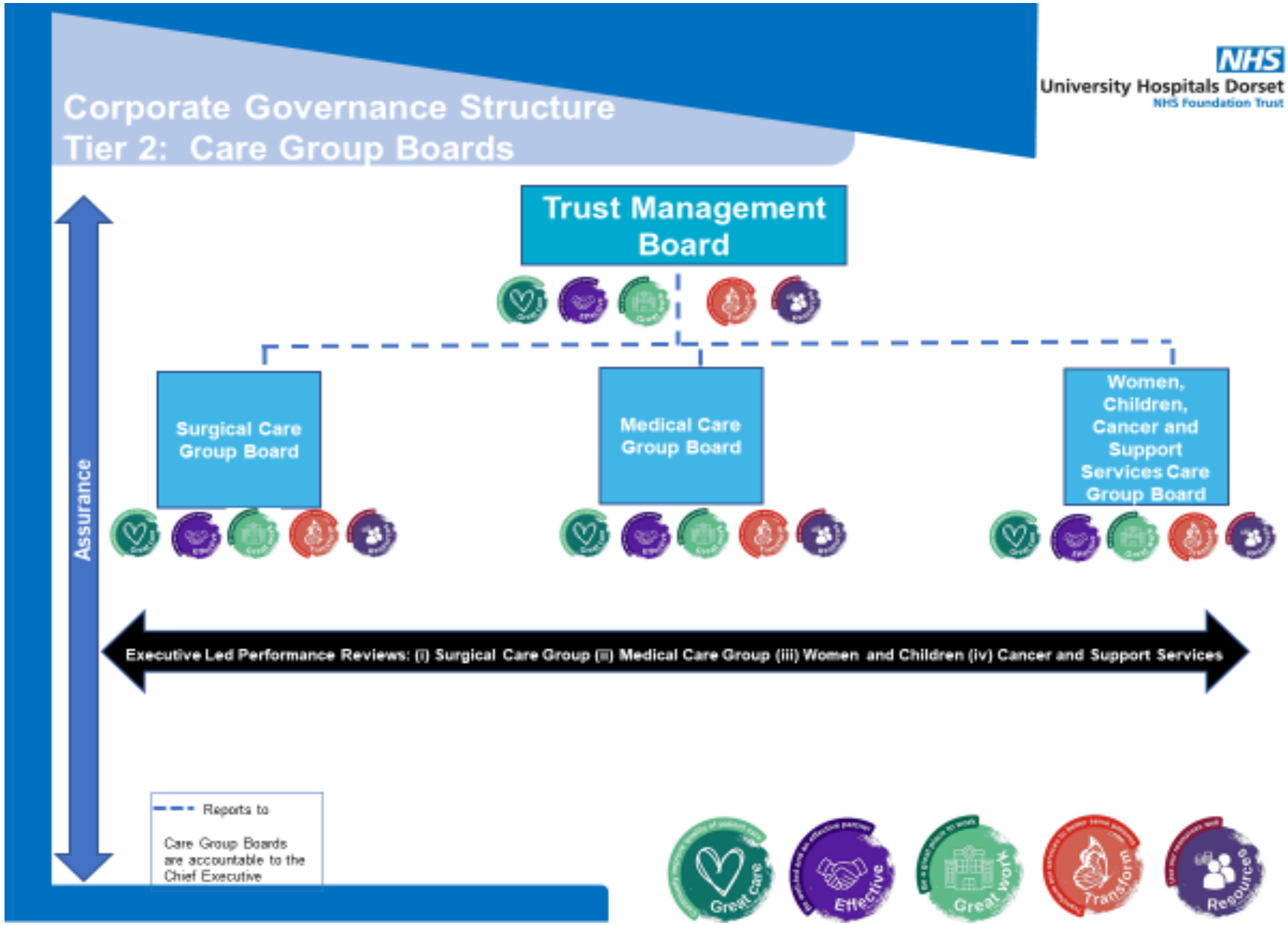
May 2023

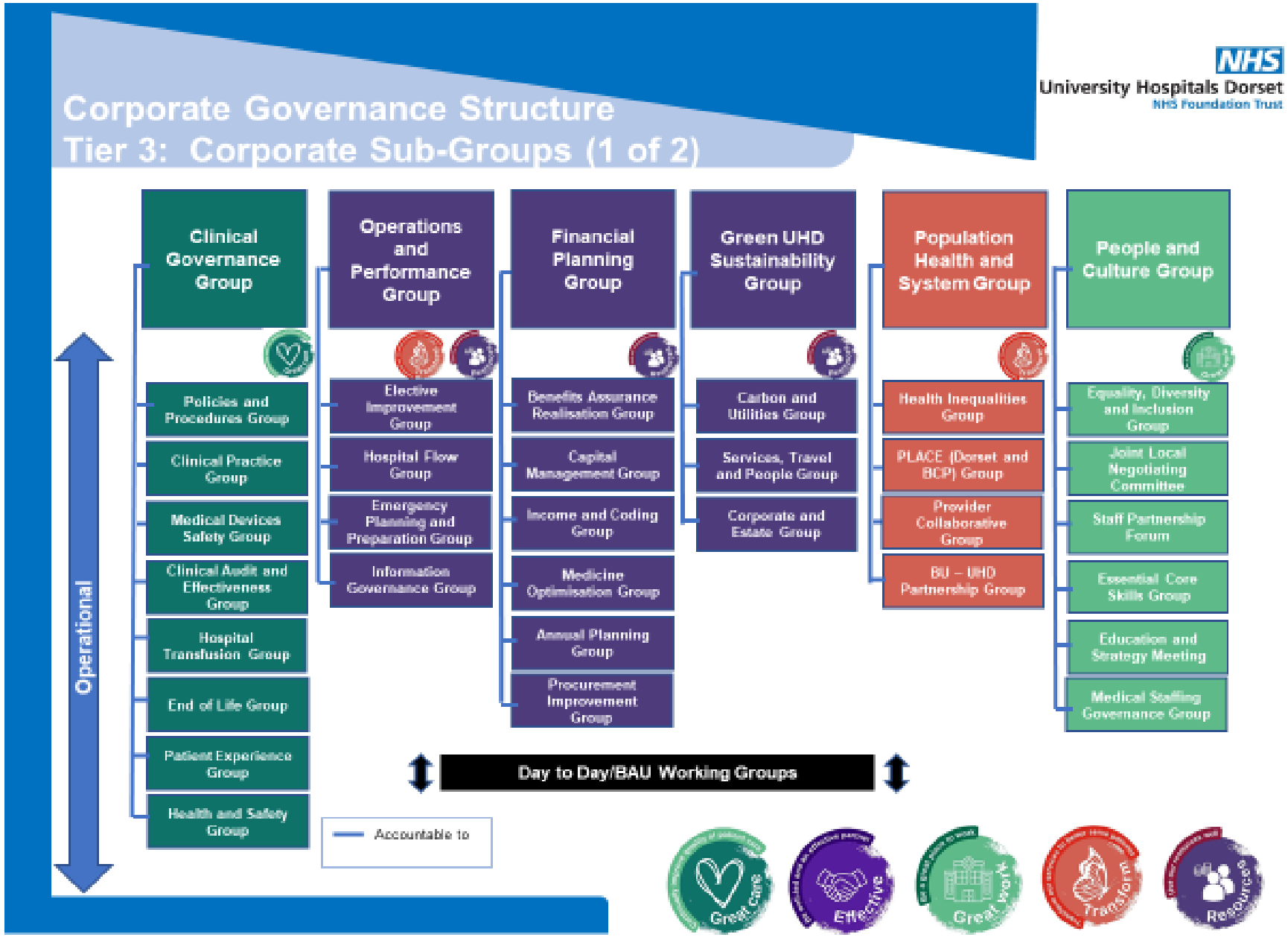
Corporate Governance Structure
Tier 1: Board and its Committees

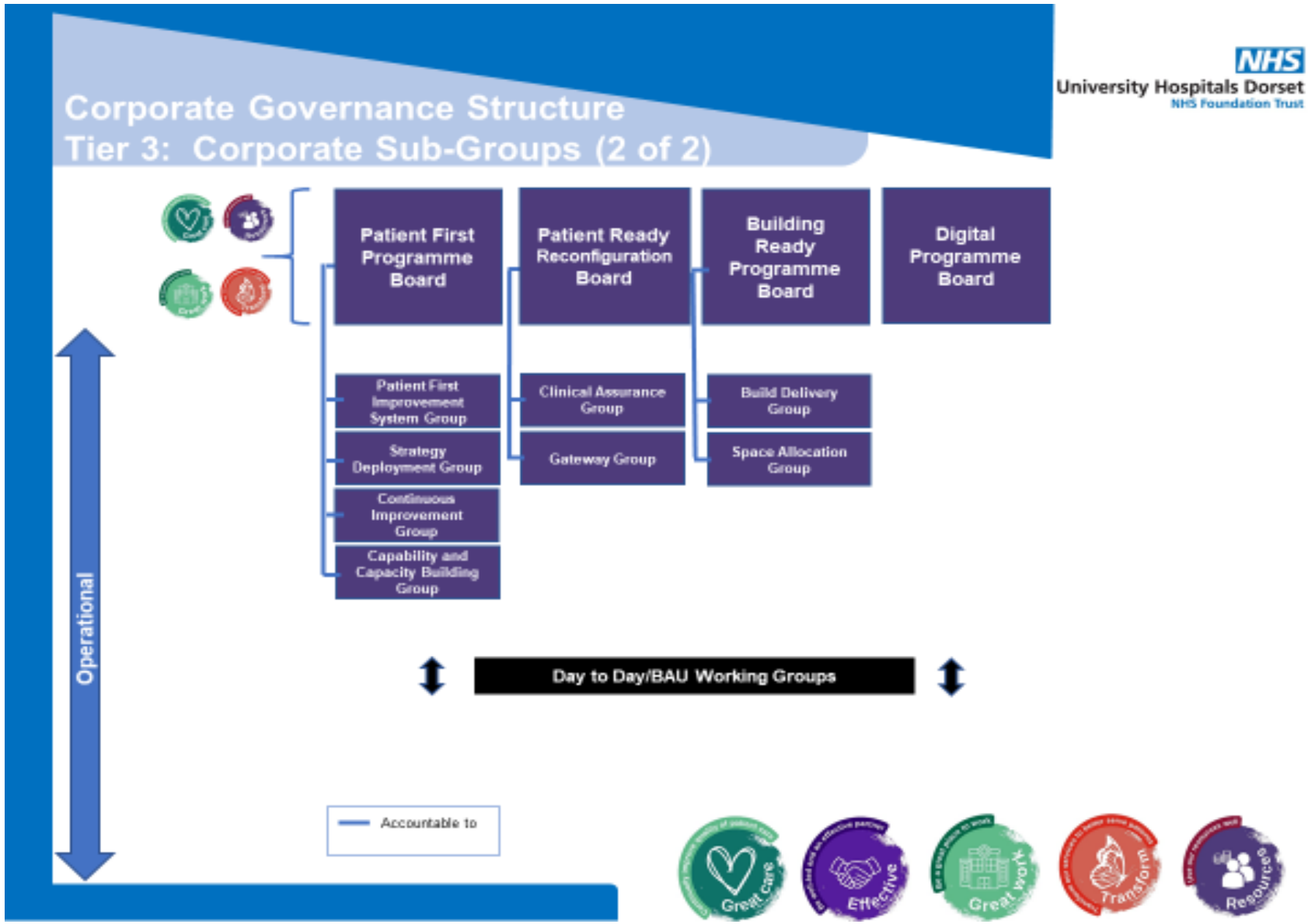
University Hospitals Dorset NHS Foundation Trust

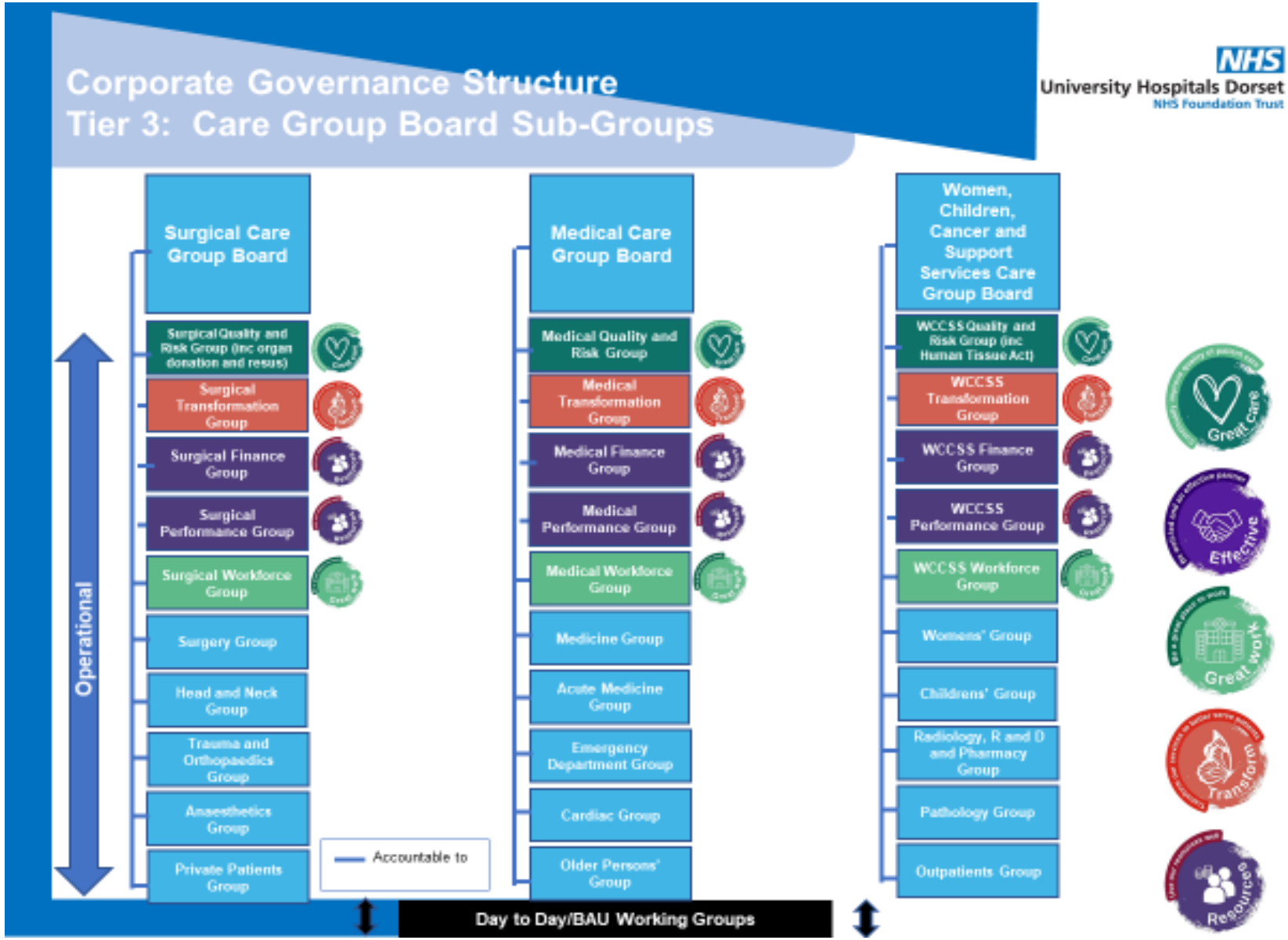



Corporate Governance Structure
Tier 2: Executive Led Groups (Corporate)
NHS
University Hospitals Dorset
NHS Foundation Trust
Trust Management Board
Assurance
Clinical Governance Group
Operations and Performance Group
Financial Planning Group
Green UHD Sustainability Group
Population Health and System Group
People and Culture Group
Infection Prevention and Control Group
Safeguarding Group
Medicines Governance Group
Mortality Surveillance Group
Radiation Protection Group
Patient First Programme Board
Patient Ready Reconfiguration Board
Buildings Ready Programme Board
Digital Programme Board
Enabling Strategic Initiatives
Reports to
These Groups are accountable to Execs
Great care
Effective
Great work
Transform
Resources


Corporate Governance Structure
Tier 2: Care Group Boards
NHS
University Hospitals Dorset
NHS Foundation Trust
Trust Management Board
Surgical Care Group Board
Medical Care Group Board
Women, Children, Cancer and Support Services Care Group Board
Assurance
Executive Led Performance Reviews: (i) Surgical Care Group (ii) Medical Care Group (iii) Women and Children (iv) Cancer and Support Services
Reports to
Care Group Boards are accountable to the Chief Executive
Great Care
Effective
Great Work
Transform
Resources


Corporate Governance Structure
Tier 3: Corporate Sub-Groups (1 of 2)
NHS
University Hospitals Dorset
NHS Foundation Trust
Clinical Governance Group
Operations and Performance Group
Financial Planning Group
Green UHD Sustainability Group
Population Health and System Group
People and Culture Group
Policies and Procedures Group
Clinical Practice Group
Medical Devices Safety Group
Clinical Audit and Effectiveness Group
Hospital Transfusion Group
End of Life Group
Patient Experience Group
Health and Safety Group
Elective Improvement Group
Hospital Flow Group
Emergency Planning and Preparation Group
Information Governance Group
Benefits Assurance Realisation Group
Capital Management Group
Income and Coding Group
Medicine Optimisation Group
Annual Planning Group
Procurement Improvement Group
Carbon and Utilities Group
Services, Travel and People Group
Corporate and Estate Group
Health Inequalities Group
PLACE (Dorset and BCP) Group
Provider Collaborative Group
BU – UHD Partnership Group
Equality, Diversity and Inclusion Group
Joint Local Negotiating Committee
Staff Partnership Forum
Essential Core Skills Group
Education and Strategy Meeting
Medical Staffing Governance Group
Operational
Day to Day/BAU Working Groups
Accountable to
Great Care
Effective
Great Work
Transform
Resources


Corporate Governance Structure
Tier 3: Corporate Sub-Groups (2 of 2)
NHS
University Hospitals Dorset
NHS Foundation Trust
Patient First Programme Board
Patient Ready Reconfiguration Board
Building Ready Programme Board
Digital Programme Board
Patient First Improvement System Group
Strategy Deployment Group
Continuous Improvement Group
Capability and Capacity Building Group
Clinical Assurance Group
Gateway Group
Build Delivery Group
Space Allocation Group
Operational
Day to Day/BAU Working Groups
Accountable to
Great Care
Effective
Great Work
Transform
Resources


Corporate Governance Structure
Tier 3: Care Group Board Sub-Groups
NHS
University Hospitals Dorset
NHS Foundation Trust
Surgical Care Group Board
Surgical Quality and Risk Group (inc organ donation and resus)
Surgical Transformation Group
Surgical Finance Group
Surgical Performance Group
Surgical Workforce Group
Surgery Group
Head and Neck Group
Trauma and Orthopaedics Group
Anaesthetics Group
Private Patients Group
Medical Care Group Board
Medical Quality and Risk Group
Medical Transformation Group
Medical Finance Group
Medical Performance Group
Medical Workforce Group
Medicine Group
Acute Medicine Group
Emergency Department Group
Cardiac Group
Older Persons' Group
Women, Children, Cancer and Support Services Care Group Board
WCCSS Quality and Risk Group (inc Human Tissue Act)
WCCSS Transformation Group
WCCSS Finance Group
WCCSS Performance Group
WCCSS Workforce Group
Womens' Group
Childrens' Group
Radiology, R and D and Pharmacy Group
Pathology Group
Outpatients Group
Operational
Accountable to
Day to Day/BAU Working Groups
Great Care
Effective
Great Work
Transform
Resources

Appendix 2 – Template Care Group Board Terms of Reference and Membership and Agenda

Template

[…] Care Group Board

Terms of Reference and Membership

Date

1. PURPOSE

The Care Group Board is the main senior leadership group of the Care Group, with delegated decision-making responsibility for defined areas, within the parameters of annual operating plans agreed by the Trust's Board of Directors and/or Trust Management Board (TMB) (and the Trust's Standing Financial Instructions).

The Care Group Board functions to support oversight, scrutiny and assurance at a Care Group level in accordance with the Trust's Accountability Framework. It is required to provide assurance to TMB about progress and performance in defined areas and do the work-up on recommendations to TMB about policy, resource allocation and change plans.

The Trust Management Board will receive the minutes of Care Group Board meetings.

2. RESPONSIBILITIES

The primary aim of the Care Group Board is to ensure scrutiny, assurance and delivery of all objectives / targets, to monitor, control and escalate risks as appropriate and develop and oversee implementation of strategies and plans for all services within the Care Group.

The Care Group Board shall provide advice to the Chief Executive and Chief Officers on the development of the Trust strategy, quality improvement strategy, development of services and any proposed capital investments. It will also monitor the performance of the Care Group, advising and agreeing any mitigating or corrective action as appropriate. This will include the following:

Strategy

- Oversee development and implementation of strategy and operational plans at a Care Group level and associated Key Performance Indicators (KPIs), ensuring the adoption of best practice where available.
- Develop and oversee implementation of an Annual Plan, aligned with priorities agreed through our Trust operational planning process and Patient First.
- Consult upon and agree any relevant policies, procedures, guidelines, standard operating procedures and protocols and monitor their implementation, where relevant, at a Care Group level.
- Oversee the annual business planning process and advise the Board of Directors via the TMB on the distribution of available resources.
- Review progress in delivering the Trust's transformation programme.
- Review and agree specific strategies prior to submission to TMB for approval. This may include the following:
    - The development of clinical services;
    - Trust's strategy on research and innovation;
    - Relationship management with external partners.

Performance

- Overseeing the delivery of the annual corporate objectives of the Trust, including the delivery of all financial, quality, access and other targets and standards.
- Receive assurance on the delivery of strategy and relevant key performance metrics, ensuring the appropriate allocation of resource.
- Monitor the operational systems and processes which ensure competent management within the Care Group.
- Identify, delegate and review relevant actions to improve performance.
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Performance Management Review process.

Risk Management

- Where relevant, monitor Root Cause Analysis / trends relating to adverse incidents, ensuring that appropriate action is taken, and lessons are learned (this may be delegated to the Care Group Quality & Risk Group although the Care Group Board will retain responsibility for oversight).
- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Strategy.

Governance

- Review clinical governance arrangements and performance, including meeting required clinical standards and recommend appropriate action.
- To review national legislation, guidance and best practice and address local implications of such guidance as appropriate.
- Oversee / monitor implementation of actions plans arising from internal / external review, audit, assessment or accreditation.
- Approve business cases, prior to their submission to, and approval by, the Trust Management Board or Board of Directors where appropriate.
- Undertake an annual self-assessment of effectiveness to inform any changes to Terms of Reference and Membership

3. MEMBERSHIP AND ATTENDANCE

3.1 Membership of the Care Group Board comprises:

- The Group Director of Operations (Chair)
- The Group Medical Director
- The Group Director of Nursing
- Directorate Managers and General Managers
- Directorate Clinical Directors
- Directorate Matrons
- Directorate Heads of Profession

3.2 In addition, it is expected that the following individuals will routinely attend the meetings:

- Finance business partner
- HR business partner
- Business intelligence representative

- Governance lead
- Transformation & improvement leads for the Care Group
- Communications representative

3.3 The Care Group Board will be chaired by the Group Director of Operations. In his/her absence, an individual nominated by the Group Director of Operations will take the chair.

3.4 Subject to paragraph 3.2 above, only members of the Care Group Board have the right to attend its meetings. If one of the individuals referred to in paragraph 3.1 or 3.2 above is unable to attend, he/she may exceptionally nominate a suitable deputy empowered to act in his/her place.

3.5 Members should aim to attend all scheduled meetings but are expected to attend a minimum of two thirds of meetings on an annual basis. The secretariat for the Care Group Board will maintain a register of members' attendance.

3.6 Other individuals may be invited to attend for all or part of any meeting, as invited by the Chair. The Chief Medical Officer, Chief Nursing Officer and/or Chief Operating Officer may attend meetings of the Care Group Board by prior notice to the Chair.

4. CONDUCT OF BUSINESS

4.1 The Standing Financial Instructions of the Trust, as far as they are applicable, shall apply to the Care Group Board and any of its meetings.

4.2 The Care Group Board will normally meet monthly and at such other times as the Chair shall require. Executive Directors (or some of them) will attend meetings of the Care Group Board on a quarterly basis.

4.3 Meetings of the Care Group Board shall be quorate if there are at least eight members present with representation required from all Directorates and the Care Group senior management tri/quadrumvirate.

4.4 Meetings of the Care Group Board shall be called by [ ] at the request of the Group Director of Operations.

4.5 [ ] is responsible for preparing the agenda for agreement by the Chair. [ ] shall collate and circulate papers to Care Group Board members. Unless otherwise agreed by the Chair, the agenda and papers should be circulated not less than five working days before the meeting.

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

4.7 Proceedings and decisions made will be formally recorded by [ ] in the form of minutes, which shall be submitted to the next meeting of the Care Group Board for approval.

5. RELATIONSHIPS & REPORTING	
5.1	The Care Group Board is accountable to the Chief Executive for the operational management of the Trust to meet the Trust's corporate objectives and the implementation of its strategy and policies.
5.2	Care Group Board members will be responsible for ensuring that staff within their areas of responsibility, are kept appropriately informed about Care Group and Trust issues.
6.	**MONITORING**
6.1	Attendance will be monitored at each meeting of the Care Group Board. A matrix (see example in the Appendix to these Terms of Reference) of membership attendees will be used for monitoring purposes.
7.	**REVIEW**
7.1	These Terms of Reference will be reviewed annual or sooner if appropriate.

Template

[….] Care Group Board

Agenda

Meeting held on xx20xx at xx [time]

Venue, site or via Microsoft Teams

Time	No.	Agenda Item	Purpose	Lead	Format
		PROCEDURAL ITEMS			
	1.	Chair's Welcome, Apologies and Quoracy	Information		Verbal
	2.	Declarations of Interest	Assurance		Verbal
	3.	Minutes of the Meeting held xx 2022	Approval		Enclosure
	4.	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	5.	Feedback from TMB	Information		Verbal
		RISK MANAGEMENT			
	6.	Risk Register – including risks scoring 8 and above			
		HIGH QUALITY			
	x.	Care Group Quality and Governance Committee Highlight Report (date)	Assurance		
	x.	Executive Quality committee report	Information		
	x.				
		PEOPLE			
	x.	Care Group Workforce and Culture Committee Highlight Report (date)	Assurance		
	x.	Executive People and Culture committee report	Information		
	x.				
		RESOURCES			
	x.	Care Group Finance Report	Assurance		
	x.	Business Cases (ad hoc)	Approval		
	x.				
		RESPONSIVE			
	x.	Business and Performance Committee Highlight Report (date)	Assurance		
	x.	Executive Finance and Performance Committee report	Information		
	x.				
		IMPROVING AND INNOVATING			
	x.	Care Group Transformation Steering Group highlight report	Assurance		
	x.				
		SYSTEMS AND PARTNERS			
	x.				
	x.				
		CLOSING MATTERS			
	x.	Review of meeting effectiveness			Verbal
	x.	Items for celebration			Verbal
	x.	Agreement of Items for Escalation to Executive Groups			Verbal
		Any other business			Verbal
		DATE AND TIME OF NEXT MEETING			

[…] CARE GROUP BOARD - MEETING ATTENDANCE RECORD

NAME OF COMMITTEE:	Xx Care Group Board											
REPORT TO :	Trust Management Board											
Membership (as per Terms of Reference). Please give names and/or full job title below:	**MEETING DATES**											
	January	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Was the meeting held in quorum? (Please refer to Terms of Reference) Y / N												

Notes
1. Please include names and titles of any staff deputising at individual meetings, and indicate who they are deputising for

Appendix 3 – Performance Management Framework (KPIs) Integrated Performance Report

Under development

NHS
University Hospitals Dorset
NHS Foundation Trust

Financial Management Accountability Framework

Introduction

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

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

Context

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

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

Purpose

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

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

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

Financial Risk Appetite

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

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

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

financial plans.

Financial Management Accountability Framework

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

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

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

Care Groups	Corporate Directorates	Finance Directorate
Chief Finance Officer Chief Operating Officer Group Director of Operations	Chief Finance Officer Corporate Chief Officer	Chief Executive Chief Finance Officer

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

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

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

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

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

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

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

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

Risk ratings will be defined using the following criteria:

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

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

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

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

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

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 10.2.1

Subject:	Freedom to Speak Up Annual Report 2022/23
Prepared by:	Helen Martin, Freedom to Speak Up Guardian
Presented by:	Helen Martin

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☒ Use resources efficiently ☐ Be a well led and effective partner ☒ Transform and improve ☒
BAF/Corporate Risk Register: (if applicable)	BAF/ not applicable
Purpose of paper:	Information
Executive Summary:	The purpose of annual report is to: • Review our Speaking up culture over 2022/23 and • understand why our staff are raising concerns and what we have learnt.
Background:	Every Trust is mandated to have a named FTSUG in post and an expectation as part of the well led domain, to see FTSUG reports submitted at least 6 monthly to enable the board to maintain a good oversight of FTSU matters and issues. Reports are to be presented by the FTSUG in person. Reports must include both quantitative and qualitative information and case studies or other information that will enable the senior team to understand the issues being identified, areas for improvement, and take informed decisions about action.
Key Recommendations:	• Seven years have passed since the publication of the Francis Freedom to Speak Up Review. • Progress during 2022 including Speaking up Month, internal and external activities, new FTSU model with fixed term FTSUG deputy. • Of note; poor uptake of Speak Up, Listen Up, Follow Up', e-learning modules. Comms campaign in place and including in all inductions/other e-learning packages. To review uptake 6mths. • Staff Survey (2022) - less staff at the Trust felt that they had a voice that counts than 2021. All 4 speaking up questions show a deterioration including feeling secure and addressing concerns. 46.3% vs 50.1%.

	• Case headlines; number of FTSU referrals increased by 20% from 2021/22. • 42%: 58% (Poole: RBCH). • Five per cent of referrals were made anonymously (same as 2021/22 and lower than national). • The greatest FTSU theme had an element of behaviours (108 staff; 39%) followed by process and procedures (95 staff; 34%) and then worker safety and wellbeing (68 staff; 24%). Same trends for Ethnic minority staff • 18% of staff from ethnic minority raised FTSU concern. • 42% of cases were escalated to the line manager to investigate and action. 33% to experts, 9% senior escalation • Nurses accounted for the biggest portion (37%) of FTSU cases, followed by our administrative staff (25%) and medical workforce (8%). • Lowest referrals from operations (15), surgery (41), specialities (68), Medicine (69), Corporate (71) • Future work in areas with low FTSU referrals and poor staff survey speaking up questions (emergency, cardiology, surgery and pathology). • Learning; civil and respectful culture, support during organisational change and share learning, Explore working patterns Improve clinical engagement and behaviours. Encourage Compassionate and Inclusive leadership programmes and Management Modules Encourage FTSU e-learning modules psychological safe working environments Develop a racial statement with a strong infrastructure. Contribute, embrace and be involved in our Patient first programme.
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 ☐ Speaking up is everyone's business. Sharing the learning and reflections is essential for us to embed speaking up in the culture of UHD.

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

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
People and Culture Committee	10/05/2023	Committee noted the report
Trust Management Group	09/05/23	Trust Management Group noted the report

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

Freedom to Speak Up (FTSU)

Annual Report 2022/23

1.0 Introduction

> The Freedom to Speak Up movement has been a catalyst for positive change but there is still much more to be done. Together we can build upon the foundations of the past five years, and give the workers and the people we serve, the services they so richly deserve.
>
> **Dr Jayne Chidgey-Clark**
> National Guardian for the NHS

National Guardian Annual Report 2022/23.

Seven years have passed since the publication of the Francis Freedom to Speak Up Review. The speaking up culture within the health sector in England has changed with a network of over 800 Freedom to Speak Up Guardians (FTSUG) hearing over 75 000 cases in the last 4 years. Such an increase of cases reflects how trusted FTSUG are as additional channel for speaking up.

Speaking up benefits everyone. Building a more open culture in which leadership encourages learning and improvement, leads to safer care and improved patient experience. At UHD, we have many routes that our people can use to speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route which is both well used and evaluated by staff whom use it.

Despite these routes, we are hearing that some staff do not feel they are able to speak up and when they do, we do not address the concerns. Indeed, our staff are feeling less confident from previous years. This is not a position we want to be in and so there is clearly more work for us to do to collectively create a speaking up culture and meet our vision and values (refer to section 2.0). This work is however more than the FTSU team. Their role is to highlight the challenges and effectively act as an early warning system of where failing might occur. Our leaders need to play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture at UHD. Indeed, it is the experience of how our managers listen and act to concerns that we are often judged. Over 50% of staff whom come to the FTSU team is because their line manager is the issue or that they are not addressing it. We need to better at this for us to be an embedded speaking up organisation.

Twenty-twenty three is going to be an exciting year. Not only do we have a challenging strategy recently agreed by our board, but we have the approval for another FTSU guardian to join the team. This will now allow us to meet our current demand but also act in a proactive way and help address the barriers to speaking up better and contribute to larger projects such as civility. It will also make the team more resilient and be able to plan for the future. Twenty-twenty three is also the year that UHD will commence its exciting Patient first

programme. Patient First will help us all by improving the way we work. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients. Speaking up is integral to this work and we look forward to supporting this moving forward.

This annual report will remind us of how far we have come over 2022 in terms of speaking up and how alongside larger cultural programmes we can reset and focus on improving the experience of our NHS workers and ultimately the care they give our patients.

The purpose of this paper is to review our speaking up culture over 2022/3 and understand why our staff are raising concerns and what we have learnt.

2.0 Vision of Speaking up and Commitment from the FTSU team

Supporting you to raise concerns
Freedom to speak up

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

2.1 Speaking up at UHD – A new structure following NGO guidance

In February 2023, the Board and Charity committee approved the recruitment of another fulltime FTSUG, This decision was made in line with guidance set out by the National Guardian Office (NGO) on developing FTSU internal networks. This development will allow the service at UHD be both sustainable and resilient, meeting the demands of our staff using the FTSU route, but also allow us to contribute to the organisation overcoming the barriers that result in workers feeling that they must come to a guardian in the first place. This is an exciting opportunity which will build on our FTSU network of Ambassadors set up since 2018. This network raises awareness and promotes the value of speaking up, listening up and following up and helps address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

3.0 Key Progress during 2022/23

3.1 Speaking up – Our Senior Leaders

Every year our board take time to reflect and publicly commit to the Sir Robert Francis principles of speaking up, alongside a declaration of their behaviours. This commitment was made in September and is a visual statement, reminding us that the board commit to speaking up and to developing a culture of safety. The declaration of behaviours sets out how the board will role model this and sets the tone of the culture for UHD.

The FTSUG remains fully supported by the board and speaking up arrangements with direct access in place. The FTSUG role is complex and often isolating. In a recent NGO FTSUG survey (2022) almost half felt that their role as FTSUG reduced their emotional and psychological wellbeing. At UHD the FTSUG has a number of internal and external support including our senior team. Our Executive lead, Siobhan Harrington and our Non-Executive Director, Pankaj Dave lead this work alongside the FTSU team.

We plan to work together in 2023 at a board development session, taking time to assess where we are in terms of speaking up, where we need to be and how our senior leaders can support it.

3.2 Speaking up Month – October 2022 Reflections

Speak Up Month is the highlight of our calendar and is a chance to raise awareness of speaking up and the work which is going on to make speaking up business as usual. This October, we celebrated the fifth Speak Up Month and the theme this year was “Freedom to Speak Up for Everyone” with each week having a specific focus including safety, civility, inclusion and for everyone. Throughout the month we promoted the importance of speaking up through written articles, visual flags, post it notes, pens and literature, videos from our executives and staff who have used the service and worked alongside our staff networks jointly walking our clinical and non-clinical areas with our award winning decorative roaming trolley (NGO, 2017 runners up in the

National Communications Category). Nearly 20,000 social media hits occurred from this work which no doubt contributed to a 79% increase of referrals to the FTSU team during October. Staff who raised issues in October to the FTSU team reflected similar themes to that reported and presented in previous reports this year. Saying that however, there was a noticeable increase of referrals regarding colleagues with more longstanding and complex behaviours and our wellbeing (including workload and burnout).

3.3 FTSU Networks – "Looking in and out"

Our networks are key to our success in sharing the speaking up message but also as a support for each-other. We have several networks which continue to grow and mature.

3.3.1 UHD FTSU Network: Our FTSUA network meets monthly and discusses our observations and recent guidance. It allows us to quality assure the work we are doing and more recently focus on updating and reviewing the model going forward. We have planned a programme of work for 2023 including some personal development in September.

3.3.2 South-west regional Network: The NGO also recognises the need to develop and engage within formal regional networks. UHD has been co-chair for this network since 2020 and chairs quarterly regional meetings, six weekly check ins and mentoring for new guardians. This network is excellent for support and sharing good practice.

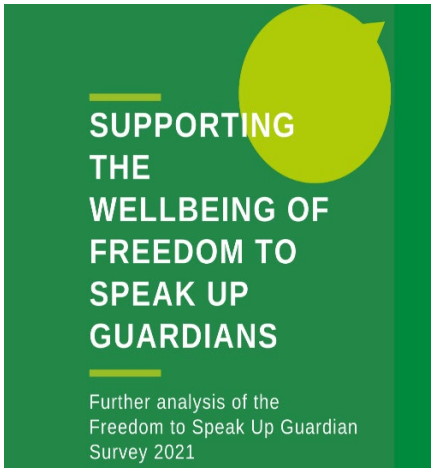
3.3.3 Dorset FTSU Network: UHD set up and chairs this network since September 2018. The vision of this group was agreed to share best practice and act as mentors for difficult cases. The membership has since expanded and now has representation across CCG, private healthcare, ambulance service, acute trusts and our regional lead for NGO. The focus of these meetings has consequently changed to supporting speaking up across our multi-agency systems in Dorset.

3.4 National Guardian Office (NGO)

The NGO was created in response to recommendations made from Sir Robert Francis review in 2015 and leads, trains and supports a network of FTSUG in England. There are now over 800 FTSUG in NHS, independent and third sector organisations and national bodies. The office provides challenge and learning to the healthcare system as a whole, and conducts speaking up reviews to identify learning and support improvement.

3.4.1 National NGO Key Documents over 2022/23

3.4.1.1.FTSUG Survey (June 2022)



FTSUG survey looked in more detail at the responses from guardians about their wellbeing and the support available to them. Just over half of FTSUGs who responded to the survey said that their role can negatively affect their emotional well-being. Yet when they are able to effect positive change, the role can be the most fulfilling. A key message from the results highlighted again the importance of adequate ring-fenced time for carrying out the FTSUG role.

At UHD, the FTSUG has strong support from a number of sources including Board members, line manager, clinical supervision, network and national guardian support and FTSU team.

3.4.1.2 Speaking up Policy (June 2022)

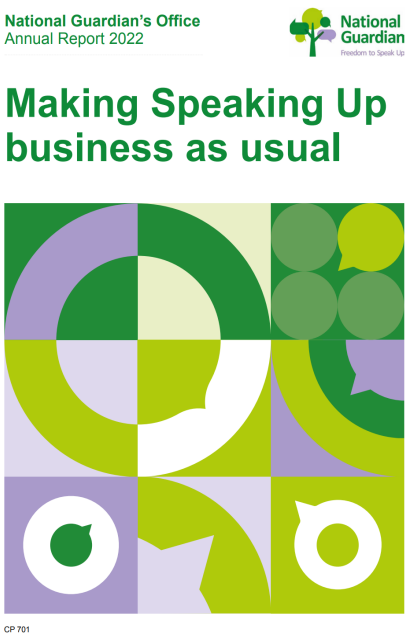
NHS England published an updated national Freedom to Speak Up policy to be adopted by all Trusts by January 2024. The policy provides a minimum standard with space to add local information. It is designed to help organisations deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement.

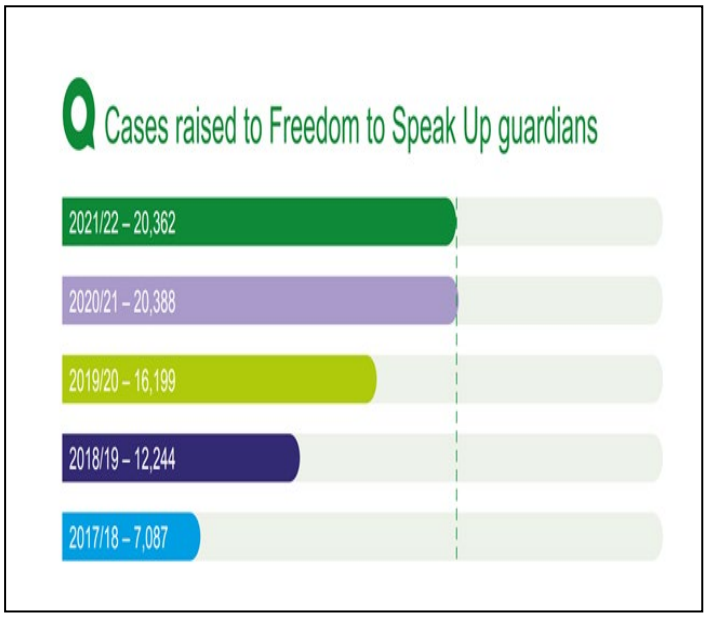
This Policy has been assured by People and Culture Committee in February and is anticipated to be approved and in place by May.

3.4.1.3 NHS England and NGO: A guide for leaders (June 2022)

In June 2022, NHS England and NGO updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool. This document was designed develop a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement. A number of expectations from these publications will need to be evidenced by January 2024 and UHD are on track to meet these.

3.4.1.4 NGO Annual Report; 2022 (February 2023)





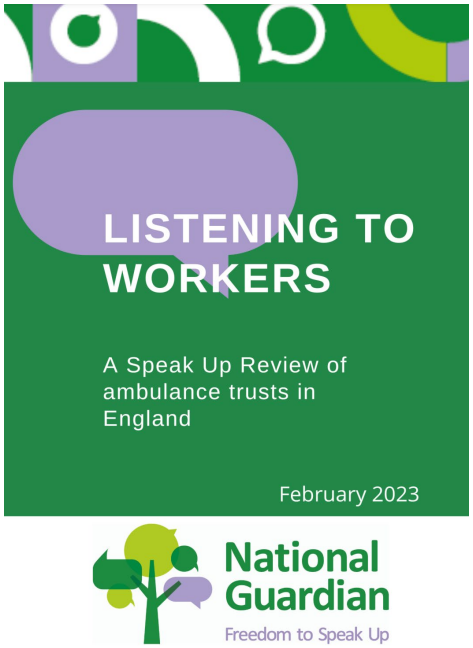
The NGO has published its annual report in March 2023 highlighting the activity and themes of speaking up across healthcare for 2021/22. Key points from the annual report are illustrated below and are benchmarked against our position at UHD.

Table 1: National and local key data from 2021

National Data (2021/22)	**UHD data (2021/22)**	
Over twenty thousand (20,362) cases were raised and remain at pandemic levels. This is seen at UHD	Similar trend seen at UHD. 2020/21 – 238 cases raised to FTSU team 2021/22 – 232 cases 2022/23 – 279 cases	
The percentage of cases raised anonymously decreased to 10.4%	5%	
Nineteen per cent of cases raised included an element of patient safety, a slight increase on 2020/21	5%	
13.7% of cases had an element of worker safety	15%	
Poor behaviour remains a cause for concern, with the highest proportion of cases. Over a third (32.3%) includes an element of behaviours. This is a rise from 30.1% in 2020/21	47%	
Reported detriment for speaking up has increased to 4.3% from 3.1% in 2020/21	1%	

Table 1 above highlights how UHD benchmarks against national data and shows that those cases raised to the FTSU team at UHD are related more to worker safety and wellbeing with elements of poor behaviour. Those cases raised anonymously and with reported detriment are below that seen nationally as are those cases with elements of patient safety. In terms of number of cases, UHD continues to increase in those staff using it as an avenue to raise concerns and as table 2 illustrates, above like sized trusts across the country and also that seen locally.

3.4.1.5 A Speak Up Review – Ambulance Trusts (February 2023)



This report reviewed the speaking culture of NHS ambulance trusts in England and found that it did not support workers to speak up and that this was having an impact on worker wellbeing and ultimately patient safety. The NGO recognised that NHS Ambulance Trusts appeared be more challenged compared to other trust types and calls for an independent cultural review with Ministerial oversight.

The Speak Up review heard from a number of ambulance workers, ex-workers, managers and senior leaders of their experiences of a culture of bullying, harassment and discrimination which contributed to not feeling able to speak up for fear of retaliation. Workers spoke about cliques between directors, managers and workers which was stopping people feel able to speak up. The fear of the consequences was one of the main barriers to people speaking up about anything getting in the way of delivering great patient care. Those who did speak up, often faced intimidation or inaction as a result.

The report summarises the key findings of the review into five themes: Culture of ambulance trusts, Leadership and management, Experience of people who speak up, Implementation of the Freedom to Speak Up guardian role, Role of system partners and regulators. The target-driven, command and control environment of ambulance trusts meant that Freedom to Speak Up – and by extension – workers' wellbeing, was often not viewed as a priority by leadership.

Recommendations and learning for us at UHD include mandating training Speaking up Modules, implementing a robust just culture, tackling bullying and harassment including discrimination.

3.4.2 NGO data

UHD continues to be an active contributor to the work from the NGO. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, census information and other surveys.

Quarterly information about speaking up cases are submitted to the NGO, outlining the themes and reporting the feedback received from those cases closed. Whilst number of referrals does not fully reflect the speaking up culture it does illustrate whether the FTSU is an established route for staff to use. Table 2 below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 2: Quarterly NGO data submissions 2022/23 (x = no data submitted to NGO)

2022/23	Size	Qtr1	Qtr2	Qtr3	Qtr 4	TOTAL
Dorset County	Small	8	14	7		**29**
Dorset Healthcare	Medium	27	26	43		**96**
Salisbury	Small	31	31	42		**104**
Solent	Medium	7	24	25		**56**
University Hospitals Dorset	Medium	55	65	93	66	**279**
University Hospitals Southampton	Large	15	x	x		**15**

This data validates the recent investment of the FTSU team, improving our sustainability and resilience. Investing in another fulltime position will also allow the team to meet the reactive work (listening to workers) and build on contributing to proactive work (supporting the organisation to learn from the opportunities that speaking up brings and tackling the barriers). Speaking up will not become business as usual if FTSGU are spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place.

Table 2 does however create some questions. Why do our staff use the FTSU route when raising concerns? An initial hypothesis was a product of significant staff changes in management following a Tiers 1-3 re-structure, resulted in staff being unaware of whom to escalate issues to. This hypothesis continues however not to be the case. Data for 2022/23 shows us:

- Fifty-eight per cent of referrals to the FTSU team are because either their line manager was the issue of the concern or that the line manager was aware of the issue but not addressing the issue. This trend is mirrored in the staff survey (2022) Q23f, where 46.3% reported saying that they are confident issues would be addressed as compared to 50.1% in 2021. Question 23f is highly regarded to reflect a speaking up culture (refer to section 3.7).
- Twelve per cent staff reported that the reason they came to the FTSU team was because they felt insecure in raising concerns with line managers. A culture of speaking up needs a strong foundation of psychological safety and so needs to be monitored.
- A more recent trend is staff are using the FTSU route for advice prior to escalating themselves via the correct route. Twenty-six per cent of staff knew what they needed to do but wanted a confidential, impartial viewpoint to draft their thoughts.

3.4.3 NGO: Freedom to Speak Up training programme

'Speak Up, Listen Up, Follow Up', is an e-learning package, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

There have been 121 people who has accessed the training, approximately 2% of the Trust. This is disappointing and needs further addressing and promotion. Conversations have occurred with our leadership training team as speaking up and creating psychologically safe space is essential toolkit for our line managers and leaders. Other Trusts have mandated this training. We need to be mindful that following recent NGO Speak Up review with the Ambulance Trusts these packages were mandated for all staff. At UHD we have agreed to complete another focused communications campaign in spring 2023 and implement them into core induction programmes such as Trust induction, preceptorship, medical and international educated programmes.

Ruth's reflections

with Dr Ruth Williamson

Anniversaries, appraisals, research, and recipes...

This month it's my birthday - so there will be cake.

It's also my annual appraisal this week - a time to look back and reflect, to check my mandatory training is up to date and set some goals for next year.

This year on top of the mandatory training I've added some things to my 'heart'. While radiation safety is probably not part of many of your roles, the Freedom to Speak Up (FTSU) modules and the patient safety syllabus are relevant to all of us and quite interesting. They are interactive and take you through what our FTSU guardian does and also have modules for people managers and senior leaders.

Similarly the patient safety syllabus has bits for all of us. For me the key is creating a no blame culture when things go wrong. I chair a couple of learning panels most weeks and am acutely aware that no one comes to work for things to go wrong. One of our most common incidents is patient falls and I read an interesting paper a couple of weeks ago about how the layout of rooms can influence falls risks - it's a long paper and raises as many questions as it answers but with a new build and new patient rooms coming it is food for thought.

Further evidence from Liverpool where they've moved to single rooms for patients has shown a reduction in length of stay. Read more here.

While we are talking things academic, I'm going to flag a couple of things relating to our university partnership. Firstly, we have a Level 7 (Masters) apprenticeship running for its second year in September 2023 - see page 16 for details.

Secondly, the BU biomedical science course is now IBMS accredited. Our biomedical sci... function, do a transfusion, diagnose cancer and many many more things we take for granted so it's great that they can now train and accredit locally. Healthcare Science Week is coming up - read more on page 17 - and there's a national webinar on 15 March where you can learn more about the incredible work done by this diverse group of staff.

I promised you cake... Jane Bruccoleri-Aitchison, my partner in crime for Ask Me, is partial to a bit of coffee and walnut, but I'm more of a lemon drizzle fan so here's a couple of recipes.

Classic '4-4-4-2' lemon drizzle recipe (in old money four ounces of butter, sugar and flour plus two eggs) scaled up and modernised by the queen of baking Mary Berry - top tip don't let the drizzle boil as you warm it as that makes it bitter.

it up and make up for the missing egg colour.

And for Jane - coffee and walnut cake.

Buon appetito!

Ruth

In the March 2023 Core Brief, our Acting Chief Medical Officer used her reflections article to encourage all staff to complete their FTSU module training. This unprompted action sends a clear signal that speaking up is important for us becoming a speaking up culture.

3.5 Freedom to Speak Up Strategy at UHD

There is an expectation from National Guardian Office (NGO) that each Trust has a clear, robust and ambitious FTSU improvement strategy articulating our speaking up vision and goals. The strategy at UHD was built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy which will have planned progress updates. The strategy was signed off by the senior team/board in January 2023 and will be part of a communications programme over the Spring to ensure full buy in from managers and ensure its successful delivery.

3.6 NHS Staff Survey

The NHS Staff Survey is aligned to the People Promise which sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

1. We are Compassionate and inclusive
2. We are recognised and rewarded
3. **We each have a voice that counts**
4. We are safe and healthy
5. We are always learning
6. We work flexibly
7. We are a team

The results of the NHS Staff Survey are now therefore measured against these seven People Promise elements and sub-scores, which feed into the People Promise elements. 4167 staff at UHD took part in 2022 NHS staff survey, giving us a response rate of 45.5% and an increase from the previous two years.

Speaking up is measured within the People Promise Element "We each have a voice that counts". There are 2 sub-scores within this element of which raising concerns is one of these. All of the scores are on a 0-10 scale, where a higher score is more positive than a lower score. With this in mind, table 3 and graph 1 show us that less staff at UHD felt that they had a voice that counts as compared to 2021.

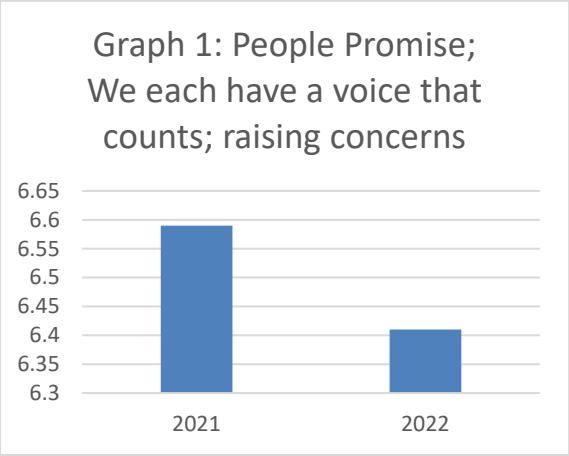
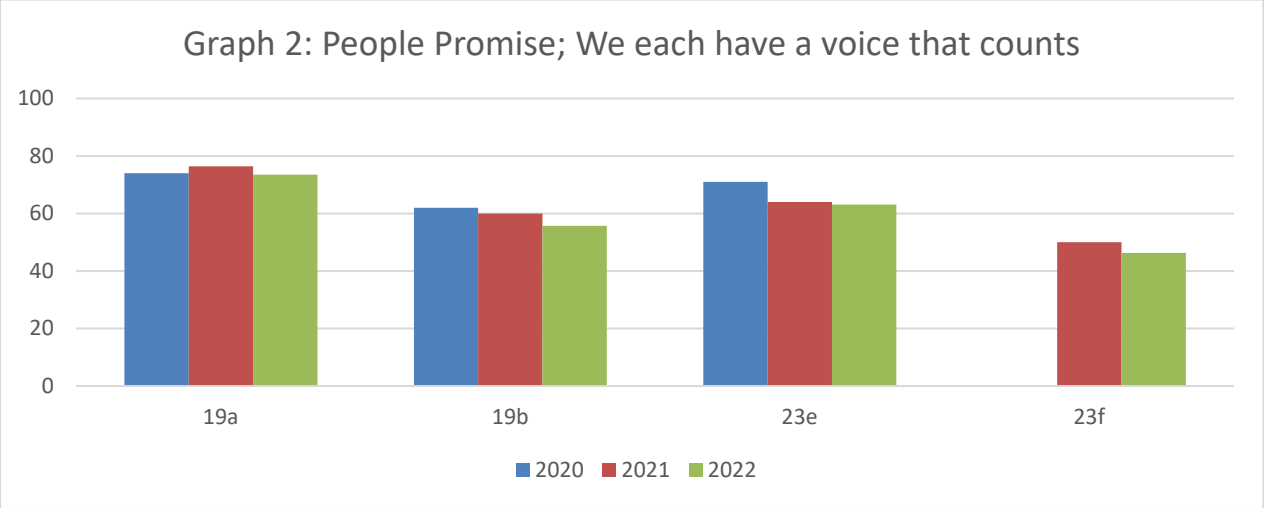


Table 3: People Promise 3, sub-score 2

We each have a voice that counts; Raising concerns		
UHD	**2021**	**2022**
	6.59	6.41

To understand exactly which factors are driving the raising concerns sub-score, a number of questions feed into it and are represented in Graph 2. You will notice that in all 4 questions there is a deterioration; a reduction in staff feeling secure, confident and safe to speaking up. Indeed, question 23f, which is highly regarded to reflect a speaking up culture, shows that 46.3% of staff whom completed the staff survey felt UHD nurtured a speaking up culture as compared to 50.1% in 2021.

A full discussion of the data was presented at the February People and Culture committee and the where observations and variations across UHD were highlighted.

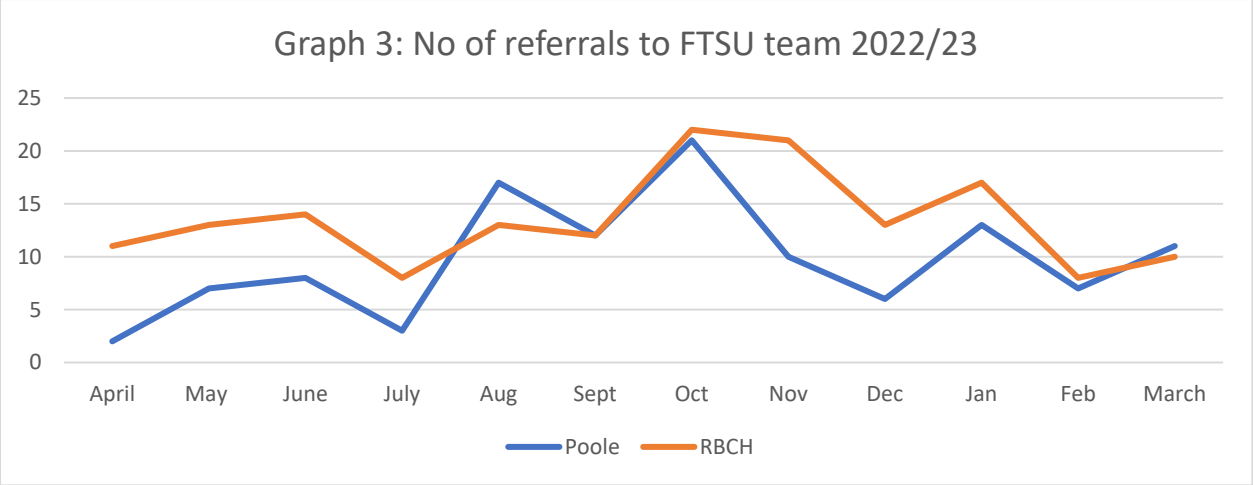


Q	Speaking up - clinical safety
19a	I would feel secure raising concerns about clinical practice
19b	I am confident that my organisation would address my concern
	Speaking up -raising concerns
23e	I feel safe to speak up about anything that concerns me in this organisation
23f	If I spoke up about something that concerned me, I am confident my organisation would address m concern

4.0 Case Referrals – the headlines

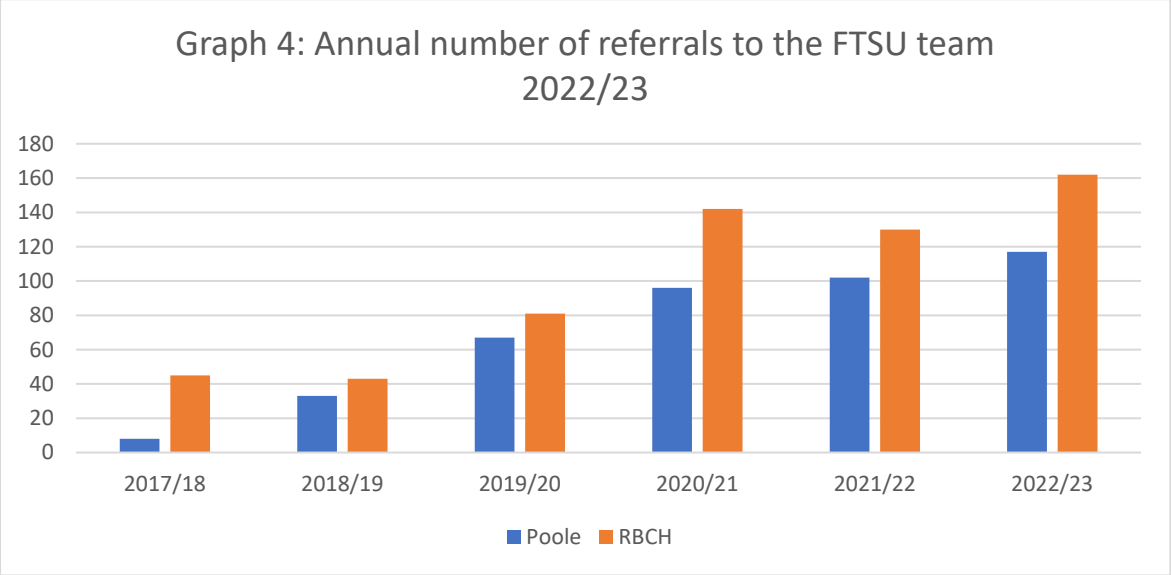
A range of data is collected by the FTSUG. This report will review the data including the key themes of concerns raised, where concerns have been raised and by whom. Referrals come from a number of routes including trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs, the UHD app and personal recommendation.

Graph 3 highlights the number of referrals received on a monthly basis to the FTSU team over 2022. Forty-nine per cent of referrals came from Poole site and fifty nine percent from Bournemouth and Christchurch. Referrals dipped during July but soon picked up again throughout August and peaked in October, a direct result from the activity in October reflecting the impact of Speaking up month.

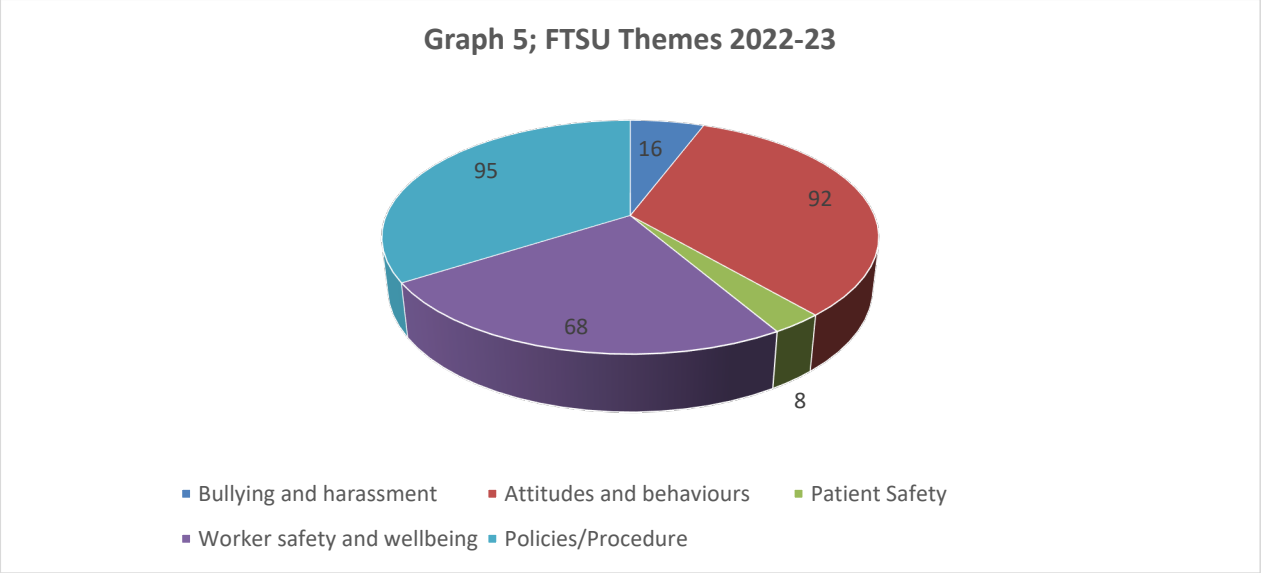


4.1 Key Themes of concerns

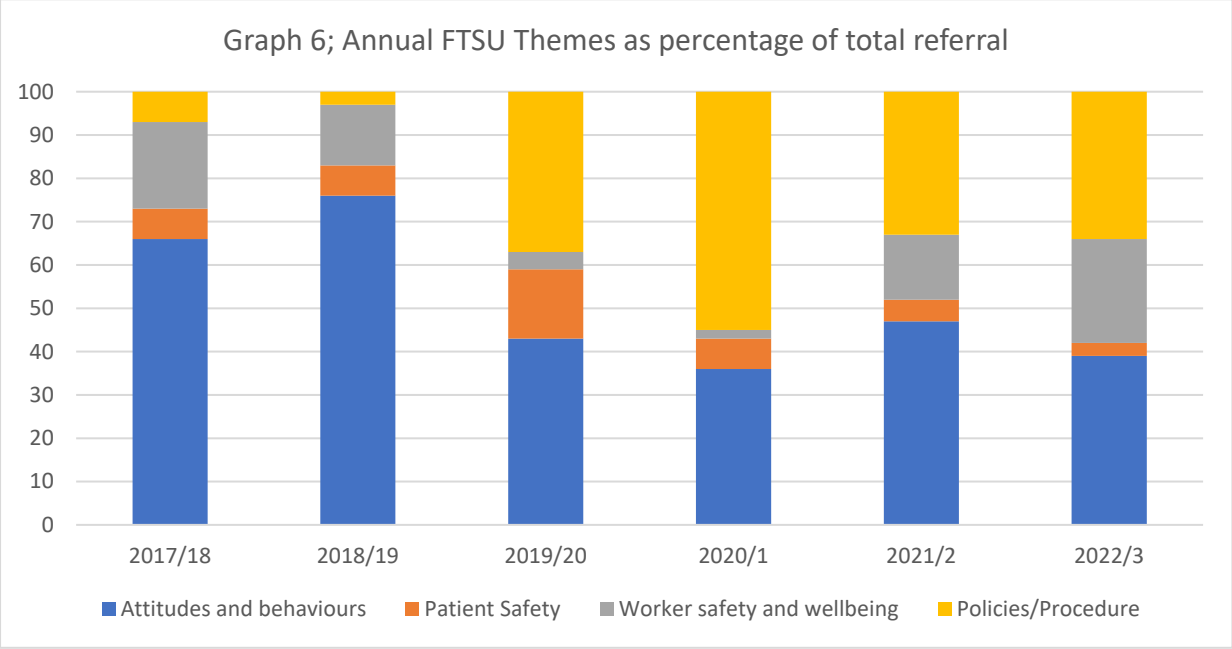
Graph 4 shows that the number of referrals to the FTSU team increased by 20% from 2021/22. Forty-two per cent of referrals come from staff at our Poole site and 58% from RBCH. Five per cent of referrals to the FTSU team were made anonymously which is the same as 2021/22 and continues to be lower than that seen nationally (10.4%; NGO annual report 2022).



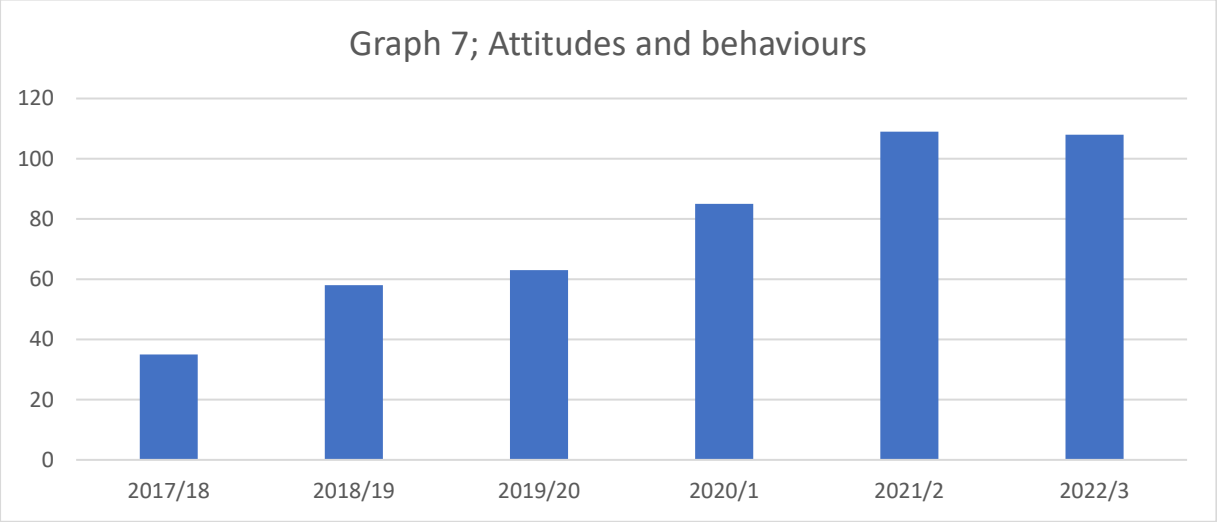
Staff approach the FTSU team for a number of reasons. Graph 5 illustrates the greatest theme had an element of behaviours (108 staff; 39%); of which 15% of those (16 staff) were raised as bullying and harassment. This is followed by process and procedures (95 staff; 34%) and then worker safety and wellbeing (68 staff; 24%). Only 3% of referrals were related to patient safety and may be a product of our strong LERN culture in capturing our patient safety issues.



The themes have varied since setting up the FTSU service, illustrated in graph 6, and looks at the percentage of theme as compared to the total number of referrals. What is interesting is growth of referrals to the FTSU service relating to worker safety and wellbeing such as burnout over the last 2 years which mirrors the national picture (see section 4.1.3). The number of referrals relating to attitudes has decreased from 2017 when the service was set up, however remains the greatest theme year on year.



4.1.1 Behaviours and Attitudes (incivility)



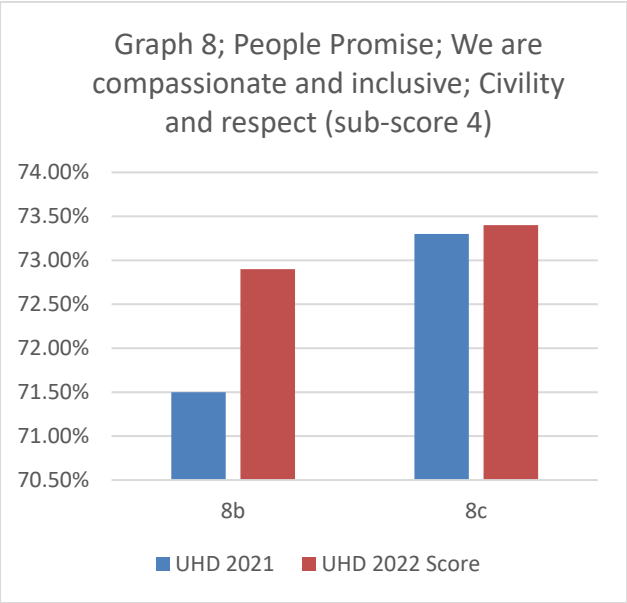
Attitudes and behaviours are a recurring theme that the FTSU team hear. This year there has been a significant increase in a number of referrals relating to longstanding complex behaviours. Intractable behaviours and lack of engagement particularly from our clinical workforce, has been increasingly cited by staff. All these cases are escalated but nonetheless are exceptionally difficult to resolve for all parties quickly. Other behaviours also difficult to address are more subtle ones including the tone we are spoken to or an abrupt email. In today's fast and stressful workplaces, where lots of us are juggling multiple challenges, our best self may not always be visible. Indeed, often they are the product to what we are holding. That said, it has its consequences, with many staff feeling undervalued or not important. It takes a brave member of staff to speak up to power and whilst we have a clear set of values and behaviours, for these to become truly embedded we need to encourage our staff to call these behaviours out and allow our seniors be vulnerable and humble to be challenged and see things through a different lens.

Having the infrastructure to manage these intractable behaviours will also need to be key to ensure support to some and to others whom choose not to follow our values, consequences applied. It will also give our people the confidence that there is a point to speaking up as we will listen and action. The way an organisation handles issues like these says a lot about the culture.

Case Studies. Concerns raised about coercive, undermining, hostile and nasty behaviours. Little clinical engagement and behaviours being learnt by more junior roles. Relationships are broken and it feels like warfare between nurses and Drs. "I have lost my love for my work".

A clinical disagreement occurred and despite numerous conversations hostile behaviours played out and guidelines attempted to be navigated around. When this was called out, "that is just x, they do it all the time when they do not get what they want"

A hostile email was written to a junior nonclinical member of the team who was trying to sort something out for them. The tone was direct and capital letters used to express their exasperation. They copied in a number of people, humiliating the individual. This individual was just back from sick leave due to stress and was again going home crying because of this email. When escalating to line manager they said, "just ignore it, they are having a bad day". When escalating further the manager was too busy to see them.



There are however some signs of green shoots as demonstrated in the results of this year's staff survey. Graphs 8 shows us improvements in the questions relating to civility and respect as compared to 2021.

People Promise; We are compassionate and inclusive; Civility and (sub-score 4)	
8b	% of staff reported that the people they work with are understanding and kind to one another (q8b)
8c	% of staff reported that the people they work with are polite and treat each other with respect (q8c)

4.1.2 Process and policy – compassionate and inclusive leadership

It is well documented that at times of significant change such as merger, operational re-structuring, healthcare structural changes or building work will increase workloads for FTSU teams and part of this is due to issues relating to process or procedure. (NHSE, 2022). Thirty-four per cent of referrals had an element of process and procedure. These issues range from requests for agile working, support of staff going through organisational change, assurances that recruitment is both fair with equal access, support through probation and access to study leave. Since October 2022, these issues have been broken down further into sub themes and represented in table 4. Forty-one per cent of referrals are relating to HR issues and how to navigate employment issues. All concerns are signposted to our experts such as HR and our union colleagues.

Table 4: Process and Procedure (Oct-end of March 23)	Poole	RBH	XCH	TOTAL
Organisation Change	2	6	1	**9**
Guideline/pathway (clinical)	1	4	1	**6**
HR related issues (regrading, re-deployment, HR policy)	9	14		**23**
Recruitment and selection	1	1	1	**3**
Parking	1	2		**3**
Education/training	1	2		**3**
Non-clinical guideline/pathway	2	6		**8**
Health and Safety	1			**1**
TOTAL	**18**	**35**	**3**	**56**

A number of these issues often arise from a conversation or miscommunication. When asking staff as to why they are choosing to raise concerns to the FTSU team rather than their line manager, 58% stated that their line manager was the issue of the concern or knew about the issue but not addressing it. A further 12% said it was that they felt insecure in raising this issue. The gift of change lies predominantly with our line managers and clearly in most cases a resolution needs to happen with them. In other cases, it has been signposting them to the experts such as HR or our unions.

It is well documented about the importance of delivering compassionate and inclusive leadership. It is encouraged that our leaders, listen to our teams (with fascination), acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change (Michael West). Delivering compassionate leadership and care requires investment in time, in skill and an appreciation of the benefits for our people and ultimately the care we give to our patients. Compassion needs to meet people's needs for belonging and develop and sustain trust for psychological safety

Case Studies: A number of staff approached the FTSUG with complaints following the commencement of a re-structure. The issue was not always relating to the process itself (indeed that was well understood) but it was more relating to the perceived lack of care, support and empathy of those managing the process to those staff. "I feel that they do not care about me or want me". It is essential that we have the processes in place to share our integration successes and failures so that we do not fall into the same traps.

A request to better balance their home and work life was submitted but not supported. They felt that the area was not willing to try a new work pattern and have since decided to leave the Trust due to "the archaic" working patterns that are in place

4.1.3 Worker safety and wellbeing

This theme related to any cases with an element that may indicate a risk of adverse impact on worker safety or wellbeing. This can include issues such as lone working arrangements, insufficient access to equipment and stress at work. Twenty-four per cent who accessed the FTSU team described this theme and predominantly as a result of excessive workload. Burnout is a commonly used term and is used to describe a form of exhaustion caused by constantly feeling overwhelmed,

emotionally drained and unable to keep up with demands. A deep level of hopelessness often accompanies these referrals and whilst our input to wellbeing continues and access to psychological and counselling services, until we address the triggers of burnout, we will continue to have a workforce suspectable to burnout.

Case Studies. A leader wept to the FTSUG about what they were seeing to staff, uncomfortable decisions having to be made and knowing that the alternative is staff leaving. They felt a deep level of hopelessness and no light at the end of the tunnel.

A staff member met the FTSUG as part of their exit. They were leaving as it was exhausting to have any decision made. Changes in the structure has made a simple decision more difficult with a 4 fold increase of those needed to be cited before the decision is made. A loss of autonomy and being able to use the skills they had made them feel unappreciated, untrusted, frustrated and exhausted.

A member of staff wept regarding the care, pressures and deep levels of hopelessness over the Christmas. They felt so guilty that they left their small family on Boxing Day to come back to work, to work on the wards. "I have never experienced this stress and pressure before and watching the pain from my colleagues is unbearable"

4.2 Outcome of referrals

Table 5 illustrates the outcome of referrals once they were made to the FTSU team. Of those referrals 42% of cases were escalated to the line manager to investigate and action. In 33% of cases, the member of staff was signposted to experts in the field of the concern such as HR, OH, or other including infection control, risk and governance or our networks. Nine per cent of cases were escalated to director or executive level which is similar to last year (8%). These issues would be deemed as needing senior leadership/direction or immediate action.

Table 5: Outcome of referrals received by FTSU team

2022/23		Poole	RBCH	Total UHD
Line manager		56	62	**118**
FTSU advice		13	31	**44**
Escalate to Chief/Director		11	14	**25**
Signpost	HR	17	25	**42**
	OH	3	1	**4**
	Other	17	29	**46**
TOTAL		**117**	**162**	**279**

4.3 Who are raising concerns?

Table 6: Staff who are raising concerns to the FTSU team

2022/23	Poole	RBCH	Total UHD
Additional Clinical services*	15	8	23
Additional Professional#	3	11	14
Admin and clerical	31	39	70
AHP	10	8	18
Estates and Ancillary	2	8	10
Healthcare scientists	0	0	0
Medical and Dental	9	15	24
Nursing/Midwife	41	62	103
Students	0	1	1
Other	0	1	1
Anon	6	9	15
TOTAL	**117**	**162**	**279**
BAME	12	38	50

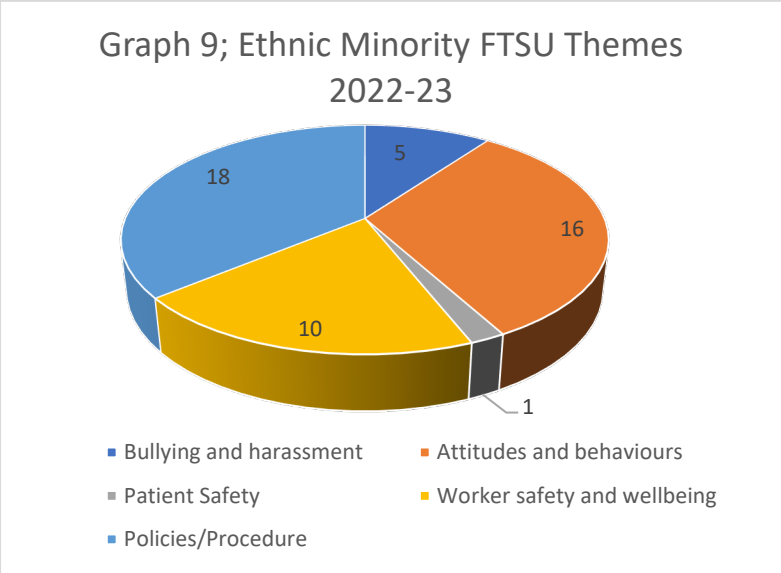
*Additional clinical services includes staff directly supporting those in clinical roles such as HCAs, AHP support workers. They have a significant patient contact as part of their role.
#Additional professional scientific and technical include scientific staff including pharmacists, psychologists, social workers

Table 6 shows that our shows nurses accounted for the biggest portion (37%) of speaking up cases raised with FTSU team, followed by our administrative staff (25%) and medical workforce (8%). Special attention was made this year to engage with our medical workforce through our increased presence at junior doctor meetings, jointly presenting with our BMA team, presenting at our core induction and working with Acting Chief Medical Officer, Guardian of working times and lead Medical Educator.

Fifteen staff felt necessary to remain anonymous, of which 9 were for staff across RBCH site. This figure remains lower than the national figure of 10.4% (NGO annual report, 2022).

Another area of the workforce that needs focus is that within minority groups of the organisation. The Francis Freedom to Speak Up reviews highlighted that ethnic minority staff, including ethnic minority workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews, also showed that minority staff groups are more likely to suffer detriment for having spoken up. The National Guardian Office (NGO) case reviews at Southport and Ormskirk Hospital NHS Trust highlighted the importance for every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.

Eighteen per cent of staff (50 staff) raised a concern from an ethnic minority background. All staff were signposted to our BAME networks who were also able to support and advise. The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee and will continue to work together to improve and support our ethnic minority employee experience.



Data from graph 9 show similar themes from our ethnic minority communities when using the FTSU route. Concerns with elements of behaviour is the greatest theme (42%; 21 staff), followed by 20% relating to worker wellbeing and 36% (18 staff) with policy or procedure.

4.4 Where are concerns being raised?

Significant effort has been made to ensure that the FTSU team visit and meet all members of staff across each site and the ambassador model allow for this. Table 7 outlines the concerns raised across our care group structure. The FTSUG monitors this closely so to ensure that all areas are aware of the FTSU service and how to access it.

Table 7: The number of concerns raised in UHD

2022-23					23f
Care Group	**Directorate**	**PHT**	**RBCH**	**Total**	
Medical (69)	Emergency and Urgent	0	6	**6**	37.9%
	Acute and Ambulatory Medicine	2	7	**9**	47.4%
	Cardiology and Renal	0	4	**4**	43.2%
	Medical specialities	5	16	**21**	46.6%
	Older Persons and Neurosciences	7	22	**29**	48.1%
Surgical (41)	Surgery	2	6	**8**	37.9%
	Anaesthetics	15	6	**21**	39.3%
	Head and Neck	3	2	**5**	44.1%
	Trauma and Orthopaedics	4	2	**6**	50%
	Private	0	1	**1**	
Specialties (68)	Cancer Care	5	5	**10**	53.3%
	Child Health	2	0	**2**	50.4%
	Women's Health	13	1	**14**	51%
	Radiology and Pharmacy	9	15	**24**	43.9%
	Clinical Support	6	11	**17**	50.1%
	Pathology	1	0	**1**	39.6%
Operations (15)	Clinical Site	3	1	4	43.2%
	Facilities	2	9	**11**	45.5.%
	Partnership, integration and discharge	0	0	0	
	Emergency Planning	0	0	0	
	Operational Performance	0	0	0	50%
Corporate (71)		32	39	**71**	
Anon (15)		6	9	**15**	
TOTAL		**117**	**162**	**279**	

Interesting questions can be posed, and future work can be planned when triangulating the data from table 7 looking at the numbers of staff using FTSU route and the speaking up question, 23f on the staff survey which is highly regarded to reflect a speaking up culture. Of particular concern are those staff whom are not using the FTSU route and have low confidence in raising concerns such as emergency, cardiology, surgery, pathology and clinical site. Further evaluation and future FTSU focus will be key in these areas for 2023.

5.0 Learning and reflections

Whilst each referral will have its own learning, themes can be drawn to help develop and embed into the culture at UHD. The following points are the learning and reflections of the FTSU team based on the information presented today:

- Develop a civil and respectful culture – being mindful of how we speak/our tone to our colleagues or how we write emails can make our staff feel both un-important and undervalued.
- Invest time at the beginning of any re-structure or organisational change to explain the process and ensure their wellbeing is in the forefront of our minds with access to support if needed.
- Share team re-structures challenges and tips for those who have still to embark on this journey
- Challenge the working patterns we offer; staff are leaving because they are too rigid
- Improve clinical engagement and behaviours.
- Promote our leaders to attend Compassionate and Inclusive leadership programmes and People Management modules
- Encourage our leaders to complete HEE/NGO Speak up, listen up and follow up modules on BEAT
- Upskill our leaders on how to create psychological safe working environments to speaking up
- Develop a racial statement with a strong infrastructure to address these issues if they arise.
- Contribute, embrace and be involved in our Patient first programme. Patient First will help us all by improving the way we work. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients. Speaking up is integral to this work and we look forward to supporting this moving forward.

6.0 Summary and Next Steps

University Hospitals Dorset's values aspire to having an open and honest culture. Speaking up has never been as important as it is today and yet our staff are telling us that we do not address concerns nor make people feel safe to raise them. Speaking up takes courage and therefore deserves the time to listen and address them. It is everyone's business to encourage speaking up. We are #TeamUHD and collectively we need to Speak Up, Listen Up and Follow Up so to continually improve our culture of safety.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 10.2.2

Subject:	Freedom to Speak Up Policy for the NHS
Prepared by:	Helen Martin, Freedom to Speak Up Guardian
Presented by:	Helen Martin

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☒ Use resources efficiently ☐ Be a well led and effective partner ☒ Transform and improve ☒
BAF/Corporate Risk Register: (if applicable)	BAF/ not applicable
Purpose of paper:	Decision/Approval
Executive Summary:	The Freedom to Speak Up policy has been developed following the publication of NHS England national template. Local information has been added (including those set out within our document control policy) onto the national minimum standard and needs to be adopted in this format by January 2024.
Background:	NHS England published an updated national Freedom to Speak Up policy to be adopted by all Trusts by January 2024. The policy provides a minimum standard with space to add local information. It is designed to help organisations deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement.
Key Recommendations:	To consider and if thought fit approve the Freedom to Speak Policy.
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 ☐ Speaking up is everyone's business and this policy will be subjected to a comprehensive communications campaign to remind our staff hoe to speak up and what will happen when they do so.
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	09/05/2023	Trust Management Group endorsed the policy
People and Culture Committee	02/02/2023	Committee endorsed the policy subject to an amendment in relation to responsibility for financial conduct

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

Freedom to Speak Up policy for the NHS

May 2023

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

Out of date policy documents must not be relied upon.

A) EXECUTIVE SUMMARY POINTS
This policy aims to improve the experience of raising concerns at University Hospitals Dorset Foundation NHS Trust
This policy outlines why speaking up is important and gives examples of the concerns you can raise
This policy outlines the process on how staff raise concerns and how this can be done confidentially.
This policy describes the local escalation process for raising concerns

B) ASSOCIATED DOCUMENTS

- Civility, Respect and Dignity at Work Policy
- Managing disciplinary Policy
- Managing Performance Policy
- Managing Grievances Policy
- Fraud, bribery and corruption policy

C) DOCUMENT DETAILS	
Author:	Helen Martin
Job title:	Freedom to Speak Up Guardian (FTSUG)
Directorate:	Corporate
Version no:	1
Equality impact assessment	12.12.22
Target audience:	Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.
Approving committee:	Trust Board of Directors
Chairperson:	Chair of Board
Review Date:	May 2024

D) VERSION CONTROL

Date of Issue	Vers No.	Date of Review	Nature of Change	Approve Date	Approval Committee	Author

E) CONSULTATION PROCESS

Version No.	Review Date	Author	Level of Consultation
1	8th February 2023	Helen Martin	People and Culture Committee

Contents

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Speak up – we will listen

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos

This policy

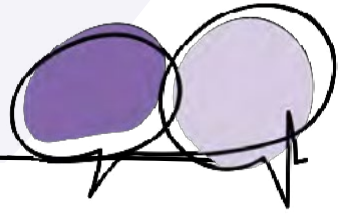
All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients. **Speaking up is about all these things.**

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes. For example, this may include referring to the existing suite of Employee Relations Policies such as Civility, Respect and Dignity at Work, Managing Disciplinary Policy, Managing Grievances Policy and Managing Performance Policy. Alternatively, if the concern relates to a financial misconduct, bribery or corruption, this will be better suited using our Fraud, Bribery and Corruption Policy or by making a referral to our local counter fraud team.

That's fine. At University Hospitals Dorset (UHD), we will listen and work with you to identify the most appropriate way of responding to the issue you raise.



We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about. We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

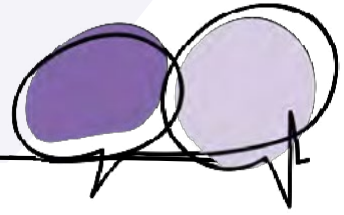
Who can I speak up to?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you.

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.
- The patient safety team or clinical governance team, via a LERN form, where concerns relate to patient safety or wider quality.
- Local counter fraud team when you have a suspicion of fraud. This includes all concerns relating to financial misconduct, bribery and corruption. We encourage anyone who has reasonable suspicions of fraud to report it, including all employees, patients, agents, trading partners, stakeholders and contractors. Please refer to our Fraud, Bribery and Corruption Policy on the intranet or contact our local counter fraud team on:
    - Tony Hall. Tony.hall@nhs.net or 07580 971240
    - Kim Hampson. Kim.hampson@nhs.net or 07881 840869
    - Central NHS fraud and corruption hotline. https://cfa.nhs.uk/reportfraud or 0800 028 4060



Alternatively you may wish to speak to our non-executive director who has the responsibility for financial conduct, Mr Stephen Mount on Stephen.mount@uhd.nhs.uk

- Our Freedom to Speak Up (FTSU) Team. At UHD, our FTSU Guardian (FTSUG) is Helen Martin who can be contacted by emailing freedomtospeakup@uhd.nhs.uk or leaving a message on 0300 019 4220 (accessed only by FTSU team) or via UHD app. The FTSU team can support you to speak up if you feel unable to do so by other routes. The FTSUG will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here.
- Our HR team who can be contacted on via the HR intranet site or
    - HR RBCH site – 0300 019 4252
    - HR Poole site - 0300 019 4221
- Our executive lead responsible for Freedom to Speak Up and Chief Executive is Siobhan Harrington who can be contacted on Siobhan.Harrington@uhd.nhs.uk or 0300 019 4242. She will provide senior support for our speaking-up guardian and is responsible for reviewing the effectiveness of our FTSU arrangements.
- Our non-executive director responsible for Freedom to Speak Up is Mr Pankaj Dave who can be contacted on Pankaj.Dave@uhd.nhs.uk]. This role is specific to organisations with boards and can provides more independent support for the guardian; provide a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed.

Speaking up externally

If you do not want to speak up to someone within UHD, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about:
  - GP surgeries
  - dental practices
  - optometrists
  - pharmacies
  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
  - NHS procurement and patient choice
  - the national tariff.

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

- NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a 'protected disclosure'.

How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

Advice and support

You can find out about the support available to you at UHD here. Your local staff networks can also be a valuable source of support.

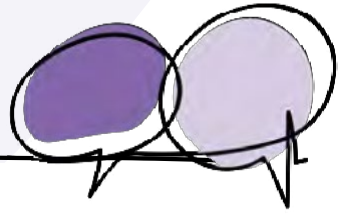
You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Law Society may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.



What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix B.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

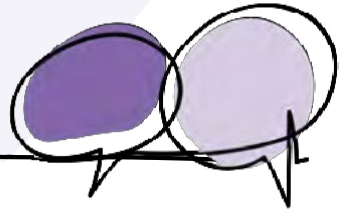
We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).



Appendix A:
What will happen when I speak up?

We will:

Thank you for speaking up

- Help you identify the options for resolution
- Signpost you to health and wellbeing support
- Confirm what information you have provided consent to share
- Support you with any further next steps and keep in touch with you

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

- Referral to HR process
- Referral to patient safety process
- Other type of appropriate investigation, mediation, etc

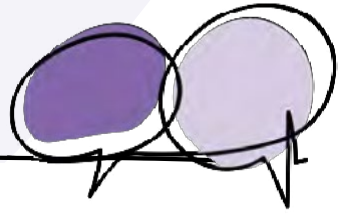
Outcomes:

The outcomes will be shared with you wherever possible, along with learning and improvement identified

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU (if you are in an NHS trust)

- Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England

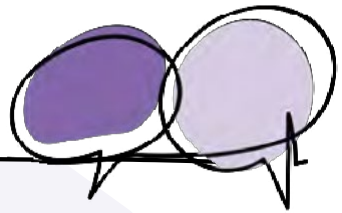


Appendix B:
Making a protected disclosure

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from the Protect or a legal representative.

Appendix C: Equality Impact Assessment

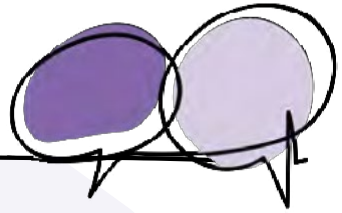


1. Title of document	**Freedom to Speak Up policy for the NHS**
2. Date of EIA	12.12.22
4. Directorate/Specialty	People Directorate, Organisational Development

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

	Yes/No	Rationale
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	No	The policy applies to all staff working for the trust
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	No	The Trust will consider the impact making adjustments if the process deemed helpful e.g. meeting room for conversation. The policy can be in braille or larger print if needed
• Gender reassignment – the process of transitioning from one gender to another.	No	The policy applies to all staff working for the trust
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	No	The policy applies to all staff working for the trust
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.	No	The policy applies to all staff working for the trust
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	No	The policy applies to all staff working for the trust. The policy can be made available in an alternative language

Appendix C: Equality Impact Assessment



• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	No	The policy applies to all staff working for the trust. When arranging conversations, the team will be mindful of religious holidays/events.
• Sex – a man or a woman.	No	The policy applies to all staff working for the trust
• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	No	The policy applies to all staff working for the trust
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	
8. If the answers to any of the above questions is 'yes' then:		**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.	N/A	
Adjust the policy to remove disadvantage identified or better promote equality.	N/A	

Monitoring compliance and Effectiveness of the Document

To ensure robust governance and effective management of risks, this document will be monitored of compliance annually by the People and Culture Committee. This will include quarterly reports from the FTSUG and any internal audits. The audit will be undertaken against an agreed pro forma and any external guidance.

Dissemination

The approved policy will form part of a regular communications campaign by the FTSUG and will be available on the intranet and internet.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 10.3

Subject:	Annual Certificate – Training of Governors
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance and Sarah Locke, Deputy Company Secretary
Presented by:	Rob Whiteman, Trust Chair

Strategic Objectives that this item supports/impacts:	Continually improve quality ☐ Be a great place to work ☐ Use resources efficiently ☐ Be a well led and effective partner ☒ Transform and improve ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The annual self-certification process is to provide assurance that NHS providers are compliant with the conditions of their NHS provider licence. While recognising changes in the requirements since 1 April 2023, for the period from 1 April 2022 to 31 March 2023, a requirement was in place for foundation trusts to review whether Governors had received the necessary training to ensure they are equipped with the skills and knowledge to undertake their role.
Background:	Training provided to Governors during the relevant period has included: • An overview of ongoing transformation activity within the Trust (particularly in relation to emergency/planned care and service changes) was presented at the Board/Council of Governors Development Session in July 2022. • A presentation was given at the October 2022 Informal Governors Briefing on the Governors role within the Integrated Care System (ICS) by Jenni Douglas-Todd, Chair of NHS Dorset. • In January 2023, new and existing Governors were provided with a training session including a regulatory and governance overview and overview of the Trust's engagement with patients. • At the February 2023 Board/Council of Governors Development Session, a briefing was provided on Patient First.

	• In March 2023 the Communications Officer provided Social Media training. As part of the Council of Governors Assessment of Collective Performance in January 2023, Governors were surveyed including in relation to whether they were equipped with the tools, skills and knowledge they require to perform their role. Some respondents considered that further training would be beneficial; feedback was also received that not all Governors had made use of the development opportunities available to them. For the coming year, the format of the Informal Governor Briefing sessions is being reviewed to incorporate further Governor development opportunities. There will continue to be Board/Council of Governor joint development sessions, which have been successful.
Key Recommendations:	The Board is asked to consider and if thought fit approve the attached draft certification. Following approval by the Board, the self-certification will be signed by the Trust Chair and Chief Executive Officer and published on the Trust's website.
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**
N/A	N/A	N/A

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 10.4

Subject:	Terms of Reference and Committee Membership
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Strategic Objectives that this item supports/impacts:	Continually improve quality ☒ Be a great place to work ☒ Use resources efficiently ☒ Be a well led and effective partner ☒ Transform and improve ☒
BAF/Corporate Risk Register: (if applicable)	All
Purpose of paper:	Decision/Approval
Executive Summary:	Following two additional Non-Executive Directors having joined the Trust in April 2023 and two further Non-Executive Directors being appointed with effect from 1 October 2023, the Board is asked to consider and if thought fit approve: • **Audit Committee –** Judy Gillow becoming a member of the Audit Committee with immediate effect; and with effect from 1 October 2023 becoming Chair of the Audit Committee. • **Finance and Performance Committee –** amending the Terms of Reference of the Finance and Performance Committee with immediate effect to provide for membership of the Committee to be increased from three to four Non-Executive Directors; and Sharath Ranjan becoming a member of the Finance and Performance Committee with immediate effect. John Lelliott becoming Chair of the Finance and Performance Committee from 1 October 2023. • **People and Culture Committee -** amending the Terms of Reference of the People and Culture Committee with immediate effect to provide for membership of the Committee to be increased from three to four Non-Executive Directors; and Sharath Ranjan becoming a member of the People and Culture Committee with immediate

	effect, with Judy Gillow becoming a member from 1 October 2023. • **Population Health and System Committee** – Sharath Ranjan becoming a member of the Population Health and System Committee with immediate effect • **Quality Committee –** amending the Terms of Reference of the Quality Committee with immediate effect to provide for membership of the Committee to be increased from three to four Non-Executive Directors; and Judy Gillow becoming a member of the Quality Committee with immediate effect.
Background:	Pursuant to section 6.3 of Annex 7 (Standing Orders for the Practice and Procedure of the Board of Directors) to the Trust's Constitution, the Board may appoint Committees of the Board consisting of the Trust Chair and Directors of the Trust. The Trust is to determine the membership and terms of reference of such Committees. Pursuant to section 6.7 of such Annex, the Board is to approve the appointments to the Committees that it has formally constituted.
Key Recommendations:	To review and if thought fit approve the amendments to the Terms of Reference and appointments to the Board Committees set out above.
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
N/A	N/A	N/A

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 24 May 2023

Agenda item: 11.1

Subject:	Seal of Documents Register
Prepared by:	Ewan Gauvin, Corporate Governance Manager
Presented by:	Yasmin Dossabhoy, Associate Director of Corporate Governance

Strategic Objectives that this item supports/impacts:	Continually improve quality Be a great place to work Use resources efficiently Be a well led and effective partner Transform and improve	☐ ☐ ☒ ☒ ☐
BAF/Corporate Risk Register: (if applicable)	N/A	
Purpose of paper:	Information	
Executive Summary:	This report contains the register of use of the Trust's seal during 2022-23. During the period, the seal was used on six occasions.	
Background:	The Trust Constitution provides that "an entry of every sealing shall be made and numbered consecutively by the Company Secretary. A report of all sealing shall be made to the Board of Directors annually."	
Key Recommendations:	For information only.	
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
N/A	N/A	N/A

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

University Hospitals Dorset NHS Foundation Trust
Register of Use of Seal – 1 April 2022 to 31 March 2023

	Company	Transaction	Authorised By	Witnessed By	Date
16	Ageas Insurance Limited	Deed of Easement for Construction Works, Access and Drainage relating to land at Deansleigh Road, Bournemouth	Siobhan Harrington, Chief Executive	Pete Papworth, Chief Finance Officer	23 June 2022
17	Southern Electric Power Distribution PLC	Lease – supply connection relating to land at Royal Bournemouth General Hospital, Castle Lane East, Bournemouth	Pete Papworth, Chief Finance Officer	Karen Allman, Chief People Officer	8 November 2022
18	Tops Day Nursery Limited	Lease of Tops Nursery forming part of the Royal Bournemouth Hospital	Pete Papworth, Chief Finance Officer	Karen Allman, Chief People Officer	8 November 2022
19	Amiri Construction Limited	New Pathology Building Deed	Pete Papworth, Chief Finance Officer	Karen Allman, Chief People Officer	15 November 2022
20	Boots UK Limited	Lease for Ground Floor Pharmacy Unit at the Royal Bournemouth Hospital	Karen Allman, Chief People Officer	Paula Shobbrook, Chief Nursing Officer	19 December 2022
21	Boots UK Limited	Licence for alterations (retrospective) relating to Ground Floor Pharmacy at the Royal Bournemouth Hospital	Karen Allman, Chief People Officer	Paula Shobbrook, Chief Nursing Officer	19 December 2022